AGENDA FOR

HEALTH AND WELLBEING BOARD

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To: All Members of Health and Wellbeing Board

Members : J. Gonda, S. North, L. Jones, B. Barlow, Councillor R. Walker, Councillor S. Briggs, Councillor R. Shori, J. Aspinall, K. Dolton, S. Taylor, Councillor A. Simpson (Chair), S. Hashmi, Dr J. Schryer, M. Russell and D. Lythgoe

Dear Member/Colleague

Health and Wellbeing Board

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

Date:	Wednesday, 13 June 2018
Place:	Meeting Rooms A&B Bury Town Hall
Time:	6.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

Members of the Health and Wellbeing Board are asked to consider whether they have an interest in any of the matters on the Agenda, and if so, to formally declare that interest.

3 MATTERS ARISING *(Pages 1 - 4)*

Forward plan is attached.

4 MINUTES OF PREVIOUS MEETING *(Pages 5 - 10)*

Minutes of the meeting held on the 28th March are attached.

5 PUBLIC QUESTION TIME

Questions are invited from members of the public present at the meeting on any matters for which the Board is responsible.

Approximately 30 minutes will be set aside for Public Question Time, if required.

6 UPDATE FROM THE PENNINE ACUTE NHS TRUST

Steve Taylor, Pennine Acute NHS Trust will report at the meeting.

7 GREATER MANCHESTER POPULATION HEALTH OUTCOMES FRAMEWORK AND DASHBOARD *(Pages 11 - 74)*

Jon Hobday, Public Health Consultant will report at the meeting. Reports Attached.

8 UPDATE FROM THE TRANSFORMATION BOARD *(Pages 75 - 80)*

Dr Jeff Schryer, Chair Bury Clinical Commissioning Group will report at the meeting. Report attached.

9 SPECIAL EDUCATION NEEDS AND DISABILITIES (SEND) UPDATE *(Pages 81 - 84)*

Karen Dolton, Interim Executive Director Children and Families will report at the meeting. Report attached.

10 BURY CLINICAL COMMISSIONING GROUP ANNUAL REPORT *(Pages 85 - 192)*

Stuart North, Chief Operating Officer, Bury CCG will report at the meeting. Annual Report attached.

11 BURY PSR HUB UPDATE

Mike Russell, Chief Inspector, Partnerships will provide members with a verbal update at the meeting.

12 JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE *(Pages 193 - 196)*

Jon Hobday, Public Health Consultant will report at the meeting. Report attached.

13 DEVOLUTION UPDATE

Stuart North, Chief Operating Officer Bury CCG will provide a verbal update at the meeting.

14 URGENT BUSINESS

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Board Date	Agenda Items
13th June 2018 18:00-20:00	• Devolution update – Stuart North
	• JSNA Update – Jon Hobday
	• GM Population Health Outcomes Framework and Dashboard – Mark Brown, Programme Managers, Greater Manchester Health & Social Care Partners
	• Update report from the Transformation Board (recent activity, update on transformation programmes and funding – Helen Smith/Philip Thomas
	• Update SEND – Karen Dolton
	• Bury PSR Hub Update – Mike Russell, GMP
	• CCG Annual Report
	• Update from the Pennine Acute NHS Trust
	Mins of Health & Wellbeing Board Sub Groups • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)

Board Date	Agenda Items
19th July 2018 18:00-20:00	• Public Health Annual Report – provisional, TBC by Lesley Jones / Jon Hobday
	• JSNA Annual Update – Jon Hobday - provisional
	• Healthy Schools – Lesley Jones
	• Health, Social Care and Wellbeing Governance in Bury – Margaret O'Dwyer / Jayne Hammond
	• IPC Policy
	• Adult Social Care Transformation Update – Julie Gonda

	Mins of Health & Wellbeing Board Sub Groups • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)
Board Date	**Agenda Items**
27th Sept 2018 18:00-20:00	• Safeguarding Adults Annual Report – provisional
	• Safeguarding Children's Annual Report - provisional
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	Mins of Health & Wellbeing Board Sub Groups • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)
Board Date	**Agenda Items**
21st Nov 2018	•
	•
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18:00-20:00	•
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	Mins of Health & Wellbeing Board Sub Groups • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)
Board Date	**Agenda Items**
12th Feb 2019 18:00-20:00	•
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	Mins of Health & Wellbeing Board Sub Groups • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)
Board Date	**Agenda Items**
21st Mar	•

2019 18:00- 20:00	•
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	•
	•
	<u>Mins of Health & Wellbeing Board Sub Groups</u> • Children's Safeguarding Board Minutes - (Priority 1) • Children's Trust Board Minutes (Priority 1) • Bury Integrated Health and Social Care Board Minutes (Priority 2, 3 & 4) • Adults Safeguarding Board Minutes (Priority 4) • Carbon Reduction Board Minutes (Priority 5) • Housing Strategy Programme Board Minutes (Priority 5)

Other issues – as per e-mail Chris Woodhouse sent on Friday 18/05/18

Future items

- Need a cross-reference with Health Scrutiny as to what are they looking to consider and will it have been considered by HWB previously?
- More focused piece on Commissioning – considering local Strategic Commissioning Function and GM Commissioning Hub?
- Role of HWB in promoting public health and other health related campaigns.

Minutes of:	**HEALTH AND WELLBEING BOARD**
Date of Meeting:	Wednesday 28th March 2018
Present:	Cabinet Member Health and Wellbeing Andrea Simpson (Chair); Councillor Roy Walker, Opposition Member, Health and Wellbeing; Representing the voluntary sector Sajid Hashmi; Healthwatch Chair, Barbara Barlow; Director of Public Health, Lesley Jones; Interim Executive Director Communities and Wellbeing, Julie Gonda; Cabinet Member for Children and Families, Councillor Sharon Briggs; Stuart North; Chief Operating Officer, Bury Clinical Commissioning Group; Steve Taylor; Pennine Acute NHS Trust
Also in attendance:	Marcus Connor, Head of Corporate Policy Jackie Waite, Strategic Policy and Planning Officer Warren Heppolette, Executive Lead, Strategy & System Development Ann Whittington, Public Health Register Lorraine Chamberlin, Head of Health & Environmental Protection Julie Gallagher – Democratic Services
Apologies:	Leader of the Council, Councillor Rishi Shori Interim Director of Children's Services, Karen Dolton Keith Walker; Pennine Care NHS Foundation Trust Jon Aspinall (GMFRS)
Public attendance:	2 members of the public were in attendance

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HWB.446 DECLARATIONS OF INTEREST

Councillor A Simpson declared a personal interest in respect of all items to be considered due to her appointment as Lord Peter Smith assistant at the Greater Manchester Health and Social Care Partnership Board.

HWB. 447 MINUTES OF PREVIOUS MEETING

It was agreed:

The minutes of the meeting held on the 14th February 2018 be approved as a correct record.

HWB.448 MATTERS ARISING

The Principal Democratic Service Officer reported that a letter will be drafted in respect of item HWB.385 Asylum Matters to the Greater Manchester Health and Social Care Partnership Board.

HWB.449 PUBLIC QUESTION TIME

There were no questions from members of the public present at the meeting.

HWB. 450 AUTISM STRATEGY

That The Strategic Policy and Planning Officer report that an updated Bury adult autism strategy has been produced in conjunction with the Autism Get Together Group and The Autism Services Development Group.

This updated strategy will ensure that initial groundwork undertaken will be extended to ensure adults with autism in Bury are able to live, study, work and enjoy Bury in the same way as everyone else.

Key priorities for the new strategy will include

1. Enabling people with autism to really be included as part of the community.

2. To promote innovative local ideas, services or projects particularly for lower level support.

Work has already started and includes, Autism Friendly Bury and Autism Get Together and a focus on how advice and information services can be more joined up.

Those present were invited to ask questions and the following issues were raised:

Responding to a Member's question, the Strategic Policy and Planning Officer reported that each Local Authority and CCG pay into a central Greater Manchester fund as part of a long standing agreement. This money is used to assist within the priorities as identified in the Strategy.

The Strategic Policy and Planning Officer reported that she has developed an Autism e-learning module, the module can be shared with the voluntary sector for their use and has already been used by the Job Centre and One Recovery.

In response to a Member's question, the Strategic Policy and Planning Officer reported that work is underway to support the existing established Autism Charities, in particular the charities that offer "buddies" support and assist with social isolation.

It was agreed:

The Strategic Policy and Planning Officer be thanked for her attendance.

HWB.451 HEALTH PROTECTION ANNUAL REPORT

Lorraine Chamberlin Head of Health and Environmental Protection
A Whittington, Public Health Register attended the meeting to provide members with an overview of the health protection annual report.

The Head of Health and Environmental Protection reported that this is the first Health and Environmental Protection Annual Report for Bury and aims to provide a means of assurance for the Council in relation to its Health and Environmental Protection Duties. The report covers work being undertaken to safeguard the people of Bury from the hazards presented by communicable diseases and the environment.

Recommendations for action:

- Bury has not yet achieved the cervical screening 80% uptake target. We will continue to work with PHE and Bury CCG to increase uptake.
- We need to develop a better understanding of our local TB prevalence and ensure prevention and treatment are optimised.
- There have been issues with data collection for HIV diagnosis in women and this needs further exploration.
- Environmental quality issues around fly tipping, accumulations and nuisance continue to dominate the reactive workload and a new Environmental Quality strategy is to be implemented.
- Food hygiene inspections are increasingly being carried out by consultants as a result of job cuts within environmental health - there was a drop in total interventions in 2016 which has come to the attention of the Food Standards Agency for monitoring in 2017/18. We will continue to monitor and manage the situation as effectively as possible within available resources.

Those present were invited to ask questions and the following issues were raised:

Members discussed the use of outside consultants, to conduct food hygiene inspections. The Head of Health & Environmental Protection reported that the Food Standards Agency is currently reviewing how hygiene ratings are undertaken. It is envisaged that the new system will expect a greater focus on the business owner and a more targeted approach to high risk business. The use of consultants is common practice across Greater Manchester and the consultants would only be used to inspect the low risk premises.

Responding to a question from the Chair, The Head of Health & Environmental Protection reported that the priority with regards to infection and prevention control audits has been Care Home with a view to inspect GP surgeries at a later date. If problems arise with failure to comply within a Care Homes, staff would work with partner agencies including the Care Quality Commission, Infection Control Nurses, Commissioning staff and environmental health enforcement officers to address the issues raised.

Bury CCG's Chief Operating Officer reported that the infection control rates are in the top 15% within Greater Manchester. The Pennine Acute Trust

representative reported that there were no reports of MRSA within the Trust and flu vaccinations update rates were one of the best in the northwest.

It was agreed:

The Head of Health and Environmental Protection and the Public Health Register be thanked for their attendance.

HWB.452 GREATER MANCHESTER EARLY HELP MODEL

It was agreed:

The Greater Manchester Early Help Model would be deferred for consideration till the next meeting of the Health and Wellbeing Board

HWB.453 GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP UPDATE

Warren Heppolette, the Executive Lead, Strategy & System Development Greater Manchester attended the meeting to provide an update on the work at the Greater Manchester Health and Social Care Partnership Board. The presentation contained information with regards to: `

- Devolution timeline
- Transformation themes
- Improving the health of Bury/GM Residents
- Transforming community based care
- Local Care Organisations
- Enabling Better Care

The Executive Lead, Strategy & System Development acknowledged that there still remains a number of challenges in respect of the Devolution agenda; including the pace and scale of transformation whilst delivering services in a complex environment (operational and financial challenges). The development of locality models will be vital to delivery of the locality plans/transformation agenda.

The Executive Lead, Strategy & System Development reported that managing the expectations of national bodies and regulators will remain an issue going forward.

Those present were invited to ask questions and the following issues were raised:

Responding to a Member's question, the Executive Lead reported that it is envisaged that the locality plans will be implemented at scale across each of the ten Boroughs. However there remains a lot to do in a short space of time

In response to a Member's question the Executive Lead reported that there were issues with managing expectations across a range of stakeholders, including the public, NHS England, NHS Improvement.

The Interim Executive Director Communities and Wellbeing reported that the GM devolution agenda will result in whole system reform.

It was agreed:

The Executive Lead, Strategy & System Development be thanked for his attendance.

HWB.454 TRANSFORMATION BOARD GOVERNANCE ARRANGEMENTS

The Chief Operating Officer Bury CCG presented the revised Transformation Board Terms of Reference for approval.

Responding to a Member's question, the Interim Executive Director Communities and Wellbeing reported that it is envisaged that the Board would be operational for 18 months to two years. Part of the transformation agenda will include the establishment of governance arrangements for the Local Care Organisation and the Once Commissioning Organisation.

A governance assurance task and finish group has been established jointly chaired by the Council's monitoring officer and a CCG representative to review governance.

It was agreed:

The Transformation Board Terms of Reference be agreed subject to a review by the Health and Wellbeing Board in three months.

HWB.455 FOR INFORMATION SUB GROUP MINUTES

The following minutes were included for information:

Children's Trust; Housing Strategy Board; Adult Safeguarding Board; Climate Change Board.

It was agreed:

Councillor Andrea Simpson
Chair

(Note: The meeting started at 6pm and finished at 7.45pm)

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Agenda Item 7

Greater Manchester Health & Social Care Partnership

Briefing Note

Date: April 2018

Subject: GM Population Health Outcomes Framework

SUMMARY:

This report provides an update in relation to establishing a GM Population Health Outcomes Framework, including a Tableau based online dashboard, as part of a Single Integrated Assurance process.

CONTACT OFFICERS:

David Boulger - Head of Population Health Transformation, GMHSCP
david.boulger@nhs.net

Wendy Meston, Consultant in Public Health, Rochdale Council
wendy.meston@rochdale.gov.uk

1.0 INTRODUCTION

1.1 This note provides an update in relation to establishing a GM Population Health Outcomes Framework, including a tableau based online dashboard, as part of a Single Integrated Assurance and improvement process.

2.0 OVERVIEW & BACKGROUND

2.1 In March 2017, the GM Health & Social Care Partnership agreed to a set of proposals to facilitate the creation of a unified population health system, to support the delivery of the GM Population Health Plan at pace and scale.

2.2 This included a commitment to the reduction of unwanted and unwarranted variation in standards, improvement in population health outcomes, more consistent adoption of evidence based practice, and the enhanced use of benchmarking data.

2.3 This confirmed a vision to drive improvements in population health across and within GM and through the 10 GM localities, reducing inequalities and setting outcomes that are aligned to place based priorities.

2.4 Over time, this programme has developed to incorporate 3 core elements:

- A GM Population Health Outcomes Framework (as part of a single integrated assurance process)
- GM Population Health Common Standards
- Excellence in GM Sector Led Improvement Programme

2.5 This briefing note will look at the GM Population Health Outcomes Framework.

3.0 SINGLE INTEGRATED ASSURANCE PROCESS – INTERIM ARRANGEMENTS

3.1 At GMHSCP Performance and Delivery Board in October 2017, it was agreed that an interim Population Health integrated assurance process would be incorporated into quarterly locality assurance meetings from Q2 2017/18, and would be underpinned by benchmarking data provided through the PHE Locality Dashboard (https://healthierlives.phe.org.uk/topic/public-health-dashboard).

3.2 This approach was implemented as planned and formed the basis for the development of key lines of inquiry during Q2 and Q3 (by exception) 2017/18.

4.0 A GM POPULATION HEALTH OUTCOME FRAMEWORK

4.1 In parallel to the interim arrangements, activity to establish the Population Health contribution to a Single Integrated Assurance Process through the development of a GM Population Health Outcome Framework has progressed at pace.

4.2 A GM Population Health Outcomes Framework has been developed through a process of engagement and co-design with key stakeholders from across the Health and Social Care system and the wider Public Service. This is included as Appendix 1.

4.3 A task and finish group was established to progress this task to completion, consisting of key partners from:

- GMHSCP
- GMCA
- Localities
- Public Health England
- Academia (University of Manchester)

4.4 The framework focusses upon the key Population Health outcomes which adversely impact upon the health and wellbeing of the Greater Manchester population and seeks to place focus and emphasis on a reduced number of key indicators, from within the multiple thousands of measures that currently exist within the wider system.

4.5 The Framework seeks to reconcile the ambitions of:

- Taking Charge
- GM Population Health Plan
- GM Strategy

4.6 The Framework, and accompanying dashboard, establishes headline data, trends, benchmarking and locality outcome trajectories.

4.7 It is recognised that there is no 'perfect' version of this framework and that there are many complementary and competing variables within the system. The final suite of outcomes was agreed as an appropriate initial set, which can be built upon going forward as required by GM or Localities.

4.8 The framework was reviewed and endorsed by GMHSCP Performance and Delivery Board on 14th March 2018, and GMHSCP Senior Management Team on 20th March 2018, and was formally signed off by GM Population Health Programme Board on 29th March 2018 .

4.9 It is acknowledged that the full initial ambitions for the framework cannot all immediately be realised due to unavailable, incomplete or flawed data sets. As such, the framework will be mobilised in two phases. Phase 1 will incorporate the outcome and output measures as set out within Appendix 1. Phase 2 (due for completion by September 2018 but with iterative development up to that date), will seek to identify alternative means of measuring additional desirable outcomes and will also include further work around trend and trajectory modelling, simulation and visual representation.

4.10 The framework and associated datasets have been built into an interactive, tableau based dashboard which will be tested during the 2017/18 Q4 Assurance Cycle in April and May 2018. The link to this dashboard is **here**.

4.11 The dashboard has been developed in partnership with localities, but now requires testing at scale in order to identify issues relating to functionality, usability, content and opportunities for improvements. Any 'snagging issues' identified through initial use during the Q4 assurance process should be emailed to gordon.adams@salford.gov.uk.

5.0 ESTABLISHING TRAJECTORIES

5.1 A key part of creating a meaningful dashboard involved the establishment of trajectories that identified a means for identifying improvements of time.

5.2 Some of the outcomes and outputs have had trajectories established by Public Health England using a range of methodologies based around benchmarking against CIPFA cohorts.

5.3 Some of the outcomes have been drawn from other ongoing GM Programmes and ambitions such as those already established for School Readiness, and those under development in relation to Physical Activity and Smoking.

5.4 As a worked example, trajectories have been established for 3 key outputs for smoking that are pertinent to the achievement of the GM ambitions that have already been agreed in the **GM Tobacco Control Strategy (Making Smoking History)**, namely:

- Smoking at Time of Delivery (below 6% in all GM areas by 2021)
- Smoking Prevalence – All Population (below 13% across GM by 2021, with individually tailored locality targets as set out in Appendix 2 to collectively contribute to achievement of GM target)
- Smoking Prevalence – Routine and Manual Workers (below 21% in all GM areas by 2021)

6.0 NEXT STEPS

6.1 The GM Population Health Outcomes Framework and Tableau Based dashboard, will be utilised for the first time as part of an integrated single assurance framework during Q4 2017/18 and will be used as the basis for the development of population health key lines of enquiry.

6.2 Steps will be taken to address "snagging issues" identified by localities during the Q4 assurance process.

6.3 Arrangements will be made to brief locality Health and Wellbeing Boards on the GM Population Health Outcomes Framework

END

Appendix 1 – GM Population Health Outcomes Framework

What is the desired outcome?	What will success look like?	How will we measure success?	What outputs will we measure?	Phase 1	Phase 2
LIFE EXPECTANCY, WELLNESS & INEQUALITIES					
In Greater Manchester we will live longer and healthier lives, with the greatest improvement in the areas and groups which have the worst outcomes.	By 2026, people in Greater Manchester will have a Life Expectancy and Healthy Life Expectancy that is at least the same as the national average (and will have matched the Northwest average by 2021)	Fewer people will die early in Greater Manchester from causes considered preventable	Mortality rate from causes considered preventable	x	
			Under 75 mortality rate from CVD considered preventable	x	
			Under 75 mortality rate from cancer considered preventable	x	
			Under 75 mortality rate for Respiratory disease considered preventable	x	
		Overall Life Expectancy will increase for men and women	Gap in life expectancy at birth between each local authority, GM and England as a whole (Male)	x	
			Gap in life expectancy at birth between each local authority and England as a whole (Female)	x	
		Overall Healthy Life Expectancy will increase for men and women.	Healthy life expectancy at birth (Male)	x	
			Healthy life expectancy at birth (Female)	x	
		There will be a reduction in Infant Mortality	Infant Mortality	x	
		More people will long term conditions will be receiving optimal treatment and there will be a reduction in the "missing thousands"	Gap between estimated and diagnosed prevalence for CvD (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Diabetes (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Hypertension (* Rightcare as placeholder)	x	
			Gap between estimated and diagnosed prevalence for Atrial Fibrillation (* Rightcare as placeholder)	x	
	By 2021, the gap between those with the worst Health Outcomes and those with the best will have reduced, due to significant improvements amongst those with the worst	We will see a reduction in Health Inequalities due to significant improvements in the areas that currently have the poorest health outcomes	Health inequalities using Slope Index	x	
			New GM inequality metric		x
START WELL					
In Greater Manchester we will have the best possible start in life.	More Greater Manchester Children will reach a good level of physical, cognitive, social and emotional development to prepare them for school and life.	We will meet or exceed the national average for the proportion of children reaching a 'good level of development' by the end of reception	% of children achieving a good level of development at the end of reception.	x	
			% of children with free school meal status achieving a good level of development at the end of reception.	x	
		GM babies will have a healthy birth weight.	% of all live births at term with very low birth weight	x	
		More children will be breast fed at the start of their life	Breastfeeding at 6-8 weeks	x	
		Fewer GM children experience dental decay	Proportion of 5 year old children free from dental decay	x	
		More GM children will be physically active	Temporary placeholder: % of children aged 5-15 meeting national physical activity guidelines (At least 60 minutes (1 hour) of moderate to vigorous intensity physical activity (MVPA) on all seven	x	
			% of GM children aged 2-15 who are active or fairly active.		x
		More GM children will be at a healthy weight at the end of reception.	Prevalence of overweight children (including obese) as measured by NCMP	x	
		Fewer GM babies will be affected by maternal smoking during pregnancy and at point of delivery.	% of women who smoke at time of delivery	x	
		Children will receive vaccinations and immunisations that prevent avoidable harmful health conditions	MMR vaccination rate	x	
LIVE WELL					
In Greater Manchester we will all have the opportunity to live well and fulfil our potential.	More Greater Manchester residents will be employed.	More people in GM will be employed	% of people aged 16-64 in employment	x	
			New GM employment and health measure to be developed		x
	People who live in Greater Manchester will choose to live healthier lifestyles.	Fewer GM residents will be affected by the harmful impact of smoking	Smoking prevalence in adults - current smokers (APS)	x	
			Smoking prevalence in adults in routine and manual occupations - current smokers	x	
		More GM residents will by physically active, and fewer GM residents will be physically inactive.	% of GM population who are Active or Fairly Active	x	
			% of physically inactive adults (>30 minutes per week)	x	
		Fewer GM residents will experience alcohol-related harm	Alcohol-related hospital admissions (narrow definition)	x	
		More GM adults will be at a healthy weight	% of adults (18+) who are overweight or obese	x	
		More GM adults will have access to appropriate contraception	Total Prescribed Long Acting reversible Contraception (LARC) (Excluding Injections)	x	
		Fewer new cases of Sexually Transmitted Infections	New GM measure		x
		New cases of HIV will be eradicated in Greater Manchester	New HIV diagnosis rate / 100,000 people aged 15+	x	
	People in GM will be in good mental health	People in GM will be emotionally well.	New GM Wellbeing Measure - GM Survey		x
		People IN GM will be social connected	New GM Social Isolation / Loneliness Measure - GM Survey		x
		Fewer people in GM will die as a result of suicide	Suicide Prevalence	x	
AGE WELL					
In Greater Manchester we will have every opportunity to age well and to remain at home, safe and independent for as long as possible.	Older GM residents will be supported to live a productive, healthy, safe and independent life in healthy communities.	Adults will remain in employment as they get older	50-64 Employment Rate	x	
		Fewer GM residents aged over 65 will be admitted to hospitals due to fall, accidents and injury.	Emergency hospital admissions due to falls in people aged 65 and over	x	
		More GM older adults will be screened for cancer	Cancer Screening Coverage - Bowel Cancer	x	
		Older GM residents will be socially connected	% of GM residents aged 65+ who report being socially isolated (GM Survey)		x
			% of GM residents aged 65+ who report being lonely (GM Survey)		x

Appendix 2 – GM Smoking Prevalence Trajectories by Locality Area

	Current prevalence (APS, 2016)	**2021 Target**
Bolton	17.9%	13.6%
Bury	19.1%	13.7%
Manchester	21.7%	15.9%
Oldham	18.8%	13.7%
Rochdale	19.4%	13.1%
Salford	20.3%	13.9%
Stockport	12.2%	9.8%
Tameside	22.1%	14.2%
Trafford	12.6%	9.2%
Wigan	17.7%	13.1%

Contributions weighted according to smoking contributions amongst routine and manual workers and the proportion of GM current smokers in each local authority

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

GREATER MANCHESTER HEALTH AND SOCIAL CARE STRATEGIC PARTNERSHIP BOARD

8

Date: 31 March 2017

Subject: Transformation Theme 1 – Public Health System Reform

Report of: Justine Palin, Programme Lead Population Health System Reform, GMHSC Partnership
Angela Hardman – Director of Public Health Programme, Tameside Council

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PURPOSE OF REPORT:

The Greater Manchester Population Health Plan serves as a key driver to re-orientate the wider system towards prevention and a focus on population health and wellbeing. The delivery of the Population Health Plan requires the support of a population health system which is organised to deliver at pace and scale.

A review of the current public health system has been underway since November 2016 with the aim of developing an-evidence based set of propositions for creating a unified population health system for Greater Manchester. An emerging set of propositions have been tested with colleagues across the system and have been further developed by AGMA Wider Leadership Team in early February 2017 and endorsed by the Strategic Partnership Board Executive 16 March 2017.

This paper sets out the findings from the review, as well as puts forward a suite of proposals for the creation of a unified population health system for GM which will ensure the necessary effective delivery of the Population Health Plan. The paper consists of an executive summary and also a fuller document.

RECOMMENDATIONS:

The Strategic Partnership Board is asked to:

- Approve of the proposals outlined in the paper.
- Acknowledge that a detailed mobilisation plan and transition plan will be developed to support the delivery of the proposals.

CONTACT OFFICERS:

Justine Palin, Programme Lead Population Health System Reform, GMHSC Partnership
justine.palin@nhs.net

1.0 INTRODUCTION

1.1. In GM, we have a shared commitment to the most ambitious approach in England to place public health at the heart of public service reform and economic growth. Rebalancing our economy also requires rebalancing our public services. Since the implementation of the NHS and Social Care Act in 2013, public health leadership has become somewhat fragmented with capacity and functions dispersed across local authorities, Public Health England (PHE), NHS England (NHSE) and more recently into the Greater Manchester Health & Social Care Partnership (GMHSCP) under the devolution arrangements. While there have been some real positives from these changes, for example, integration of public health functions into wider local services, there has also been some fragmentation of health protection, intelligence architecture and commissioning functions, and also some duplication and overlap, which limits the capacity to effect significant change across Greater Manchester (GM).

1.2. In July 2015, partner organisations across GM signed a Memorandum of Understanding (MoU) with PHE, with an ambition to create a Unified Public Health System. This would be an opportunity to support and add value to local working by reducing the fragmented nature of public health leadership in GM and drive the necessary emphasis on prevention of ill-health and integration of services, which will be central to improving outcomes in a landscape of diminishing resources. The GM Taking Charge Together Plan (December 2015) further committed to this by prioritising the prevention agenda, and recognising the need to embed lasting and relevant changes to how GM organises itself for the best outcomes for and wellbeing of GM's population.

1.3. Work has progressed since 2015 to change the premise from unifying a 'public health system' to creating a unified 'population health system'. Public health is about using the expertise of a specialist workforce to embed knowledge, skills and expertise across systems in a place based model. Population health is a wider cross-cutting perspective which is everybody's responsibility, involving collaboration across a range of sectors and partnerships (such as health, social care, other public services, voluntary sector, businesses and wider communities).

1.4. The GM Population Health Plan January 2017 set out GM's approach to delivering a radical upgrade in population health. 'System Reform' – creating a unified population health system - is one of the key programmes of work within the Plan, recognising that an ambition of the magnitude of the delivery of the Population Health Plan requires the support of a population health system which is organised to deliver at pace and scale and in the context of a devolved system, one that is better able to achieve improved health outcomes for the citizens of GM.

1.5. Broad stakeholder involvement and engagement work has taken place during 2016 which resulted in the development of a set of high-level proposals. Based on this early work, a deeper review of the current public health system has been underway since November 2016 to further develop the high level proposals into a set of

evidence based propositions for creating a unified population health system for Greater Manchester.

1.6. This summary details the main findings from the review and presents the suite of proposals for the creation of a unified population health system for GM which supports the necessary effective delivery of the population health plan.

2.0 OUR VISION

2.1. Given the strong emphasis under GM Devolution on integrated health & social care from a primary, community and acute care perspective, we see improvement of population health as an objective underpinning the entire system, thus creating an integrated wellbeing, health and care system. The focus is on a 'whole system approach' with GM and Localities working as a single system.

2.2. Our Vision is for a system that:

- is united in its focus on the delivery of agreed priority population health outcomes and long term financial sustainability.
- defines a set of population health goals that are recognised and embedded within all relevant GM programmes and services.
- develops greater consistency of approach and common standards for delivering population health outcomes across GM, in terms of planning, monitoring, commissioning and service delivery for population health.
- is consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GM, recognising the 'place' (Locality Authority footprint) as the primary unit of planning whilst also being cognisant of the needs of communities of identity.
- creates a strong and able cadre of population health leaders across GM, supported by clear governance and accountability and reporting systems, and a specialist public health workforce.
- extends commissioning and delivery of some public health functions at GM level to achieve additional impact, complementary to that at Locality level.
- drives out inefficiencies and unnecessary variation in the system where it does not make sense to do things multiple times, or where current focus and investment does not deliver the best outcomes.

2.3. Our expectation is that the nine leadership values for GM, which underpin public service reform, are embedded in system leadership for population health. Our objectives for place based assurance are underpinned by the GM Assurance framework. Our vision for commissioning for population health is ensuring consistency in how we procure, commission and contract for population health – which are quality, improvement, social value, outcome and cost driven, with a move

to commissioning across a whole system where feasible and beneficial. Our vision is underpinned by the principles set out in the GM Commissioning for Reform Strategy and aligned with the Commissioning Review currently underway.

3.0 KEY FINDINGS

3.1. The key findings from the Review are:

- Investment is not strongly related to evidence based outcomes but instead based on historical inputs.

- We have good examples of commissioners working collaboratively and moving to cluster based commissioning approaches, with lead commissioner arrangements in place and lead provider procurements underway. But this is not consistent across GM and for all commissioned services where this would make sense.

- We are seeing little evidence yet of commissioning across a whole system, use of integrated budgets across programme areas, or commissioning for outcomes.

- We have a mixed provision of health protection functions across GM as well as varied governance and assurance arrangements. There is no overarching GM system for health protection which is being held to account.

- There is a skilled public health cadre across GM but we are not fully maximising the capacity, resources nor skills sets effectively, which results in duplication and often inefficiency. We have invested in some GM leadership for Population health but given the profile and ambition set for transformation this needs expansion.

- There is a gap at GM level for PH intelligence with weak informatics support, and at the locality level there is repetition and fragmentation in the system.

- Governance and accountability needs to be strengthened in a number of areas to ensure visibility in decision making and enhanced assurance.

- As a system we are not getting the best value for money and there are opportunities for looking at efficiency savings.

4.0 OUR PROPOSALS

4.1. Enacting a new way of working as a GM system for population health is an iterative process which is about changing cultures, behaviours, perceptions and ways of working in a more integrated way. In addition, it is about putting in place the right system architecture for delivery:

- agreed target population health outcomes and common standards for the system to achieve the best health gain;
- integration of local population investment with wider community investment;
- the right spatial level for core public health functions and commissioning;
- an effective and able cadre of population health system leaders;
- effective governance and accountability supported by system enablers.

4.2. We have developed the following suite of interrelated proposals

4.3. Common Population Health Goals

4.3.1. We have developed a set of common population health goals designed to reduce unwanted variation in achieving our population health outcomes. It is intended that ways of reducing that variation will be for local discretion, but working to GM agreed common outcomes and standards to be met, and at a GM level providing facilitation through data, workforce investment, leadership development etc.

4.3.2. Key components are:

- **Common Standards** - core priority areas (0-5 including oral health; substance misuse; sexual health; tobacco control; mental health; ageing well) for all localities to prioritise and invest in. These sit alongside and enhance existing national mandation.
- **Development of core strategies** - for those areas committed in the Population Health Plan as well as for GM Sexual Health Strategy; GM Health Protection Strategy and GM Guidance and Standards on health response to outbreak; and GM Age Well Strategy.

4.4. New System Design for Public Health Functions

4.4.1. Key components are:

- **A Unified GM Health Protection Function** – designing the optimum pathway and system for GM.

- **GM Population Health Intelligence Function** – as part of the wider GM Health Intelligence function.

    - **Outcomes Framework** - refresh of the existing GM Population Health Outcomes Framework in line with the refreshed GM Strategy.

    - **Risk Stratification Tools**

    - **Information Dashboard** – at a glance view of where the system is in meeting population health outcomes, reducing variation and inequalities in outcomes, with ability to commission reports on the relationship between variables.

4.5. Commissioning for Population health

4.5.1. Key components are:

- **Whole System Integrated Sexual Health Service** – includes all commissioners and their services (NHSE; CCG; LA) and covers a range of interventions via clinics, outreach, digital platform, delivery split between GM and locality level depending on the service.

- **Substance Misuse** – As a minimum commissioning Tier 4 Inpatient Detox & Residential rehabilitation at a GM level.

- **Digital Platform for Lifestyle & Wellness** – this is the commitment made in the Population Health Plan.

- **GM Service Specifications** – for those GM Commissioned Services.

- **Good Practice Guidance** - for commissioning population health at a place based level ensuring that population health outcomes are reflected in local commissioning decisions.

4.6. System Enablers

4.6.1. Key component is:

- **Standard for Health Checks** – A robust GM Pathway for Health checks that forms a systematic and scaled approach to identifying the missing individuals with, or at risk of developing long term conditions.

- **Digital Tools**

4.7. Population Health System Leadership

4.7.1. Key components are:

- **Developing system-wide leadership** – using training and development to embed the population health ethos across services and sectors.
- **Evolved DPH role** – having a clear leadership role broader than public health to being a population health leader. DPHs acting as part of a networked structure across GM, blending working at the locality and GM level. Network arrangements are for local determination, as some may localities may decide to adopt a shared role. Accountability for the DPH resides with the LA.
- **Specialist public health workforce (consultants, health intelligence, health protection)** – Networked at the locality level and working across GM to the same arrangements as above.
- **Support from the GM Mayor** for key areas (active lifestyles; healthy environments; changes to regulatory frameworks) to enable impact at scale.

4.8. Governance and Assurance

4.8.1. Key components are:

- **Use of established local governance** – effective system stewardship by the Health and Wellbeing Board and standards, programmes and target outcomes embedded in processes for delivery of locality plans, including work of emerging Local Care Organisations.
- **Use of established GM governance** – delivery of unified health system made the responsibility of the Population Health Board reporting up to Strategic Partnership Board and GM Reform Board as appropriate.
- **Use of GM health and care assurance framework** – including review of progress as part of quarterly assurance meetings.

5.0 WHAT THIS SHOULD MEAN IN FUTURE

5.1. As a result of these reforms, we should experience:

- A stronger commitment to reduction in unwanted variation in standards and population health outcomes, and a more consistent adoption of evidence based practice and benchmarking data to reduce that variation.
- Integrated population health system leadership to join up conversations across and between children's, adults' and wider public services, spanning physical and mental health.
- Changing behaviours, to ensure that accountability for population health is spread widely, not concentrated within single organisations or within the

boundaries of traditional health and care services. Also creating a culture of mutual accountability in that system peers and partners proactively challenge and support delivery.

- Leadership for population health and collaboration through placed based systems of care requiring the breakdown of professional siloes in pursuit of the greater good of the populations they collectively serve.

- Greater local determination in using and maximising available resources in the most efficient way, including communities making more decisions for themselves about the best way to secure improvements.

- Maximising the existing skills and capacity in the system towards delivering the GM ambition for a radical upgrade in population health through more networked arrangements.

- Investing more in wider community, voluntary and business sector infrastructure to be part of a reformed delivery system and also to make better use of the wider paid public sector workforce.

- Local Care Organisations, working with the local community and voluntary sector, to provide a platform for implementing new and innovative models of care and prevention programmes which will improve population health and well-being.

- Creating a platform for further devolution 'asks' from central government to enable Greater Manchester to have more control over the key levers for securing population health gains, including regulatory and pricing mechanisms, and improvements to environmental quality.

6.0 A SET OF PRIORITIES FOR CHANGE

6.1. In anticipation of sign off of the priorities, our next steps and priorities for change will be:

6.2. Immediate Priorities (March to April):

- Working with colleagues to develop the protocol for the concurrent role of GMCA from April 2017 and any implications of the business rate pilot scheme.

- Engaging with the LCO development and single integrated commissioning framework regarding the proposals.

- Taking into account the outcomes of the Commissioning Review.

6.3. Further Work

- Development of detailed mobilisation plan and transition plan to support the implementation of the proposals.

- Financial modelling.

6.4. Implementing some quick wins:

- Introduce new governance and accountability structures and PMO office.
- Revision of GM Population Health Outcomes Framework.
- Work with SCN and Partners to design the risk assessment tool for GM health checks.

6.5. Commencing key programmes of work:

- Development work for GM Standards.
- Development of integrated health protection pathway.
- Development of model for health intelligence.
- Commencing the work on sexual health and substance misuse by mapping the AS-IS position.

7.0 RECOMMENDATIONS

7.1. The Strategic Partnership Board is asked to:

- Approve of the proposals outlined in the paper.
- Acknowledge that a detailed mobilisation plan and transition plan will be developed to support the delivery of the proposals.

GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

BUILDING A UNIFIED POPULATION HEALTH FUNCTION FOR GREATER MANCHESTER – A REVIEW

JUSTINE PALIN (GMHSC PARTNERSHIP) AND ANGELA HARDMAN (DIRECTOR OF PUBLIC HEALTH, TAMESIDE COUNCIL)

MARCH 2017

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1.0 INTRODUCTION

1.1. The implementation of the NHS and Social Care Act in 2013 marked a split in public health leadership and core functions between local authorities, Public Health England (PHE), NHS England (NHSE), with Clinical Commissioning Groups also having a significant interest. The landscape has continued to evolve with 0-5 public health commissioning functions transferring to local authorities in October 2015. There are strengths of the reformed system, for example, the ability of local authorities to develop a more place-based approach to public health and to link public health functions to wider public services. However, it has also resulted in some weaknesses, mainly that there is greater fragmentation of health protection, intelligence architecture and commissioning functions across a multitude of partners. The resulting architecture of the public health system is one of significant duplication and some unnecessary variation, which overall limits the capacity and effectiveness of the system. The GM health and care devolution programme gives us the opportunity for some significant improvements. (Appendix A provides some more detailed information on the current statutory and policy context.)

1.2. In June 2015, building on the Greater Manchester Agreement and the Health & Social Care Memorandum of Understanding (MoU) of February 2015, a set of partners (10 GM LAs, PHE, NHSE, Association of GM CCGs, GM NHS providers and GM 'blue light' services) signed a Public Health MoU. The Public Health MoU set out how public health leadership could come together to support the necessary rebalancing of GM health and care system towards prevention and early integration. The MoU therefore created a framework by which partners committed to create a single unified public health leadership system capable of contributing to a transformational and sustainable shift in the health and wellbeing of the population. The MoU described how public health leadership in PHE, NHSE, GM and other partners would work together to secure accelerated improvement in the health and wellbeing of the GM population and capitalise on the devolution package by seeking to innovate and deliver new approaches to tackling the wider determinants of health including employment worklessness, educational attainment, housing and income levels. The key operational principles were set out as:

- a robust and evidence-based public health contribution to growth and reform priorities of GM;
- a focus on wellbeing, prevention and targeted intervention;
- a recognition that the citizens of GM will be key agents in supporting and achieving better health outcomes;
- a rebalancing of investment towards prevention; and

- a commitment that no decisions on public health leadership, investment or commissioning that relate to GM residents are made without GM.

1.3. The GM Taking Charge Plan (December 2015) further committed to population health by setting out a range of transformation programmes which would see the concentration of efforts to raise population health outcomes for GM to those projected for England and made the commitment to go further and faster.

1.4. The Devolution Agreement April 2016 signalled the start of transforming public health leadership, with the devolvement of Section 7a commissioning responsibilities (immunisation and screening, CHIS and elements of health and justice commissioning) from NHSE to GMHSCP, along with the embedding of PHE and NHSE commissioning and healthcare public health resource into a newly formed Population Health Team in GMHSCP.

1.5. The GM Population Health Plan was published in January 2017 and sets out our approach to delivering a radical upgrade in population health. The plan is aligned with the broader approach to reform across GM which is predicated on a new relationship between people and public services; connecting people to the opportunities of growth and reform; placed-based integration of services and early intervention and prevention. It is clear that most change happens in communities, supported by local organisations, so the priorities for change set out within the plan have been chosen to add value to the local delivery described in each of the 10 locality plans.

1.6. The plan therefore focuses on those programmes of work that Greater Manchester Health and Social Care Partnership will deliver in collaboration with localities. It does not seek to duplicate those priorities that are best delivered at the locality level. The choices made in the plan are based on the best available evidence of impact and seek to achieve a balance of short, medium and long-term improvements.

1.7. Creating a unified population health system is one of the key programmes of work of the Plan. The intent, set out in the Plan, is to build on the commitments set out in the Public Health MoU for the development of a single population health system across the GM economy – one which maximises both the impact and the capacities of a small and specialist public health workforce, but also supports the embedding of the pursuit of Population Health as being everybody's business and sees collaboration across a range of sectors and wider communities – between NHS organisations, local authorities, the third sector and other local partners, as well as patients and the public working together as population health systems.

1.8. In addition to creating a unified leadership system for population health, we recognise the need to create a unified approach to commissioning population health that enables us to commission services at the right spatial level, in collaboration with one another, and to improve population health outcomes and health inequalities as well as contributing to a more sustainable public health, health and care system.

1.9. The proposals set out in this paper create a framework for a unified population health system for GM, which is organised to deliver at pace and scale the commitments set out in the Population Health Plan.

2.0 HOW WE HAVE GONE ABOUT THE REVIEW

2.1. Work on developing a set of evidence based proposals for creating a unified population health system commenced in November 2016, and we have combined a number of inputs:

- Review of local authority public health expenditure (for RA data 2016/2017 from Central Government Returns) to gain a better understanding of how the Public Health Grant is being used across GM.

- Work with commissioners and AGMA procurement hub to look at existing contracts for public health commissioned services. We have also undertaken a deep dive in one area by specifically engaging with sexual health commissioners and providers to gain a better understanding of how services are currently commissioned and delivered.

- Work with New Economy to do initial 'proof of concept' modelling work for sexual health to demonstrate the benefits from moving from single commissioning approaches to combined commissioning arrangements.

- Review of existing decision making and investment tools, namely Right Care and PHE SPOT (investment and outcome tools) to try and gain an appreciation of current investment in relation to outcomes. To take a GM perspective, further development work on the tools is needed.

- Assessment of the current spatial level for delivering health protection, health intelligence and commissioning for population health.

- Engagement across the system to understand stakeholder asks of a unified population health system. Those involved so far include:

    - LA CEOs
    - Directors of Public Health
    - Public Health Consultants
    - PHE
    - PSR Team
    - Wider System leaders
    - GM JCB
    - AGMA Wider Leadership Team

2.2. We have aligned our thinking with the broader approach to reform across GM that is predicated on a new relationship between people and public services; connecting people to the opportunities of growth and reform; place-based integration of services and orientating the system towards early intervention and prevention.

2.3. We have taken into consideration the wider policy context, legal duties, and the relationship with the wider health and care transformation programmes, in particular the development of locality care organisations (LCOs). We will align our proposals with the outcomes of the independent commissioning review being undertaken by Deloitte and we intend to further develop our thinking on workforce development in line with the publication of the GM workforce strategy.

2.4. Finally we recognise that achieving a radical upgrade in population health is not just the responsibility for health and social care services, nor of public health professionals, but instead requires co-ordinated efforts across population health systems. It requires efforts to change behaviours and cultures, and also to recognise that accountability for population health is spread widely, not concentrated in single organisations or within the boundaries of traditional health and care services.

2.5. The remainder of this paper describes:

- our vision for a unified population health system;
- our findings on how the system is working today;
- our proposals for a reformed population health system;
- the benefits of the proposals;
- a set of priorities for change.

3.0 OUR VISION FOR A UNIFIED POPULATION HEALTH SYSTEM

3.1. Given the strong GM Devolution agenda emphasis on integrated health & social care from a primary, community and acute care perspective, we see improvement of population health as an objective underpinning the entire system, thus creating an integrated wellbeing, health and care system.

3.2. The focus is on a 'whole system approach' to population health improvement and health gain with GM and Localities working as a system. Public health is about using the expertise of a specialist workforce to embed knowledge, skills and expertise across systems in a place based model. Population health is a wider cross-cutting perspective which is many people and organisations' responsibility across public services, voluntary and community groups, and wider employers.

3.3. Our Vision is for a system that:

- Is united in its focus on the delivery of agreed priority population health outcomes and long term financial sustainability.
- Defines a set of population health goals that are recognised and embedded within all relevant GM programmes and services.

- Develops greater consistency of approach and common standards for delivering population health outcomes across GM, in terms of planning, monitoring, commissioning, service delivery and evaluation for population health.

- Is consistent with the principle of subsidiarity (decisions are made at the most appropriate level) within GM, recognising the 'place' (Locality Authority footprint) as the primary unit of planning, whilst also recognising communities of identity.

- Creates a strong and able cadre of population health leaders across GM, supported by clear governance and accountability and reporting systems, and a specialist public health workforce.

- Extends commissioning and delivery of some public health functions at GM level to maximise outcomes and efficiencies to achieve additional impact, complementary to that at Locality level.

- Drives out inefficiencies and unnecessary variation in the system where it does not make sense to do things multiple times, or where current focus and investment does not deliver the best outcomes.

4.0 WHAT THE REVIEW HAS FOUND

Use of Resources

4.1. Appendix B provides some information on how GM public health grant resources are used today, recognising that this is only a small proportion of the total resource expenditure that impacts on population health from within the overall £22bn per annum spent on GM public service. Nevertheless, there are a number of general conclusions that can be drawn from our understanding of the use of the PH grant:

- The data suggests that investment patterns are not strongly related to evidence based outcomes but instead on historical inputs that have been allowed to perpetuate year on year.

- The data suggests that investment does not necessarily follow the life course approach, with, for example, little investment at least from the core public health grant, on services for the ageing population.

- There has been little analysis undertaken of the impact of the wider expenditure contributing towards population health, either in terms of quantum or impact.

- Investment is currently made on individual services/interventions commissioned, rather than taking a wider pathway perspective (specifically for sexual health and substance misuse).

- The way we collect and report financial data does not support the development of integrated services e.g. smoking cessation is often included within a wider well-being service offer but reported separately.

- The level of spending on national mandated services is not prescribed which is why we can see such variation per head of the population. National mandation has limited protective impact leading to high variation in interpretation e.g. NHS Health Checks may only reflect spend of invitation, not delivery, follow up, nor holistic response.

- The challenge is about ensuring that the best evidence, including economic intelligence, is used to target investment in those areas which will give the biggest improvement in health gain.

Health Protection

4.2. Health protection seeks to prevent or reduce harm caused by communicable disease and minimise the health impact from environmental hazards such as chemicals and radiation. This is achieved through programmes (e.g. national immunisation programmes), the provision of health services to diagnose and treat infectious diseases and planning, surveillance and response to incidents and outbreaks. Health protection therefore covers outbreak prevention and control; emergency planning; risk management; infection control; outbreak management; monitoring threats and immunisation.

4.3. Across GM there are a number of bodies that currently provide health protection functions namely, PHE; CSU/CCGs. GM HSCP, Local Authorities, AGMA Civil Contingencies & Resilience Unit and Transport for Greater Manchester (TfGM). Details of the role of each programme is covered in Appendix C.

4.4. As can be seen we have a mixed picture of provision of health protection functions across GM as well as varied governance and assurance arrangements. Local Authorities have already delegated emergency planning and elements of response into AGMA's Civil Contingencies & Resilience Unit. For the provision of Community Infection Prevention and Control (IPC) across LA's we are seeing variation of service provision, as well the size of any in-house teams. LA's either have direct employees or outsource that service to local providers. Where there are directly employed teams in the localities there is a mixed picture of provision, as some infection control teams are blurred with environmental health. Often this is a result of a historical position pre 2013.

4.5. We have undertaken a SWOT analysis of the current health protection functions:

Strengths

- Strong DPH and PHE leadership
- Assigned leaders – DPH & LA CEO
- Established LHRP
- Effective commissioning of immunisation services including roll out of several new programmes
- Track record of effective response
- Some strong programmes of strategic work (sexual health, hepatitis, air quality, AMR)
- Robust GM plans for generic response, outbreaks, and multiagency

Weaknesses

- No overarching GM System for Health Protection (HP)
- Variation in delivery of HP across LAs and limited delivery of IPC at GM level
- Aging specialist IPC workforce with limited succession planning
- Variable borough level operational plans for HP incidents
- Limited resilience as reliant on good relationships of individuals

Opportunities

- Upskilling wider workforce while retaining specialist expertise
- Sharing of learning across System
- Strengthening governance & assurance frameworks
- Develop resilient system
- Positive impacts on health and social care system and wider public sector through control of preventable ill health and prevention of disruption from outbreaks.

Threats

- DPHs are accountable for health protection in their own localities despite shared ownership between partners of the agenda
- Reputational damage for all organisations with any HP failings.

4.6. The following summarises our findings for health protection:

- There is clear accountability within each locality but currently there is an opportunity to develop an overarching GM System for Health Protection (HP) and overall accountability between the various partners.
- As a system there are areas where resilience could be strengthened further.
- All LAs deliver health protection functions, but there is some level of variation and an opportunity to develop overarching delivery of infection prevention and control (IPC) at GM level.
- There are locality level operational plans for HP incidents and an opportunity to create a stronger coherence through a GM standards approach.
- DPHs are accountable for health protection in their own localities, there are opportunities to strengthen joint accountability at local and GM level.
- Any health protection failings can result in significant reputational damage for all organisations.

Public Health Intelligence

4.7. Public health intelligence encompasses the range of activities needed for evidence-based public health commissioning and practice. It includes, but is not limited to, evidence appraisal and synthesis; quantitative and qualitative evaluation; and data analysis, together with the communication and interpretation into appropriate recommendations for action, policy decisions and service commissioning and delivery. Analysts are seeing a broadening of their role to provide much more corporate analytical capacity that drives council strategy i.e. works to the wider determinants.

4.8. We have a highly skilled workforce, with good examples of local integration:

- We have 22.5 public health intelligence specialists across GM (source RA returns for PH grant), who operate either as part of a dedicated public health team or as part of wider general business intelligence function.
- National PHE have a Knowledge & intelligence Team which localities have access to for accessing data and national tools/data.
- GM HSCP also has access to NHSE resources regarding the services we commission for analytics and cost benefit analysis support (New Economy).

4.9. The following SWOT summarises the current position for population health intelligence.

Strengths	Weaknesses
• The use of health intelligence data to drive commissioning decisions locally. • We have a highly skilled workforce, with good examples of local integration.	• Gap at GM level for PH Intelligence • Repetition and fragmentation in provision. • Expensive commodity not always being fully utilised. • Current barriers in the system to support GM offer
Opportunities	**Threat**
• Networking resources to maximise capacity and capitalise skillsets. • LCOs/SICFs will require access to HI specialist to support their commissioning decisions.	• In some cases the wider integration of Health Intelligence staff as part of a dedicated business intelligence poses a risk of a loss of specialism

4.10. In summary:

- There is a mixed picture of provision for public health intelligence, with in general a small highly specialised workforce which is unevenly distributed, and often repeating work locality by locality. There is little resource at GM level and there is a need to understand better how to deploy this resource to best effect alongside other partners in PHE and New Economy.
- We are not always placing intelligence at the forefront of our commissioning decisions.

- Information governance issues make it a challenge in accessing health data.
- There are opportunities in the system to support a GM offer through:
    - Creating oversight, accountability and governance across GM to enable the development of single large GM pieces of work
    - Developing more common styles/formats to support localities and to draw out overarching themes to build a GM wide narrative.

Commissioning for Health improvement

4.11. From our understanding of the utilisation of the PH grant, and from engagement with stakeholders we have found that:

- There is a varied approach to commissioning population health services and there are significant opportunities for reprioritising commissioning services/ interventions based on outcomes and greater alignment with locality plans, HWB strategies and the population health plan work-streams.
- There is good work under way in rethinking sexual health and substance misuse commissioning - with localities now working in clusters to collaboratively commission services; standardised service specifications have been introduced for sexual health, and a single 'provider framework' has been introduced for substance misuse with all providers being put onto it..
- Despite this we mainly commission in silos e.g. substance misuse and sexual health both spend on prevention and health promotion – but there are few examples of combined service offers.
- Some areas have embraced place based commissioning far more than others.
- There is significant potential to get a greater range of benefits from population health commissioning and procurement by embracing a social value based approach.
- We have a significant public health commissioning resource across GM which we may not be maximising and effectively utilising the capacity.
- We need to support more consistency across GM and for all commissioned services where this would make sense, this would increase the current ability to tie localities to agreed GM approaches.
- Stakeholders are asking for standardisation and consistency across GM such as:
    - guiding principles that express best practice;
    - standardised service specifications to reflect shared outcomes;

- GM level commissioning where it makes sense to do so and that will make the biggest difference in achieving population health outcomes.

System Leadership

4.12. Public Health leadership is primarily based within the ten localities, as well as some retained provision within Public Health England (PHE), PHE North West, GMHSCP, GM Directors of Public Health Group (this is the same resource as in the localities) and a discrete resource has been invested in the GM Public Health Network. Further details are included in Appendix D.

4.13. The role of the Director of Public Health (DPH) is a statutory role appointed jointly with the Secretary of State and has overall responsibility for their LA duties in taking steps to improve public health for their local population. There are currently a number of arrangements for how that role is constituted across localities. Directors of Public Health (DPHs) appear to be at their most valued and effective when operating at an executive level within their organisation. Enabling them to influence more broadly population health through commissioning, focusing on outcomes, managing partner relationships, lobbying and engaging with communities.

4.14. There is a long history of partnership working of Directors of Public Health across GM who have in the past taken the lead, prior to Devolution, on core pieces of work on behalf of GM around Population Health. For example each DPH is taking a leadership role in supporting GM business, for example GM Alcohol and Substance Misuse Programme; GM Civil Contingencies; GM Mental Health Executive.

4.15. There are also examples of good practice emerging from individual localities that other localities look to, for instance Stockport in spatial planning and Oldham in Asset based working. Informally, sharing of good practice is taking place across the DPHs, but there are opportunities for strengthening and resourcing those activities to enable scalability and spread across GM.

4.16. For the specialist public health workforce (consultants, public health intelligence) pressures on the public health grant have translated into a reduction of the public health workforce from that originally novated over to the LAs.

- There are also gaps in capacity to support health promotion and health improvement more generally across GM.

- Public health specialists are an expensive commodity and not always being fully utilised. The wider integration of those staff as part of a dedicated business intelligence, along with a lack of career pathways in local authorities poses a risk of a loss of specialism.

- For health protection overall we have an ageing specialist Infection Prevention and Control workforce with limited succession planning. We have an opportunity for upskilling the wider workforce while retaining specialist expertise.

4.17. For commissioning; health protection and health intelligence we have duplication in those areas where there is a shared agenda and there are opportunities for greater collaboration and aligned working.

4.18. We have invested in some GM leadership for Population health but given the profile and ambition set for transformation, this needs expansion. Currently this lack of capacity has been undermining the contribution to the Devolution programme.

4.19. In summary, although there is a good public health leadership cadre across GM the opportunity going forward is to fully maximise this capacity, resources and skills sets more effectively. There are also opportunities to maximise the strategic leadership role of the DPH to build on existing approaches to influence the wider determinants of health across a system footprint.

Governance & Accountability

4.20. We have not fully explored the governance and accountability for population health across the System. The following summarises our knowledge of systems in place.

4.21. Prior to 2013 the governance and accountability for the GM Directors of Public Health Group sat with the Association of GM PCTs. Since 2013, the group has not been within the GM governance structures. DPH groups across the country arose out of previous NHS reforms and were intended to be informal peer support and resource management tools.

4.22. We are aware that there are a number of commissioning networks that exist across GM, for instance the Sexual Health Network Commissioning Group (originally as a subset of the Public health network). Again these are arrangements that were put in place prior to Devolution and have been built on the long history of partnership working across GM. There is a huge value in those networks and indeed as a collective the commissioners operating as a forum have been able to achieve significant amounts through working at scale. Agreements have been put in place, such as SLAs between the various commissioners, but there is an opportunity of revisiting the governance per se of those networks to ensure transparency in their accountability and decision making for GM.

Value for Money

4.23. At locality level, in some areas there has been a drive on efficiency savings but we need to look at the capacity opportunity and capability of workforce across the system. As a System we can get better value for money and there are opportunities for looking at efficiency savings e.g.:

- Health Protection – there are numerous doors into the system; immunisation at scale; outsourced work.

- Estates - we have opportunities for exploring greater co-location of services, including the emerging neighbourhood hubs.

- Optimising use of scarce resources in commissioning and procurement (to be picked up with the Commissioning review)

- Prioritising the investment in those services/interventions that make a difference and decommissioning those that do not, with far better use of data and evaluation to underpin decision-making.

5.0 EMERGING OPPORTUNITIES

LCO's & Single Integrated Commissioning Functions (SICFs)

5.1. We recognise the current timeliness of embedding of population health outcomes in the architecture of the emerging LCOs, as well as the development of single local commissioning functions and the move to place based integrated commissioning across GM. This includes the incorporation of existing functions of CCGs, Adult Social Care, Children's Services and public health with the scope to further develop and expand these over time.

5.2. Population health is integral to each localities LCO development and they are using that opportunity to develop, integrated commissioning (inclusive of pooled budgets), and integrated delivery models (either community or acute or both). All at varying levels of development. In some localities public health functions and resources have aligned/or there is the intent to align them into the single commissioning function through the enablement of Section 75 agreements.

5.3. LCOs are central to our programme of reform to support the delivery of those outcomes, along with localities working together as a place based system with a range of partners towards achieving the population plan/locality plan outcomes.

5.4. We have an opportunity, through the implementation of new system architecture, to review the best delivery models for local population health services under locality plans.

5.5. What we know:

- As part of the LCO development many localities are considering moving their provision for infection control and planning into the developing organisations as part of community services.

- We appreciate that LCOs/SICFs will require access to health intelligence specialists to support their commissioning decisions.

- LCOs operating as a 'whole system', working with the local community and voluntary sector, provide a platform for implementing new and innovative models of care and prevention programmes which will improve population health and wellbeing. This is a fundamental shift towards operating as population health systems.

- Community prevention efforts to improve population health are important elements of LCO partnership models, and will need to be resourced.

- There is significant potential to get a greater range of benefits from population health commissioning and procurement by embracing a social value based approach.

Health Protection

5.6. PHE, in response to the Health Select Committee inquiry into health protection provision, will be undertaking a review of health protection provision across the country and it is expected that there will be published national recommendations/guidance in relation to that. We have the timely opportunity therefore to develop a GM blueprint for what that service offer would look like for health protection across GM which maximises the current skill set and capacity of partners to develop a resilient system.

Population Health Leadership

5.7. We have the prospect to explore and maximise the opportunity presented via the collaboration between clinical commissioners, elected politicians and public service professionals to deliver a new model of place based population health leadership. This means that Population Health is regarded as a wider system responsibility that works across education, health, housing welfare services, planning, transport and many more.

Governance & Accountability

5.8. The delivery plan for the Population Health Plan is now seeing a move to tighter governance around the SRO and leadership for those work streams. There is an opportunity to redefine the role of the DPH group specifically to include support to the continuing development and implementation of the implementation of proposals outlined in this paper, as well as for the Population Health Plan more broadly.

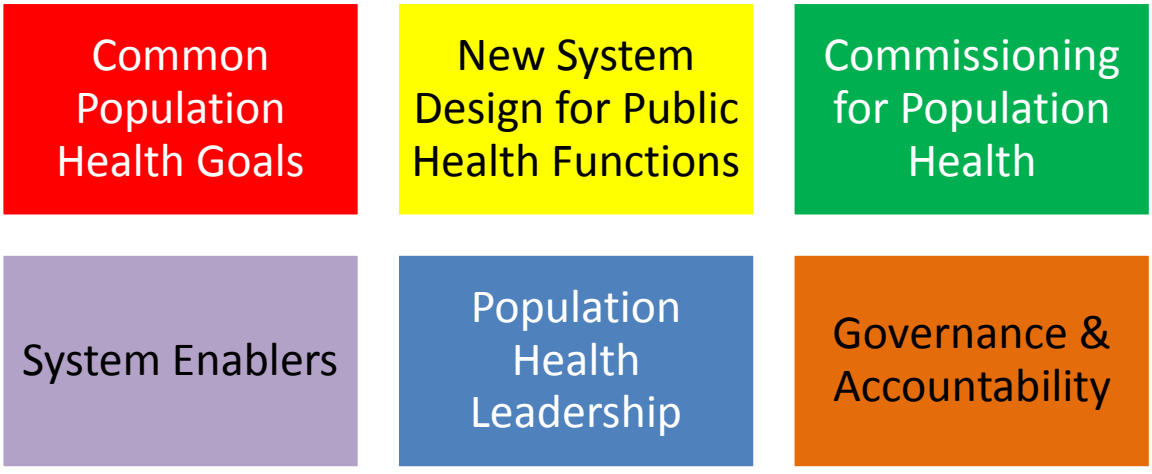
6.0 OUR PROPOSALS

6.1. Enacting a new way of working as a GM system for population health is an iterative process which is about changing cultures, behaviours, perceptions and ways of working in a more integrated way. We appreciate that for some localities this is already akin to their normal way of working, for others it will be more of a departure. Moving to a more place-based system of organising and deploying resources to improve health and care for the populations that localities serve, means organisations collaborating with themselves and the population to manage the common resources available to them.

6.2. At a minimum, developing a population health systems perspective therefore requires:

- greater pooling of data and budgets;
- informed population segmentation;
- place-based leadership drawing on skills from different agencies and sectors based on a shared vision and strategy;
- shared goals based on analysis of local needs and evidence-based interventions;
- effective community engagement; and incentives to encourage joint working;
- offering a range of interventions tailored to the needs of different individuals and population groups to support people to remain healthy and to deliver the right treatments when they become ill.

6.3. We have designed the following suite of interrelated proposals for creating a unified population health system for the whole of GM which reflects this, and will support the delivery of the population health plan, plus locality plans. Our thinking is more advanced in some areas which is a reflection of the maturity of discussions to date. Further work is needed to support the mobilisation of the proposals as well as any transition into new ways of working.



6.4. We see this work fitting in to the broader context of PSR and wider reform work, and delivery of some of the proposals may sit alongside/align with emerging work from areas such as the Transformation of Adult Social Services and, without question, the LCO Network Development.

6.5. We are aware of relatively few examples in the world where this type of vision of a unified population health approach is being harnessed with an accountable care delivery system. There are some comparisons with the Scottish model of reform and also New Zealand. Another is the New York State Medic-aid system reforms, particularly in their 'best in class' areas such as Staten Island. We have invited the

core team in Staten Island to visit GM to demonstrate how you can combine great data analytics, community-based population health programmes and integrated care to secure improved outcomes.

7.0 ACHIEVING OUR VISION: COMMON POPULATION HEALTH GOALS

GM Common Standards

7.1. We consider that there are core priority areas where we would expect that all localities work to which will make a difference for achieving the population health outcomes across GM. This is consistent with Taking Charge Together. The GM Standards will sit alongside current national mandation and supports GMs desire to use the business rates pilot, being introduced from April 2017, to see a wholescale upgrade in prevention. Each locality will be asked to review and supplement these standards where necessary to align with their own local priorities. There will be a joint responsibility to review and update the standards (both in localities and in GM) this will be done in partnership. As a minimum we would expect the following to be the core priority areas. There may be other areas that we would wish to consider over time:

- 0-5 including oral health
- Substance misuse
- Sexual Health
- Tobacco control
- Mental health
- Ageing Well

GM Strategy Development

7.2. We wish to develop the following strategies:

- GM Sexual Health Strategy (to complement the suite of strategies already developed /developing for Substance Misuse (Alcohol & Drugs); Tobacco Control and Early Years.
- GM Health Protection Strategy and GM Guidance and Standards on NHS response to outbreak – to ensure a consistent response and forms part of the LCO development.
- GM Age Well Strategy.
- GM Physical Activity Strategy (GMCA) (identified in the Population health plan)

- GM Healthy Weight and Nutrition Strategy (identified in the Population health plan)

8.0 ACHIEVING OUR VISION: NEW SYSTEM DESIGN FOR PUBLIC HEALTH FUNCTIONS

A Unified GM Health Protection Function

8.1. We intend to develop a new delivery model for health protection which unifies the existing partners and will cover a range of functions including outbreak prevention and control; emergency planning; risk management; infection control; outbreak management; monitoring threats and immunisation. It is envisaged that this model will have clear leadership, governance and work to a pooled budget model, similar to that of the service provided by the Civil Contingencies Unit for current emergency planning and response for LAs.

8.2. We wish to develop a blueprint for infection prevention and control into the developing LCOs as part of their community services offer. We envisage a level of infection control and prevention resource to be available within LCOs.

8.3. We intend to develop a system wide, multi-speciality workforce plan for health protection built into CPD. This supports succession planning and ensures a consistent minimum understanding of health protection.

8.4. We see value in the delivery of targeted immunisation programmes at scale at specific times in the year, for instance flu vaccinations.

8.5. We intend to set up a sharing and learning programme across GM from any incidents/outbreaks that occur in any locality so that as a system we can learn and move forward more proactively.

GM Population Health Intelligence Function

8.6. We propose to create a unified population health intelligence function that sits within a wider GM intelligence function as depicted below:

Wider GM Intelligence Function

- New Economy
- The Farr Institute
- Connecting to Healthy Cities
- Health Innovation Manchester
- Data Well
- Etc…

GM single population health information and knowledge repository

A networked PH Intelligence system across GM including PHE, LA, CCG other key partners including Academia and New Economy.

Minimum functions:

- Development of GM JSNAs
- Development of dashboards and metrics
- Risk Stratification Tools
- Innovation & Sharing good practice
- Development tools to support local PBC

8.7. We see the following functionalities could be incorporated into a unified population health intelligence function:

- "Do once" work across GM - could include lifestyle surveys needs assessments
- Data to inform GM Standards/commissioned services
- Specifications for collecting data – eg 0-19 Public Health services information,
- Accessing data
- Software and Data Tools - There are opportunities in procuring software and data (e.g. Tableau, Mosaic etc.) collectively across the whole of GM.
- Shared training/workforce development

8.8. We also see that the following deliverables will fall under the remit of a unified GM population health intelligence function:

GM Population Health Risk Stratification Tools & Dashboard

8.9. We wish to develop a range of risk stratification tools for locality use. Key features of the tools would thus include population segmentation and risk stratification and strategies to target different population segments. As a starting point these will be for Health checks, to ensure targeted identification and uptake; Health Protection; and supporting investment and outcomes stratification.

8.10. At GM level we will work collaboratively with the wider system to co-produce a population health dashboard and metrics which will give a system wide view of progress against target outputs and outcomes and also provide localities with a means of comparing and benchmarking their outcomes with other localities across GM. We intend to make data about programme and system performance readily available, including how money is spent, and openly tracking progress against target outcomes and impact on narrowing the health inequalities gap.

GM Population Health Outcomes Framework

8.11. We wish to undertake a refresh of the existing GM Population Health Outcomes Framework (in line with the refreshed GM Strategy) so that it can become part of the developing GM Outcomes Framework which will be used to shape and inform commissioning decisions and locality planning.

9.0 ACHIEVING OUR VISION: COMMISSIONING FOR POPULATION HEALTH

9.1. We intend to align our proposals with the propositions that result from the commissioning review currently underway and we are starting to have discussions with the LCOs/SCF leads regarding public health provision/commissioning in an LCO and within the single commissioning function.

9.2. We understand that emerging from the commissioning review will be a framework which will agree what services will be commissioned once at GM and which should be commissioned at other spatial levels.

9.3. In the interim the following are our proposals for how best to commission for population health across GM.

9.4. We have used the Commissioning for reform principles to underpin our proposals.

What this means for this work:

- Applying those CRP principles
- In addition:
  - Applying the principle of subsidiarity
  - Not wanting to disrupt local service integration
  - Seeking opportunities to maximise procurement and contracting including increasing efficiencies
  - Do once where it makes sense to e.g. lower volume, higher specialty

9.5. Our vision for commissioning for population health is to:

- Ensure consistency in how we procure, commission and contract for population health – which are quality, improvement, outcome and cost driven.
- Ensure that population health outcomes are embedded into all provider service specifications.
- Ensure that social value is embedded within procurement decisions. This means developing the GMCA Social Value Procurement Policy to cover population health outcomes and general health and wellbeing outcomes described in the GM strategic Plan ‘Taking Charge’.
- We commission as a ‘system’ and where possible move to commissioning across a pathway for population health.
- Any future commissioning/decommissioning decisions for population health are underpinned by the Commissioning for Reform Strategy.

9.6. **GM Whole System Integrated Sexual Health Service**

9.6.1. This covers a range of interventions via clinics, outreach, digital platform, delivery split between GM and locality level depending on the service.

9.6.2. Specialist access, health information, chlamydia, HIV treatment and care.

9.6.3. The intention is to look at the opportunity to include other non-LA commissioned services currently commissioned by NHSE and CCGs.

9.6.4. To enable a whole system approach to commissioning for sexual health we are proposing initially to undertake a System wide review to develop a new integrated delivery model across GM. This will include:

- undertaking a JSNA;
- modelling the best level of provision and level of estate needed;
- reviewing the possibility of pooling budgets with LA/NHSE/CCGs;
- developing a standardised payment mechanism;
- reviewing the opportunity of moving to an outcomes based and lead contractor model;
- determining the best place for the operational commissioning and contract management.

9.7. **Substance Misuse (Drugs and Alcohol)**

9.7.1. We are proposing as a minimum to commission Tier 4 Inpatient Detox & Residential rehabilitation at a GM level, supported by the development of:

- GM Drugs & Early Warning System & Intelligence
- GM Drugs & Alcohol common standards for early intervention, targeted interventions, recovery and communities, and treatment

9.7.2. We are proposing, alongside Sexual Health, to undertake a system wide review of current service provision with the aim of describing the optimum service delivery model. This will include:

- modelling the best level of provision and level of estate needed;
- reviewing the opportunity of any integrated services with sexual health and mental health for same population cohort;
- looking at current contracting mechanisms and payment flows;

9.7.3. This may mean commissioning other substance misuses services over time.

9.8. **GM Digital platform for Lifestyle & Wellness**

9.8.1. The Population Health Plan has indicated that a GM level digital platform for lifestyle and wellness to support individual behaviour at scale will be developed. It is anticipated that this will be commissioned over time at a GM level. This will complement existing locality platforms.

9.8.2. There is a possibility that over time the following could also be commissioned at a GM level. This is transformation work underway from the population health plan:

- Oral Health Improvement Programme 0-5 - (fluoride interventions and clinical dental services)
- Commissioning of Baby Clear (Smoking Cessation in Pregnancy)
- IMT proposition for Early Years – improving the collection, storage and transfer of intelligent data across a multi-agency system that includes parents

9.8.3. For any service that we are proposing to be commissioned at a GM level we are asking that localities don't decommission any services in anticipation of any change.

9.9. We also wish to develop the following:

- **GM Service Specifications** – for GM Commissioned Services
- **GM Good Practice Guidance** - for commissioning population health at a place based level ensuring that population health outcomes are reflected in local commissioning decisions.

9.10. Our summary view of what we consider might be commissioned at different spatial levels is captured at Appendix E.

10.0 ACHIEVING OUR VISION: SYSTEM ENABLERS

GM Standard for Health Checks

10.1. We are proposing to develop a robust GM Pathway for Health Checks that forms a systematic and scaled approach to identifying the missing individuals with, or at risk of developing long term conditions. This pathway will incorporate the stratification of risk prior to the invitation of 20% of the population on a rolling 5 year programme for the NHS Health Check.

10.2. Currently health checks are delivered by a range of professionals. We see the opportunity of:

- Linking health checks onto the digital platform.

- Linking the health checks with wider social care checks to form a population health check – this could link in with a range of professionals from other public sector services, such as the fire service, as well as with voluntary sector organisations eg LGBT.

- Linking in with the lung health check service.

GM Behaviour & Lifestyle Social Movements & Publication Materials

10.3. These can be used in support of the GM strategies that are being developed, and to sit alongside the digital lifestyle and wellness platform.

Sharing Good Practice

10.4. We wish to work with the PSR team and their infrastructure to actively promote and share good practice emerging from the localities.

Digital tools

10.5. We have already described the data systems, including mapping and visualisation, that we intend to develop for the localities and for GM purposes. We will also work in partnership with health innovation and others to develop apps and other digital means to engage with the population with respect to their health.

11.0 ACHIEVING OUR VISION: SYSTEM LEADERSHIP

Value-based approach

11.1. Our expectation is that the nine leadership values for GM which underpin public service reform are embedded in system leadership for population health.

1. **Delivers the GM Ambition** - Understands the GM ambition and the need for it to be delivered in all corners of GM**.**

2. **Leads from Place -** Understands what it takes to transform places. Leads within, and on behalf of their organisations, systems and places.

3. **Takes an asset based approach -** Recognises and values the strengths of people and places, enabling them to build on these to overcome challenges and make the most of opportunities.

4. **Understands impact** - Makes decisions ensuring the impact of people and places informs professional/clinical information and judgements.

5. **Is democratically astute** - Creates a collective responsibility to deliver the GM ambition, understanding governance systems, and accountability to people and place.

6. **Acts collaboratively -** Acts with authenticity, honesty, and integrity to build strong collaborative relationships and connectivity across GM.

7. **Building trusts -** Has a deeply held sense of purpose and is able to share power in a way that supports citizens and others to create the best conditions for people to thrive.

8. **Connects with people** - Connects with and respects with other people's stories and history.

9. **Is focussed on better outcomes** - Is resilient, innovative, curious, and relentless in getting better outcomes across GM.

11.2. Our intention is that any proposals for changes in system leadership are delivered through (at least) a cost neutral model supported by more integrated ways of working.

Developing system-wide leadership

11.3. We deliberately start with our proposals with respect to the wider workforce before we consider a discreet set of issues around the organisation of the specialist public health leadership whose role will increasingly be to support that wider effort.

11.4. We would expect asset based approaches, harnessing the skills of the community and VCSE, to engender a widespread focus on prevention and addressing the wider determinants of health. Population health place based leadership at the locality level is therefore about ensuring the development of a culture of 'population health is everyone's business'. This includes the role of the elected members in influencing the health and wellbeing agenda and wider population health. This applies to all councillors, not just the portfolio holder for health and wellbeing, but to other portfolio holders and ward and district councillors.

11.5. It is also about encouraging leadership and delivery of population health in LCOs, in working with other providers and creating the culture in their own organisation. Creating a culture of population health integrated into core business is through:

- Population health outcomes integrated into locality plans.
- Common standards for public health services which lift the performance to the best in GM across the whole system.
- Using peer to peer support (such as sector led improvement programmes) as a tool to support this.

- Providing population health training programmes. For example, on Staten Island in New York State, this has led to certified training opportunities around HIV, the needs of veterans, improving the health of people with disabilities etc.

11.6. This wider leadership approach extends to GM leadership. It impacts on other GM bodies such as Fire and Rescue, Police, Transport, New Economy, Growth Company etc., all of whom can contribute to our population health goals. It obviously means us penetrating a wider leadership cohort as well, most notably, educational leadership. This is one of the reasons why the new Children and Young People's Health and Wellbeing Board will have population health goals at the heart of its system stewardship work.

11.7. We will make maximum use of existing leadership training and development programmes to reach this broader leadership cadre, including the GM Leaders Programme.

Developing a Wider Public Health Networked Workforce

Directors of Public Health

11.8. Moving from a 'public health' to being more of a local 'population health leader', we are seeing, as a minimum, the following leadership role:

- Frontline leader for population health.

- Being a system leader across organisational boundaries, working strategically in a complex system with a range of stakeholders.

- Building partnerships (public, voluntary sector organisations, businesses) to deliver a whole system approach across public sector and beyond. For instance ensuring 'blue light' service integration into LCOs – spatial planning, health checks design and delivery, housing.

- Providing professional leadership on specialist public health workforce and growing that workforce.

- Developing a wider population health workforce (paid and voluntary) and ensuring that social value is embedded into the culture of the health and social care workforce, through values based discussion, training, awareness raising and participation in service design to maximise social value benefits.

- Engaging with commissioners, managers, clinicians and front line staff in the LCOs/ACOs to ensure that prevention and wider population health become embedded in the culture of emerging organisational structures.

- Providing assurance and leadership and advocacy to the cabinet members.

- Ensuring the GM population health plan and outcomes are delivered within locality plans and embedded locally.

- Ensuring evidence base, risk stratification and data for population health is driving commissioning decisions.

- Engagement of public champions/citizens programmes – cancer champions are example of this.

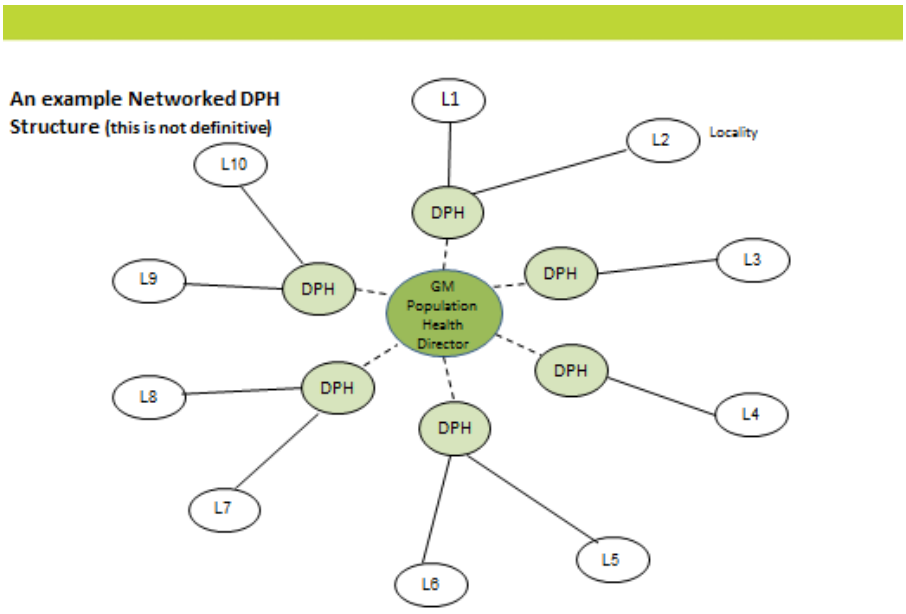
- Using local networks for social movement.

11.9. We see DPHs as being part of a networked structure across GM, which means that DPHs would be employed at the locality level but also work at a GM level, to support the delivery of the population health plan and the programmes of work which would need to underpin the proposals set out in this paper.

11.10. Similarly, we are proposing to network the specialist public health workforce (consultants, public health intelligence, health protection), to ensure a blended leadership and delivery model.

11.11. Network arrangements are for local determination, as some localities may decide to adopt a shared role. Accountability for the DPH would still reside at the LA level. A networked arrangement would still have to ensure that statutory responsibilities are being met in each authority. For any network arrangements we would anticipate that they would be underpinned by a strong and capable supportive networked consultant leadership.

11.12. The following is an example network structure:



11.13. It is unclear at this stage whether there is the right level of overall resource of the different parts of specialist workforce. A national survey is soon to be undertaken which will be reviewing this. It is proposed that we wait until the recommendations come out of that survey and we can then review the position for GM, although it is our expectation that a networked model should potentially lead to some efficiencies through economies of scale.

GM leadership

11.14. We are currently looking at the support needed at GM level to support delivery and implementation of the proposals.

The role of GM political leadership

11.15. The Population Health Plan provides a clear road map for what GM wishes to achieve for Population Health. However, we know that there are some big ticket items that can only be secured with the highest level political support. In May we will be electing the first GM Mayor and we believe that areas such as active travel; creating a smoke free GM; alcohol control; creating a GM Public Health Bill and improving the educational achievement of our young people may benefit from Mayoral support.

Organisational Change & Development

11.16. In order to evolve the model of leadership to a GM networked approach that meets the needs of both specialist and wider workforce, we will need to invest in support and development that covers at least the following common areas:

- Leadership and delivery of population health in strategic commissioning functions and LCOs.
- Developing new partner networks – with voluntary sector and commercial.
- Use of data in stratifying and targeting sub-populations.
- Integrating activity across contracts.
- Developing cross continuum protocols.
- Shaping cultures and addressing professional barriers.
- Asset based and social movement working.
- Embedding prevention in strategy and locality planning.
- Outcome-based commissioning and contracting.

11.17. We will also wish to develop a GM-wider offer for the specialist public health workforce.

11.18. These ambitions will be built into our wider Workforce Strategy and will be delivered with key partners such as Public Health England and the NW Leadership Academy.

12.0 ACHIEVING OUR VISION: GOVERNANCE AND ASSURANCE

12.1. Our proposed approach to governance and assurance is based on the following principles:

- Integrated framework – the work of a unified system in delivery of the population health plan and the relevant parts of locality plans, cannot be considered in isolation. Any governance and assurance arrangements need to be part of the wider arrangement for the whole of the health and care devolution programme.

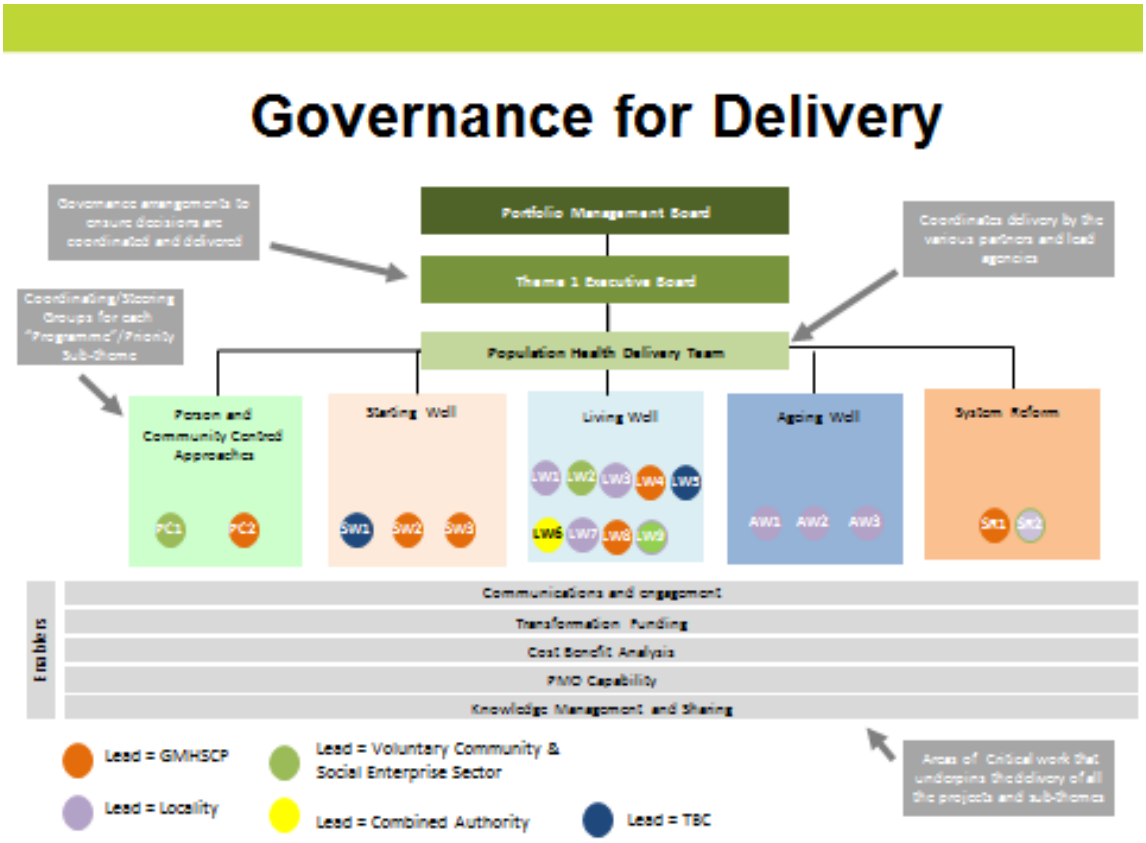
- Local democracy – in particular, respecting the work of local Health and Wellbeing Boards and the GM Reform Board under the Combined Authority.

- Transparency – we should make data about programme and system performance readily available, and how money is spent, and openly track progress against target outcomes.

- Public involvement and engagement – we should be full engaging people on design of programmes and projects, and actively seeking their feedback on progress.

Governance

12.2. In accordance with the above principles, and as this programme of work is part of the population health plan, we intend that the delivery of the proposals outlined in this paper will be mainstreamed into the governance and PMO structure of that overseeing the delivery of the population health plan, including the Population health Programme Board (Theme 1) as set out below. The Portfolio Management Board will report progress into the Strategic Partnership Board structure and thus, into the public domain. It will also report into the Reform Board which will have a lead governance role on programmes which require wider public service reform, e.g. Early Years, Work and Health



Population Health Programme Board has the wider partners from across the system including PHE. It aligns with Children's Health & Wellbeing Board and with PSR.

12.3. We will introduce a governance and reporting framework for the DPH group into the same governance framework for the population health plan. We intend to identify leaders from across the system to be SROs overseeing the delivery of the individual workstreams underpinning each of the proposals.

12.4. Going forward, there will also be an important role for the GM Joint Commissioning Board & Executive. Depending on the extended duties of the GMCA for public health and any commissioning responsibilities it may have, as a minimum we intend to work with the JCB and JCBE for the following purposes:

- New commissioning models, initially for sexual health and substance misuse.
- Development of GM common standards.
- Development of GM service specifications.
- Good practice commissioning guide for population health.
- Other commissioning areas that may come on stream over time (these may require engagement with the Children's HWB Board).

12.5. At the locality level, we would expect the population health transformation work to be integrated into the wider governance arrangements overseeing the delivery of the Locality Plan under Taking Charge Together. The overall stewardship of local population health would continue to sit with the Health and Wellbeing Board, and we envisage that the DPH, in their statutory role, will continue to have overall accountability for public health leadership.

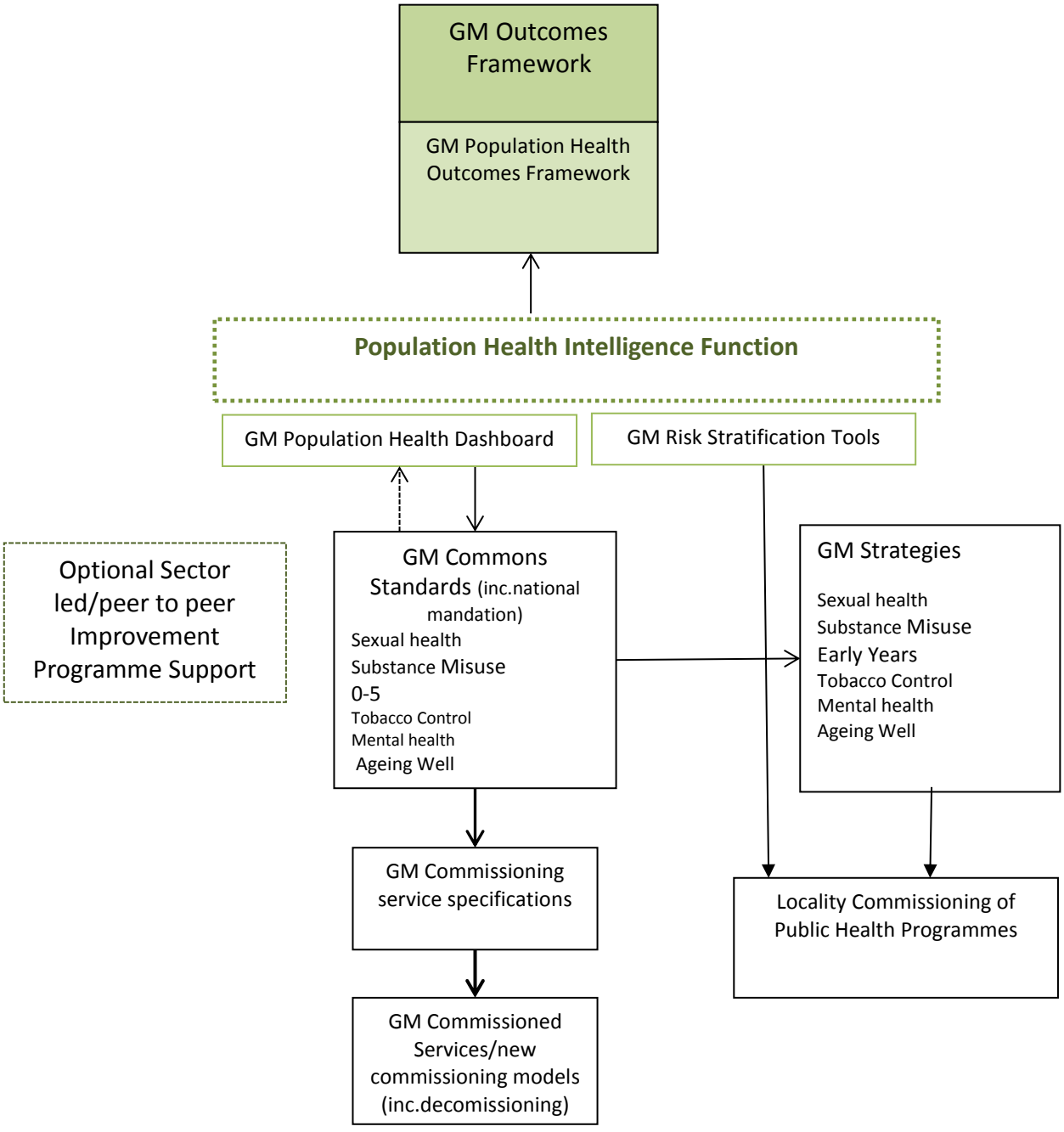
Assurance

12.6. While there is much merit in collectively agreeing joint GM standards, what we do not want to do is create a layer of assurance on top of national mandation. As LAs are accountable for improving population health it will be for localities to self-assure with respect to meeting the agreed standards, with the GM Partnership only raising issues where additional support may be required to facilitate delivery of the improved outcomes.

12.7. We intend to agree a programme of sector led improvement around agreed priority areas to support any localities which may require additional support. Over the next year, we propose that there is an initial in-depth review to baseline localities' current strengths and weaknesses, and therefore where a sector led/peer-to-peer improvement programme may add value.

12.8. Progress against common goals and the ambitions in locality plans would be assessed through existing GM quarterly assurance meetings with localities.

12.9. Bringing it all Together - The following illustrates the relationship between the various proposals.



13.0 A SUMMARY OF THE PROPOSALS

COMMON POPULATION HEALTH GOALS

1. GM Common Standards
2. Development of GM Strategies

NEW SYSTEM DESIGN FOR PUBLIC HEALTH FUNCTIONS

3. A Unified GM Health Protection Function
4. GM Population Health Intelligence Function
    - GM Population Health Outcomes Framework
    - GM Population Health Risk Stratification Tools

COMMISSIONING FOR POPULATION HEALTH

5. GM Whole System Integrated Sexual Health Service
6. GM Substance Misuse
7. GM Digital Platform for Lifestyle & Wellness
8. GM Service Specifications
9. GM Good Practice Guidance

SYSTEM ENABLERS

10. GM Standard for Health Checks
11. GM Behaviour & Lifestyle Social Movements & Publication Materials
12. Sharing Good Practice
13. Digital Tools

POPULATION HEALTH SYSTEM LEADERSHIP

14. Developing system-wide population health leadership
15. Evolved and networked DPH role
16. Networked Specialist public health workforce (consultants, health intelligence, health protection)
17. The role of GM political leadership

GOVERNANCE & ASSURANCE

18. Use of established local governance

19. Use of established GM governance

20. Use of GM health and care assurance framework

14.0 BENEFITS OF THE PROPOSALS

14.1. As a result of the reforms we are expecting to see:

- A sustainable system that secures better outcomes for local people.
- A reduction in unwanted variation in standards and population health outcomes, with a more consistent adoption of evidence based practice and benchmarking data.
- The system working together to deliver the scaled implementation of the Population Health Plan's transformation programme of work.
- Accelerated knowledge and skills exchange, with the implementation of best practice and innovation consistently.
- A focus on the role of health and care provider system to make a substantial contribution to population health growth, both in their role in being part of the pathways ('making every contact count') and as a major employer.
- Visible integrated population health system leadership across the system which will minimise siloed working and enable join up conversations across and between children's, adults' and wider public services, spanning physical and mental health.
- Maximising the existing skills and capacity in the system towards delivering the GM ambition for a radical upgrade in population health through more networked arrangements.
- Greater local determination in using and maximising available resources in the most efficient way, including communities making more decisions for themselves about the best way to secure improvements.
- Commissioning at GM level to achieve additional impact complementary to that at locality level.
- The deployment of Population health intelligence in the context of a GM place based function focused on GM priorities of growth and reform.
- Creating a platform for further devolution 'asks' from central government to enable Greater Manchester to have more control over the key levers for securing population health gains, including regulatory and pricing mechanisms, and improvements to environmental quality.

14.2. We see benefits for specific proposals:

Common Population Health Goals

- Enables Localities to be rooted in a set of common priorities, as the business rates pilot sees the ring fencing of public health grant end, and with the general move to pooling of budgets and integrated commissioning.
- It also reflects the ask of stakeholders across the system of having a clearer direction as to the core set of priorities that all localities need to be working to that which will make a difference for achieving the population health outcomes as a GM system.
- We believe that it drives more of a system wide approach to prevention.
- Ensures alignment with transformation programme for Adult Social Care and PSR Children's review so that the GM System is aligned around a single set of priorities.
- The shared goals reflect the 'asks' outlined in the Population Health Plan.

Unified GM Health Protection Function

- Maintains and transforms GM Health protection planning and response capabilities.
- Provides a clear and consistent and safe offer to each LA across the GM system.
- Embracing and fostering change and innovation to deliver quality improvement in infection prevention and control.
- Brings health protection assets in line with the local authority AGMA CCRU arrangements, which also have a shared statutory duty.
- Maximises potential specialist expertise in health protection and recognizes the need for succession planning around geographical areas.
- Drives out inefficiency and creates savings in the system from redesigning the pathway and decommissioning some services.

Unified GM Health intelligence function

- Networking our specialist public health intelligence resource across GM to ensure the continued localised place based intelligence support, whilst at the same time as working at a GM level on a 'do once' approach. This will

maximise the capacity of our specialist workforce and avoid duplication in the system.

- Maximising the capacity of specialist workforce.
- Enabling consistent access to specialist support to shape and inform commissioning and locality planning.
- Avoids duplication by commissioning products on a ‘do-once’ basis across GM

Population Health Commissioning proposals

- Enables the freeing up of resources for investment elsewhere in the system.
- Allows the delivery of more efficient and integrated services.
- Ensures consistency in how we procure, commission and contract for population health – which are quality, improvement, outcome and cost driven.
- Ensures that population health outcomes are embedded into all provider service specifications.
- Ensures that social value is embedded within procurement decisions. This means developing the GMCA Social Value Procurement Policy to cover population health outcomes and general health and wellbeing outcomes described in the GM strategic Plan ‘Taking Charge’.

Population health system leadership

- Ensures that every locality has ready and effective access to public health expertise and skills.
- Maximises and strengthens skills, knowledge and expertise.
- Aligns capacity in support of delivery of GM Population health Plan and the proposals in this paper.
- Manages capacity better across the system
- Strengthens skills and competencies
- Builds system resilience.
- Avoids unnecessary disruption of structural change.

System enablers

- Supports the achievement of the population health goals in localities and across GM, and also to underpin the new system design and commissioning model.

15.0 A SET OF PRIORITIES FOR CHANGE

15.1. Our intended next steps and priorities for change will be:

Immediate Priorities (March to April):

- Working with colleagues to develop the protocol which describes the operational working for the concurrent duty between LAs and the GMCA. (see A3 - Appendix A)

- Determining the governance for business rates pilot from April 2017 and thus providing assurance into the DH.(see A4 – Appendix A)

- Engaging with the LCO development and single integrated commissioning framework regarding the proposals.

- Taking into account and applying, where relevant, the outcomes of the Commissioning Review.

Further Work:

- Development of a detailed mobilisation plan and transition plan to support the implementation of the proposals.

- Undertaking further financial modelling work alongside the redesign of new pathways/commissioning models. In the short term we wish to do more of a deep dive to enhance our current financial understanding.

Implementing some quick wins:

- Introduce new governance and accountability structures and PMO office, aligned with that supporting the delivery of the population health plan.

- Revision of GM Population Health Outcomes Framework.

- Work with SCN and academic partners and PHE to design the risk assessment tool for GM health checks.

Commencing key programmes of work:

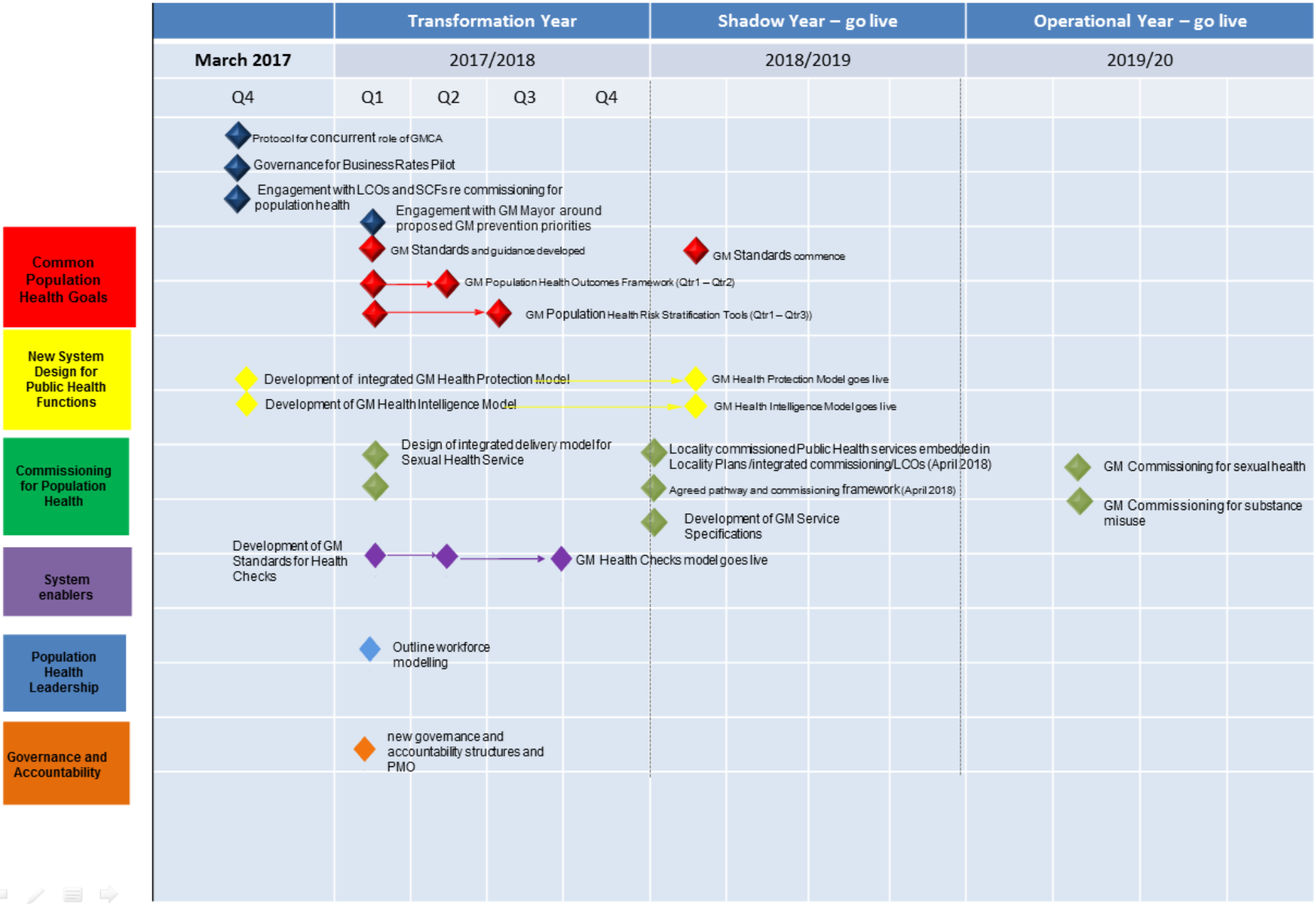
- Development work for GM Standards - Detailed work to work up overall guidance (governance, reporting, ongoing monitoring) and detail behind each GM standard.

- Development of integrated health protection pathway with partners.

- Development of model for health intelligence – a workshop has been scheduled to do this.

- Commencing the redesign the system work for sexual health and substance misuse by mapping the AS-IS position.

Indicative Timeline



APPENDIX A – CURRENT STATUTORY & POLICY CONTEXT

A1. The current statutory public health (PH) responsibilities of LAs are:

- Duty to improve public health - LAs to take appropriate steps to improve the health of the people who live in their areas. The Secretary of State continues to have overall responsibility for improving health with national public health functions delegated to PHE.

- Regulations on the exercise of LA PH functions - LAs to take particular steps in exercise of their PH functions, or aspects of the Secretary of State's PH functions under which LAs are mandated (national mandation) to:

  - protect the health of the local population;
  - ensure NHS commissioners receive the PH advice they need;
  - ensure appropriate access to sexual health services;
  - deliver the National Child measurement programme;
  - deliver the NHS Health Check Assessment;
  - provide health visiting services (0-5 services).

- Responsibility for oral health improvement services.

- Responsibility for sexual health services (commission testing of STIs, including HIV together with sexual health advice, prevention and promotion).

- Duties of Directors of Public Health (DPH) – Each LA to appoint a DPH whose duties and responsibilities are to:

  - be responsible for all their LA duties to take steps to improve public health;
  - health protection/health improvement functions delegated to LA;
  - planning for and responding to emergencies that present a risk to public health;
  - co-operation with police, probation and prison service to assess the risks posed by violent sexual offenders;

A2. National mandation was introduced at the point of transition (from PCTs to LAs in 2013) to ensure a nationally consistent approach, with a standard format (such as health protection) to ensure universal coverage. Mandation was not determined on the basis of importance in contribution to population health outcomes and is open to local discretion as to how much is invested in provision of those mandated services.

A3. From April 2017 GMCA will be given the same duty as LAs to 'take such steps as it considers appropriate for improving the health of the people'. Currently the GMCA has no health functions. The steps that may then be taken by the GMCA would include: providing information and advice; providing services or facilities designed to promote healthy living providing services or facilities for the prevention, diagnosis or treatment of illness. Consideration needs to be given to the development of a protocol which describes the operational working for this concurrent duty between LAs and the GMCA. We have an opportunity through this work to support the development of the protocol.

A4. From April 2017, the GM Business Rates Pilot (BSR) will commence which will see funding transfer from being a specific grant to being funded by business rates income and the ring-fence on the grant will be removed. National mandation will however remain. We understand that LAs may have already have budgeting strategies which includes PH grant.

A5. This programme of work should be directly informing the pilot so that we can work with the Department of Health and PHE on the development of our outcomes tracking to give them the reassurance they require.

A6. In May 2017 we will see the appointment of the GM Mayor. We have looked to London and Liverpool, where at a city-wide level, the Mayoral Health Commissions have cited ambitious plans for services to work together across their cities, boroughs and local communities to improve the health of their populations and tackle the wider determinants of health. We have the opportunity of framing a number of ambitions for the GM Mayor which would make the biggest health gains for our population. Identified in the GM Population health Plan is the ask for instance that the Mayor could lead the way for GM by making the public places controlled by Greater Manchester authorities smoke free.

APPENDIX B - HOW PUBLIC HEALTH GRANT IS CURRENTLY USED IN GREATER MANCHESTER

B1. We have looked at the utilisation of the PH grant as a starting point to understand the application of available resources. This is work in progress and currently gives an indication of, rather than a definitive position due to the lack of robustness of existing data (reporting and classification) at this stage. The data is from Central Government returns (RA returns 2016/2017) which relate to budgets and an intention to spend across the various categories which may differ significantly from what actually happened as detailed in the RO return.

Headlines - Our current understanding of the use of the PH Grant

- The allocation varies and the way it is spent is an amalgam of various commissioners.
- Year on year reductions to the Public Health Grant – 9% over 4 years.
- All areas are under significant pressure due to the recent significant funding cuts to LAs
- LAs have focussed on transformation and service redesigns to date to drive out efficiencies at the same time as improving outcomes.
- PH Grants form part of integrated LA budgets transitioning to single commissioning function pooled budget arrangements.

B2. The total LA spend across GM is £229.2M

- This equates to £67.78 per head of population in GM
- 34% of overall expenditure is on mandated services
- The largest use of the grant is allocated to:
  - 0-5 children's services (26%)
  - substance misuse (19%)
- ***** miscellaneous spend (19%) – see below
- sexual health (13%)

Miscellaneous Spend

Category	£ ,000	Category	£,000
Management & General salaries	7,772	Falls	227
Other Council PH Priorities	4,594	Young People inc Teenage Parent Floating Support	218
Various proportions of PH contracts not fitting other RA Criteria	2,566	Social Inclusion	200
Health Integration	2,437	Neighbourhood Investment	184
Central Support Services	1,911	CVS	130
Live Well / Big Life Contract	1855	Local Authority Role in Surveillance and Control of Infectious Disease	128
Wellbeing services	1,820	Acute Contract-Staffing	125
Mental Health Supported Accommodation	1,819	Community Alarm	119
Equipment and adaptations	1,750	Dental Public Health	111
Homelessness Prevention schemes	1,372	Commissioning support	100
Extracare	1,321	JSNA & Research	75
Youth and Play	1,096	Healthy Schools	75
Mental Health Recovery Prog	1,015	Specialist Physical Activity Service	70
Sheltered housing	959	Primary & Secondary Prevention in Primary Care	70
Prevention Activities	911	Other Child Health	63
Healthy Contract	845	Vulnerable People Commissioning	52
Domestic Violence	702	Seasonal Death Reduction initiatives	51
Advocacy and Advice	680	Start Well	50
Well North, Falls, Nutrition	657	Health Inequalities	47
Carers	644	Health Chats	35
Management & General salaries	449	Housing Energy	33
Other Council PH Priorities	435	Good Neighbour Scheme	26
IDC's/Supplies & Services	389	Volunteering Budget	25
Age Well / Older People Services	332	Public Health Capacity Building	25
Marketing/Training/Admin Costs/Rent	314	Project Delivery	19
Long Term Condition Prevention	308	Information & Intelligence	9
GM Public Health Network Subscription	303	Public Health Campaigns	5
Nutrition Initiatives	238	Total	41,770

Figure 1: Distribution of expenditure of PH grants:

Figure 2 above suggests that for both those commissioned services, services are commissioned individually rather than as a full pathway. There may be opportunities for combining parts of the provision e.g. prevention.

Figure 3: Range of spend per head of the Population

Spend per head amounts have been arrived at by dividing total spend by total population of the borough – and not weighted for age / sex / deprivation – so any variation may be warranted.

Spend per head below suggests variation in investment.

Spend per head	Minimum	Maximum	Average	Median
Sexual Health	4.67	15.57	10.81	9.89
NHS Health Check Programme	0.46	1.33	0.86	0.95
Health Protection – local authority role	0.02	3.63	0.89	0.79
Public Health advice to NHS Commissioners	0.2	2.1	0.79	1.28
Obesity / NCMP	0.04	9.26	3.19	5.10
Physical activity	0.01	7.7	2.68	5.97
Substance misuse	11.21	24.36	16.23	17.34
Smoking and Tobacco	0.04	5.01	1.42	2.77
Children 5-19	3.13	16.69	7.90	6.77
0-5 children's services	14.44	29.07	22.04	24.54
Health at work	0	2.15	0.31	1.07
Public mental health	0	1.61	0.67	1.08

Variation in spend can be down to:

- Sexual health –demand for open access in certain areas
- Health protection – LA dedicated teams v outsourced contracts
- Local interpretation by LA when reporting
- Local prioritisation by LA

APPENDIX C – OUR GM PARTNERS IN HEALTH PROTECTION

PHE	PHE North West provides case and incident response, technical expertise, surveillance, epidemiology, strategic and system leadership for health protection in GM with reach back into highly specialised PHE national functions and resilience from wider PHE North West. There is a dedicated GM function within the PHE NW Health Protection Team.
CSU/CCGs	CCGs have a key role in the NHS response to cases and incidents as well as strategic programmes to prevent and control health protection threats. CCGs have commissioned the CSU to do their NHS emergency planning.
GM HSCP	Immunisation was delegated from NHSE to GMHSCP as part of Devolution. There is a PHE Screening and Immunisation team embedded within GMHSCP. GMHSCP also has responsibility for elements of the NHS planning and response to incidents.
LA's	Community Infection Prevention and Control (IPC) and Environmental Health resides with LAs. For IPC, LA's either have direct employees or outsource to local NHS providers For directly employed teams, there is a mixed picture of provision, as some IPC teams are integrated with civil contingencies and/or environmental health.
AGMA CCRU	AGMA Civil Contingencies & Resilience Unit provides emergency planning & elements of response across GM for local authorities. A business partner model has been established which enables the collective working of a team across GM with the agility to support localities.
TfGM	TfGM leads air quality work across GM with support from LAs and PHE.

APPENDIX D – CURRENT PUBLIC HEALTH LEADERSHIP

D1 Public Health went through the most radical reform for decades post Health & Social Care Act 2012, which saw Local Authorities taking responsibility for public health within their locality. At the time there was little reimagining of public health for the transition into local authorities. This resulted in a variety of different approaches to how public health was integrated into local government leadership structures.

D2 When PH teams moved from PCTs to LAs, the opportunity that public health presented was not always initially understood and this has been reflected in the positioning and embedding of public health as part of the core functions. Across GM therefore we have a range of different public health models in operation:

- **Fully distributed model -** Fully integrated Public Health capability within Council functions which sees the embedding of population health responsibility and perspectives across the local system, to shape environmental factors and wider determinants of health.

- **A retained PH function -** A minority of councils have a model whereby the PH expert advisory function is retained either as a defined directorate or integrated within a broader directorate infrastructure.

- **Alignment to ICO/LCO development and locality plans**

D3 The Devolution of NHS England S7a commissioning resources to GM saw the transfer of relevant commissioning and contracting resources to the GMHSCP, as well as the responsibility for commissioning screening (cancer and non-cancer); immunisation and vaccination programmes, Child Health Information Services and elements of health and justice commissioning.

D4 A Population Health Team within GMHSCP was established in 2015 which includes NHSE public health commissioners and PHE's assigned staff which operates as an integrated commissioning team under the leadership of the GM Executive Lead – Commissioning & Population Health. The team has recently expanded its resources and remit by securing the existing GM resource which supported the development of the population health plan, as well as resource from the GM Public Health network (which has been redesigned and is being aligned into the population health function). The additional remit of the team, working with system leaders across the system, is to support the delivery of the GM Population Health Plan. The overall SRO for overseeing the delivery of the Population health plan is a LA CEO.

D5 PHE is committed to supporting GM in its aim to transform health and ensure that the full range of expertise and capabilities available to PHE as a national body are made available to support the major transformational programmes associated with delivery of the Population Health Plan. PHE North West Deputy Director of Health and Wellbeing is working as part of the GMHSC as the Population Health Lead for GM. The purpose of the role is to work within and collaboratively with GM Health and Social Care Partnership and wider population health stakeholders in GM to take forward the population health work programme, to build public health capacity and

the potential for sharing good practice and success from GM in other parts of the country.

D6 For several years the Public Health Network has been funded by each Locality to support the implementation of cross GM working. The team is hosted by Tameside Borough Council, and managed by the Tameside DPH, in her capacity as Chair of the GM Directors of Public Health. A comprehensive service review of the Network has been completed to develop a fit for purpose team structure that can effectively mobilise, align and complement capacity in the wider GM population health team.

APPENDIX E: POSSIBLE SPLIT IN COMMISSIONING FUNCTIONS

Greater Manchester

PH Functions	Commissioning Greater Manchester
Unified Health Protection	√
Health Intelligence Function	√
Section 7a	√
Whole System Integrated Sexual Health Service	√
Alcohol & Drugs Initially - Inpatient Detox & Residential rehabilitation Overtime the move to an integrated whole system approach	Tier 4 √
Oral Health Improvement Programme (0-5) *	√ *
GM Digital Platform – Lifestyle & wellness	√

Cluster/Locality/Integrated Commissioning Function

PH Functions	Commissioning Cluster/Locality/Integrated Commissioning Function
Health Intelligence Function	√
Section 7a	
Whole System Integrated Sexual Health Service	
Alcohol & Drugs Initially - Inpatient Detox & Residential rehabilitation Overtime the move to an integrated whole system approach	Tier 1Interventions
Oral Health Improvement Programme (0-5) *	√
GM Digital Platform – Lifestyle & wellness	√
Health Checks	√
Integrated Lifestyle & wellbeing services (physical, obesity, tobacco control) including National Child Measurement Programme (NCMP)	√
New Focussed Model of Care	√
Dental Public health	√
Integrated Services for 5-19	√
EYDM/Core model	√
Nutrition & Hydration	√

LCO/ICO/Neighbourhoods

PH Functions	Delivery
	LCO/ICO/Neighbourhood
Unified Health Protection	Infection control within LCO
Section 7a	√
Whole System Integrated Sexual Health Service	Levels 1 & 2
Alcohol & Drugs **Initially - Inpatient Detox & Residential rehabilitation** **Overtime the move to an integrated whole system approach**	√
Oral Health Improvement Programme (0-5) *	√
GM Digital Platform – Lifestyle & wellness	√
Delivery of Health Checks	√
Integrated Lifestyle & wellbeing services (physical, obesity, tobacco control) including National Child Measurement Programme (NCMP)	√
New Focussed Model of Care	√
Oral Health Improvement	√
Integrated Services for 5-19	√
EYDM/Core model	√
Nutrition & Hydration	√
Falls prevention & fracture	√

Agenda Item 8

Bury Health and Wellbeing Board

Title of the Report	Locality Plan – Update from Transformation Programme Board
Date	13 June 2018
Contact Officer	Philip Thomas
HWB Lead in this area	

1. Executive Summary

Is this report for?	Information √	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	To update the Board on progress made to implement Bury's Locality Plan, its plan to transform health and care		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	All		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page			
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	• Note actions agreed to progress implementation further faster following the year-end review; • Note progress made to further develop the transformation programmes and towards the creation of a Locality Care Alliance and a One Commissioning Organisation for Bury. • Be active advocates for the transformation programme,		

	within their organisations, with partners, the community and wider stakeholders. • Receive further updates on locality plan implementation
What requirement is there for internal or external communication around this area?	None
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	No

2. Introduction / Background

2.1 Bury's Locality Plan: Transforming Health and Social Care, sets out the borough's ambitious programme to transform health, adult social care, children's and public health services by 2021, securing a sustainable health and care system whilst improving health and wellbeing, ensuring that all people have a good start and enjoy a healthy, safe and fulfilling life.

2.2 This report updates the Health and Wellbeing Board on progress made to implement that plan.

3. key issues for the Board to Consider

3.1 Locality Plan Year End Review

3.1.1 During February and March of 2018, as part of a Greater Manchester process, Bury undertook a year-end review of progress made to implement its locality plan. This review identified that, whilst a number of the 2017/18 milestones had been achieved, there was significant slippage against the implementation timeframes set out in the plan, impacting upon transformation delivery, financial planning and outcome assumptions.

3.1.2 Provider and commissioning partners from across Bury, working with colleagues at Greater Manchester Health and Social Care Partnership (GMH&SCP), undertook a detailed analysis of the key issues that had impeded progress and agreed a set of actions to move the programme forward further faster, specifically:

i. By end of May:

- Completion and approval of all programme plans and investment agreements – by end of May
- Programme Management Office operating at full capacity

ii. By end of June:

- Revised Locality Plan and investment agreement between Bury and GMH&SCP completed
- Significant additional capacity sourced and in role

3.1.3 In addition, there was also agreement for a system-wide development programme, involving provider and commissioner organisations, and to strengthen system support for transformation, e.g. through role of Programme Management Office (PMO) and transformation programme board.

3.2 Transformation programmes

3.2.1 As signalled in the February 2018 update to Health and Wellbeing Board, programme leads have been undertaking a detailed refresh of their programmes and developing project level investment agreements which set out the financial requirement, how that will be spent, project benefits and return on investment.

3.2.2 A process is underway and will be completed by the end of May whereby a multi-disciplinary and multi-partner scrutiny panel reviews the programmes and projects and makes recommendations to the Transformation Programme Board for it to decide which programmes and projects should be prioritised and mobilised first. Programme and project implementation will be supported and monitored through the PMO.

3.3 Creation of a Locality Care Alliance

3.3.1 Effective delivery of these transformation programmes requires transformational changes in the way that services are organised and delivered. To support this Bury has created a Locality Care Alliance (LCA) (previously known as Locality Care Organisation). The LCA is an alliance of local provider organisations, working together to transform how services

are delivered, improving outcomes, increasing efficiency and reducing demand.

3.3.2 A key stage in developing the LCA, in April 2018 all partners signed a mutually binding agreement setting out how they would work together on the design and delivery of transformed health and social care services in Bury. The partners have also agreed that the LCA will be referred to as 'Together 4 Bury'.

3.3.3 Chief Executives from each of the Together 4 Bury partner organisations have developed and are driving forward the delivery of an implementation plan. This plan details actions to clarify the objectives and outcomes, the services in scope, the capabilities required to successfully deliver the transformation and ultimately the organisational form that the Alliance will move towards.

3.3.4 Recruitment to key executive positions is progressing. Dr Kiran Patel has been appointed as the Medical Director until March 2019 and the post of Chief Officer will be advertised shortly.

3.3.5 The Alliance is also participating in a peer to peer session with the other North East Sector local care organisations in order to share learning and to explore where there may be economies of scale benefits.

3.4 Creation of One Commissioning Organisation

3.4.1 Bury has also committed to establishing a strategic single health and care commissioning function – One Commissioning Organisation. In April a key step in this journey was achieved with the establishment and first meeting of Bury One Commissioning Organisation Partnership Board. Bringing together officers, politicians, clinicians and lay members from the CCG Governing Body and Bury Council Cabinet, the partnership board will:

i. Set OCO strategic direction, vision and values;

ii. Provide leadership and direction to OCO development;

iii. Set the framework to describe how all stakeholders work together across organisations;

iv. Provide a joint forum to oversee and hold to account OCO partners for the development and delivery of strategies and plans to develop and maintain a diverse and vibrant health and care economy that meets the needs of local people and improves outcomes for all.

3.4.2 A number of key priorities were agreed by the Board, namely development of:

i. A commissioning and decommissioning strategy;

ii. A joint financial plan and reporting;

iii. Pooled and aligned budgets and management arrangements;

iv. A performance and outcomes framework;

v. A risk and quality assurance framework;

vi. Governance structures for the partnership, to be incorporated into a partnership agreement including integrated commissioning proposals.

3.4.3 The Board agreed to formally meet monthly, supported by a Board development programme, with the first development session held on 25 April 2018 and a visioning session held on 22 May 2018.

3.5 Programme Management Office

3.5.1 The PMO has been running at full capacity since the beginning of May. The Programme Director for the PMO started in post on 23 April and since being in post has commenced a quick review on the PMO function.

3.5.2 This has included current project planning processes, sign off and governance and the roles and responsibilities of the PMO team and project officers within the system.

3.5.3 The review has so far resulted in a process for bringing all projects to investment agreement stage by the end of May and the creation of a one off Transformation Scrutiny Panel to recommend the prioritisation for first phase funding.

3.3.4 Any further recommendations from the review will be communicated through the system by the PMO.

3 Recommendations for action

4.1 Health and Wellbeing Board is recommended to:

i. Note actions agreed to progress implementation further faster following the year-end review;

ii. Note progress made to further develop the transformation programmes and towards the creation of a Locality Care Alliance and a One Commissioning Organisation for Bury.

iii. Be active advocates for the transformation programme, within their organisations, with partners, the community and wider stakeholders.

iv. Receive further updates on locality plan implementation.

4 Financial and legal implications (if any)
If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

N/A

5 Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

N/A

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Date: 30 May 2018

Agenda Item 9

Bury Health and Wellbeing Board

Title of the Report	SEND Update
Date	13 June 2018
Contact Officer	Karen Dolton
HWB Lead in this area	Karen Dolton

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	Information and discussion		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	Special Education Needs and Disabilities (SEND) is a cross cutting theme across all the priorities in the strategy.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	A SEND rapid needs assessment is currently being undertaken so there will be a specific reference to SEND incorporated within the JSNA		
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	To note and ensure there continues to be progress and commitment to SEND from the top down in partner organisations		
What requirement is there for internal or external communication around this area?	Important that positive messages on SEND are promoted via a range of communication mechanisms so parents/families know that progress is being made by the Council and CCG		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	SEND Partnership Board meets monthly to have oversight and review		

2. Introduction / Background

2.1 In June 2017 Ofsted and CQC carried out a Joint Area Inspection of SEND in Bury. This identified eight areas of weaknesses and Bury Council and Bury CCG were required to submit a Written Statement of Action (WSoA) to the Minister for sign off. All senior leaders in partner organisations have committed their organisations and staff to taking forward the actions in the WSoA and to fully implement the SEND Reforms (2014) which we were found as an area to be lacking at the time of the Joint Inspection.

2.2 As at May 2018 we have had three quarterly monitoring meetings from the Department of Education and NHS England and they have acknowledged our progress and have been very positive in support of the actions which we have taken to date. At the last monitoring visit on 26 April 2018 we were rated for progress in the work-streams as:

- Leadership - Green
- Co-Production & Engagement; Schools; Joint Commissioning - Amber/Green
- Joint Working Arrangements; Sharing of Health Information; Local Offer; Health Practitioner Awareness of SEND/EHCPs - Amber

2.3 Our areas of strength/key areas of learning to date have been in:

- Leadership - we have strengthened the governance and elected member involvement, and have established work-streams accountable to the SEND Partnership Board. The responsibility for overseeing the SEND Reforms and holding the SEND system to account in Bury, sits with the SEND Partnership Board which reports to the Strategic Leadership Team and into the Health and Wellbeing Board.
- Co-Production - There is now a maturing working relationship between the Council and CCG with Bury2gether (Bury's Parents Forum) with a clear commitment to co-production from all sides. This was demonstrated by the Co-Production Event organised by Bury2gether on 18 May 2018. Parents, young people and professionals across adults, children's and health participated in work-shops and there were inputs from local and national leaders. Feedback from the event has been very positive from parents and professionals, and the outcomes of the workshops will inform the SEND work-streams and action plans.
- Schools - a lot of work with schools to ensure that schools take ownership of inclusion and develop a graduated support model that supports young people staying in mainstream and so reduces the number of exclusions

and the demand for out of borough placements. SEMH Partnerships have been established across the primary and secondary schools and with health involvement. Work to date has included development of an Inclusion Standard for consultation; planned recruitment of Inclusion Managers; a sufficiency exercise to identify needs and gaps in current provision.

3. key issues for the Board to Consider

3.1 The following are priority areas of work in the next quarter, though the workstreams are at varying pace and with different development issues:

- Local Offer - Feedback from the Co- production Event is that families do not know about the local offer, are not clear about the purpose of it and/or the information is not easy to find. A fresh impetus has been established across adults and children's and priority actions have been identified.
- Joint working - 0 – 5 years is a critical phase where transition pathways need reviewing. We have started to take an MDT approach with health to review the more complex cases and lessons learnt but we also need to take on board the views of parents from the Co-Production Event for this age range
- Schools – continuation of work-plan and to build in the messages from the Co-Production Event
- Co-Production –to begin work on an Engagement Strategy
- Joint Commissioning – Co-Production Event feedback on health commissioning to be incorporated into the work-stream

3.2 Next DfE/NHSE Quarterly Monitoring Meeting on 10 July is critical. If we can demonstrate continued progress and provide evidence as outlined above the DfE/NHSE officers may recommend to the Minister that the quarterly monitoring schedule can be stepped down as they are satisfied with our direction of travel.

4. Recommendations for action

HWB to note:

- the progress with the SEND Written Statement of Action and the outputs of the work-streams; and
- Ensure their organisations' continued participation in the work-streams and ownership of the actions.

5. Financial and legal implications (if any)
If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

There are escalating demands on SEND budgets with pressures from:

- Educational Placements in out of borough settings due to a lack of suitable and appropriate local provision
- Increasing numbers in schools and colleges (post 16) with an Education Health and Care Plan.

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

CONTACT DETAILS:

Contact Officer: Karen Whitehead SEND Lead

Ruth Wheatley Strategy and Commissioning

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Date: 31 May 2018

Bury Health and Wellbeing Board

Title of the Report	NHS Bury CCG Annual Report 2017/18
Date	13th June 2018 HWB meeting
Contact Officer	Carrie Dearden, Comms and Engagement Manager, NHS Bury CCG
HWB Lead in this area	Stuart North CCG Chief Officer, who will present the item at the June HWB meeting

1. Executive Summary

Is this report for?	Information X	Discussion	Decision
Why is this report being brought to the Board?	It is important that the CCG's Annual Report has input from the Health and Wellbeing Board. This year, due to the timing of the report's publication and HWB meeting schedule, input on activities during the year were crafted and incorporated virtually. It was agreed that the final report would come to the June meeting of the HWB for information/noting.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	The report cross cuts all priority areas. In addition, there is a specific section which focuses on the work of the HWB during the reporting year.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	The report cross cuts all themes.		
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	The CCG Annual Report for 2017/18 is now finalised and approved by the CCG Audit Committee and Governing Body. We would kindly ask the HWB to receive the final report for information/noting.		
What requirement is there for internal or	None.		

external communication around this area?	
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	CCG Audit Committee, CCG Governing Body.

2. Introduction / Background

It is a statutory requirement for the CCG to produce an Annual Report and Accounts. The final report for 2017/18 is brought to the Bury Health and Wellbeing Board for information/noting.

3. key issues for the Board to Consider

Receiving the final CCG Annual Report for 2017/18 for information/noting.

4. Recommendations for action

Receiving the final CCG Annual Report for 2017/18 for information/noting.

5. Financial and legal implications (if any) If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

N/A

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

N/A

CONTACT DETAILS:

Contact Officer: Caroline Dearden, CCG Communications & Engagement Manager

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Date: 30th May 2018

NHS
Bury
Clinical Commissioning Group

NHS Bury CCG

Annual Report 2017/18

Contents page

Foreword

As Chair and Chief Officer of NHS Bury Clinical Commissioning Group (CCG) during the year, we are pleased to present our Annual Report for 2017/18, which covers our fifth year of operation.

Overall, 2017/18 has been a year of emerging change for the CCG and the wider health and social care system locally as we made further progress towards our aspiration to become one integrated commissioning function with the Local Authority (Bury Council). This joint commitment to work more closely and make decisions together to plan and purchase health and social care services took shadow form from 1st April 2018.

We have also supported the development of our Locality Care Organisation, this is the alliance of local providers of services that have come together to deliver the transformational changes that are required.

Working together is fundamental to ensuring that our ambitious plans to improve and transform health and care services by 2021 are realised, and the changes will be made possible through the investment of a transformation fund that has been secured for the Bury locality totalling £23 million.

By transforming services we are confident that local people will remain well for longer than is currently the case, and that we can reduce the health inequalities that continue to adversely impact some of our most deprived communities. The changes will also put us in a stronger position to manage demand for services and overcome some of the operational and financial pressures we currently face in the most critical parts of our system. Having a health and care system fit for the 21st century will also put Bury on the map as an attractive place for exceptional health and care staff to work and thrive.

Whilst we achieved our financial duties during the year, financial challenges remain. Towards the end of the year we started to consider what steps might need to be taken to close the expected financial gap (deficit) in the year ahead.

Reflecting back on the past year, a number of the priorities that we talked about in our last Annual Report are now taking shape and providing better outcomes for patients.

Patients and carers are now benefitting from more co-ordinated care at the end of life as specialist palliative care nurses relocated to Bury Hospice to work with the Hospice at Home team to provide a joined up service called the Community Palliative Care team. The move enabled the teams to work more closely to offer a co-ordinated approach to plan and deliver care, ensuring people are able to live as well as possible, that their wishes and preferences are known and that they are able to die with dignity.

Working alongside Bury Cancer Support Centre, Macmillan Cancer Support and a number of local organisations, Bury Multi-agency Cancer Service launched in the early part of 2018 to offer free and confidential non-clinical support and advice, such as financial advice, health and lifestyle advice, counselling and emotional support to

people affected by cancer. We are proud of the co-productive approach taken to plan and shape this new service.

Towards the end of the year we reported that over 35,000 patients were using GP online services enabling them to book and cancel appointments, order repeat prescriptions and access parts of their GP medical record. We hope to increase the number of patients benefiting from these services in the year ahead.

During the year we undertook further engagement work, including a focus on cardiology (heart) and gastrointestinal services (caring for patients with conditions affecting the digestive system). This engagement work will help us to plan and improve care in the future, and is talked about in more detail later in this report.

Patients and the public also shared their views on a proposed future model for urgent care through a public consultation. Patient and public involvement is a very important aspect of our work. We listened to feedback from local people about the importance they placed on retaining access to walk-in services, and considering this valued feedback alongside new guidance, revised proposals were developed.

The CCG was one of 28 organisations across the country to become an NHS Employers Equality and Diversity partner during the year. The programme supports us to progress and develop our equality performance, as well as offering advice, guidance and examples of good practice.

We feel it is important to recognise the significant contribution and achievements of our 30 Member practices. The pressures on general practice are widely known nationally, and this is no different locally. Despite these challenges, our practices have continued to provide high quality care and achieved good levels of patient satisfaction.

At the end of March 2018, the majority (28) of our practices were rated as ‘Good’ by the Care Quality Commission, another was rated as ‘Outstanding’. We will continue to support all of our practices to continually improve their quality and standards of care.

On the theme of the work of our GP practices, a scheme to free up clinical and administrative time to care for patients was shortlisted for a national award. The Productive General Practice scheme aims to put in place more efficient administrative processes, and following its successful implementation, the approach was shortlisted for a ‘General Practice Award’.

In addition, Garden City Medical Centre won a Transforming Services Award, part of the Greater Manchester General Practice Nursing Awards, for changes the team put in place over the past year to improve the standards of their service.

As health and social care enters an exciting new chapter, we hope that you enjoy reading this annual report. If you have any comments or questions on the information contained within it, please do let us know using the contact information at the back of the report. We would be pleased to hear from you.

Towards the end of the financial year, following a recruitment process to appoint a new CCG Chair *(note: Dr. Kiran Patel stepped down as CCG Chair after 5 years’ service at*

the end of the year to take up a new role), Dr. Jeff Schryer, a GP from Prestwich, took over the reins as CCG Chair from 1st April 2018.

Dr. Kiran Patel	**Stuart North**
Chair and Clinical Lead	**Chief Officer and Accountable Officer**
Until 31st March 2018	

Performance report

Performance overview

Introduction from the Chief Officer

This report aims to provide a fair and balanced review of NHS Bury CCG's business, development, activity and performance during the year. It cross-references other sections of the Annual Report for further details where relevant.

NHS Bury CCG was established under the legislative framework of the Health and Social Care Act 2012. We certify that we have complied with the statutory duties laid down in the National Health Service Act 2006 (as amended). The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the Act (as amended). There is no doubt in relation to the going concern principle.

Within this performance report we provide information to give readers an understanding of our role and the population we commission services on behalf of, provide details of our business and planning strategies, our finances and our performance against objectives, risks and challenges.

Our organisation

We are an ambitious and forward thinking organisation. We were fully authorised by the NHS Commissioning Board with no conditions from April 2013 and this report marks our fifth year of operation.

We remain committed to working with other NHS organisations, and partners including Bury Council, those within the third sector such as voluntary organisations and local people in relation to the delivery of our agenda, working in collaboration to ensure that the services that we plan and purchase are high quality, meet peoples' needs and offer good value for money.

We outlined in last years' report our commitment to more joined-up working with Bury Council. During the year, we made further progress towards our aspiration to become one integrated commissioning function, and this joint commitment to work more closely and make decisions together to plan and purchase health and social care services took shadow form from 1st April 2018.

We have identified areas where our financial resources can be pooled, which is a change from the historic arrangement in place of separate health and social care budgets. We will continue to identify new areas where our legislative framework allows us to operate in this way to not only ensure best value, but to enable our patients to experience care and services that are seamless, personalised, high quality, responsive and eliminate avoidable and unnecessary delays.

Bury's vision for joined up health and social care is outlined in its Locality Plan. This year we have undertaken significant work on refreshing this to be more ambitious so that our population, both current and future generations can experience better health outcomes.

The plan outlines the town's vision for the future of health and social care services which will involve closer working between these services so that they are more co-ordinated and people only have to tell their story once, whilst making services more convenient and accessible. Preventing poor health and intervening quickly with care and support when it is needed is a key theme in Bury's plan, as is making sure people have the support and information they need to take an active part in their own health and wellbeing. We will continue to embrace the challenges ahead of us to make a difference for our population.

All 30 GP practices in Bury are known as our 'Member practices', and together we are working to achieve a healthier Bury by commissioning services that meet local needs. CCGs have clinicians taking the lead on making decisions about local health services and we are committed to giving local health professionals the freedom to respond, innovate and develop services in a way that best meets the needs of local people.

In addition, a key part of the process to plan and purchase a range of services is ensuring that we listen to patient feedback. We want to hear and learn from patient experience and in turn ensure that this influences the way that services are designed and delivered.

Our aspirations are far reaching and include delivering improved outcomes, providing quality services so that patients receive the care that is right for them every time, ensuring better access, reducing health inequalities and ensuring services are locally focussed and more joined up.

During the year we received a budget of just over £291 million to plan and purchase a range of health services including those provided in hospitals, out in the community and for GP (primary care) services, for our population of around 190,000 patients.

At the end of the financial year in relation to the Governing Body (Board) members, both voting and non-voting, there were 13 male and 5 female members. In relation to all other CCG employees, there were 44 male and 86 female members of staff (including inward and outward secondments). The average number of employees during 2017/18 was 95.39 whole time equivalent.

Our vision, values and strategic ambitions

Our vision remains ***to continually improve Bury's Health and Wellbeing by listening to you and working together across boundaries.*** This was set when NHS Bury CCG was authorised as a statutory organisation and developed by our Members and employees.

Through the development of the Locality Plan, an overarching aim for Bury has also been developed by all stakeholders and partner organisations. This is reflective of our vision and we are committed to the realisation of this aim, which is to ***ensure our population is as healthy, happy and independent as possible, living with minimal intervention in their lives, achieved through targeted strategies of self-help, prevention and early intervention, reablement and rehabilitation***.

Our values, which we expect to be demonstrated through all that we do, are:

- to be inclusive and transparent about the decisions we make
- to challenge inequalities through partnership working
- to be bold, inclusive and supportive
- to value everyone
- to listen and learn, and
- to secure people centred, clinically effective, efficient and sustainable care

During 2017/18 the Governing Body reviewed its strategic objectives to ensure they remained relevant to continue to support the delivery of our vision. These were agreed and have directed our priorities during the year:

- To empower patients so that they want to, and do, take responsibility for their own healthcare. This includes prevention, self-care and navigation of the system.
- To deliver system wide transformation in priority areas through innovation.
- To develop Primary Care to become excellent and high performing commissioners.
- To work with the Local Authority to establish a single commissioning organisation.
- To maintain and further develop robust and effective working relationships with all stakeholders and partners to drive integrated commissioning.
- To deliver long term financial sustainability in partnership with all stakeholders through innovative investment which will benefit the whole Bury economy.
- To develop the Locality Care Organisation to a level of maturity such that it can consistently deliver high quality services in line with commissioner's intentions.

Our Governing Body has assessed the CCG's performance in delivering against these objectives and felt that significant achievements have been made during the year, whilst also recognising that there is still more for us to do.

Our population

According to the most recent mid-year estimates in 2016, the population of Bury was estimated to be 188,700. We anticipate this will rise to over 199,000 by 2026. According to the Census in 2011 (the most recent source of data), 10.8% of our population are from black and minority ethnic (BME) communities.

We need to consider population changes in terms of our objectives in the long term. Like many areas, Bury has an ageing population and it is expected there will be 6,490 (or 19%) more people aged over 65 by the year 2026. This means Bury's total 65 and over population will be in the region of 40,200, equating to over 20% of the estimated overall 2026 population. It is also anticipated that the proportion of people aged 85 and over will increase by 41%, to around 5,600.

An ageing population brings with it an increased burden of poor health in later years and a significant increase in demand for health and social care services. This strengthens the need for health and social care to work more closely moving forward. You can read more about our progress to join up health and social care, later in this report.

As the population ages, according to POPPI (Projecting Older People Population Information) 2017 estimated projections, the level of people aged 65 and over who are

living with dementia is expected to rise by around 47% by 2030 (2,269 to 3,335 people). This will result in a higher dependency on services, specialist care services and carers. We have continued to build on our already excellent dementia and memory assessment services to improve care in this important area.

We are working on shaping our services to anticipate these population changes and our focus will continue to be on supporting people to remain safe and independent for as long as possible.

Life expectancy in the borough remains below the England average and the gap is widening. Life expectancy for males in Bury is 77.9 years, 1.6 years less than the England average (79.5 years). For women life expectancy in Bury is 81.6 years, which is 1.5 years less than the England average (83.1 years). Within Bury there are significant differences in life expectancy. The most recent inequalities information (2014/16) indicates for men there is a gap of 11.3 years, and 8.5 years for women, between the most and least deprived areas of the town.

There are around 1,800 deaths a year (average for 2013/16 is 1,806 deaths per year) in Bury with the main causes being due to cancer, circulatory disease (for example heart disease and stroke) and diseases of the respiratory system (for example chronic obstructive pulmonary disease or asthma).

Early death rates from stroke have fallen, and are now similar to the England average, although deaths from heart disease have seen an increase and are worse than the England average. Deaths from diseases of the nervous system are also increasing.

Greater Manchester Health and Social Care Devolution

In April 2016, Greater Manchester took charge of its health and care system as one Partnership spanning NHS and local government, commissioners and providers of both physical and mental health services.

In doing so, we embarked upon the most radical health and care transformation programme in the country.

We are now approaching the third year of the delivery of our strategy ‘Taking Charge’. Two years into our journey, we can see a health and care landscape in Greater Manchester that looks fundamentally different.

Our approach to this change has been guided by a core principle: identifying who contributes to health creation and how they can be better connected.

Through our programme of reform and investment, we now see our way to the system architecture in Greater Manchester that will be in place as a legacy of Taking Charge. This will comprise these recognisable and consistent features:

- The establishment of 10 Local Care Organisations (LCOs) integrating provision
- Pooled health and social care resources into a single budget, managed through an integrated Single Commissioning Function in all ten localities
- New models of hospital provision seeing hospitals working together in Greater Manchester at a much greater scale than ever before to a set of consistent quality standards

- A Greater Manchester-wide architecture where it makes sense to do things at greater scale – including the Greater Manchester Commissioning Hub, Health Innovation Manchester, a Digital Collaborative, a Workforce Collaborative and a 'one public service estate' strategy

Devolution gives Greater Manchester the freedom and flexibility to do things that benefit everyone by allowing us to make our own decisions. We're tackling serious conditions like cancer and heart disease, and looking at bigger problems that affect health.

In the future in Greater Manchester, services will be built around the person, helping people live healthier and happier lives. For the first time in the history of the NHS, the home not the hospital will be the default setting of care. The main aims of Greater Manchester's plan are to:

- Help everyone manage their own health more efficiently
- Provide more joined-up care near to where people live
- Offer easy access to specialist treatment when it's needed
- Do things better, more efficiently, and to the same high standards, right across Greater Manchester

Two years after taking control of our health and social care budgets, devolution is making a difference to everyday lives, examples include:

- Giving children a better start – we're spending an extra £1.5 million on oral health to improve children's teeth, and getting more children 'school ready'.
- Improving lifestyles – for example in Greater Manchester 115,000 smokers are being helped to quit over the next three years.
- Fighting cancer with a mobile screening programme and 'cancer champions' out and about in communities.
- Spending £74 million on child and adolescent mental health, bringing more mentors into schools and training teachers on mental health.
- Spending a further £50 million on adult mental health services.
- Services are rapidly improving, for example stroke centres are top-rated and it is estimated that 200 lives have been saved because of the specialist care people have received in them.
- Creating more services closer to people's homes, and making it easier to see medical professionals at convenient times.
- And, spotting and treating dementia earlier – seven more people a day are diagnosed with dementia, and getting the help and support they need.

Business information

During the year we revisited our Operational Plan and set out how we will shape services to better meet local needs and health challenges. We also refreshed our strategic objectives and have focussed on delivery of these throughout the year. Our strategic objectives are listed earlier in this report and can be found on page 8.

The high level business of the CCG can be summarised into our duties and our commissioning responsibilities. Duties include delivery of the NHS Constitution which brings together in one place details of what staff, patients and members of the public

can expect from the NHS. Our commissioning responsibilities include the planning and purchasing of a range of services to meet local needs, such as community services, hospital services, emergency and urgent care, mental health and learning disability services and continuing health care.

The organisations which provide care for local people on our behalf are known as our providers. Our providers deliver services to patients across a range of settings including hospitals such as Fairfield General Hospital in Bury and North Manchester General Hospital, to community settings including health centres, and where safe and appropriate, in a patient's own home.

Pennine Acute Hospitals NHS Trust is our main provider of hospital services, of which Fairfield General Hospital in Bury is one site. Pennine Care NHS Foundation Trust is our main provider of mental health and community services. We also commission health care from a small number of independent and third sector providers.

Commissioning updates at a glance

End of life and palliative care – comparing Bury against best practice

In Bury we have a range of established end of life and palliative care services. In a bid to continually strive for excellence and review our current services against best practice, we have been using a toolkit developed by the Greater Manchester and Eastern Cheshire Strategic Clinical Network.

The toolkit has six ambitions including ensuring that each person is seen as an individual when planning and co-ordinating their care, and that people are supported to take control of their end of life care.

The toolkit also includes:

- Understanding the diverse needs of the local population ensuring that everybody gets fair access to care
- Having a workforce that is appropriately trained and skilled to meet the needs of people receiving end of life care
- Delivering integrated care across the local health and social care system, and
- Engaging with the local community to raise awareness to build compassionate and resilient communities

Using the toolkit we benchmarked Bury against the six ambitions at two workshops with support from a wide range of statutory, provider, charitable and third sector organisations.

We are using the valuable insight and information gathered during this process to identify, benchmark, prioritise and implement areas identified for improvements. This work will help to shape the Bury end of life and palliative care vision and strategy moving forward.

Gastrointestinal services - patient engagement

Demand for gastrointestinal diagnostic services, specifically for gastroscopy (a procedure to look inside the oesophagus, stomach and first part of the small intestine)

and endoscopy (a procedure where the inside of your body is examined using an instrument called an endoscope), remains high.

Whilst reviewing these services with a view to alleviating pressures and improving patient experience, we felt it was important to understand how patients are supported when accessing these services.

Working with our commissioning manager and clinical lead for planned care a patient questionnaire was developed with a view to capturing important information about patients' experience in this area. The questionnaire captured information from GP referral, to having tests and treatment, and about a patient's ongoing care and confidence in managing their condition.

The questionnaire was made available through a wide range of organisations including the voluntary sector and charities supporting patients with gastrointestinal conditions, it was promoted in the press and media, via our website and social media, our providers of services locally promoted to survey and sought feedback directly from patients accessing the services. Hard copies were also made available on request.

The results from the period of engagement are currently being reviewed and analysed, to ensure that this important patient feedback helps us to plan and improve services in the future.

Cardiology (heart) services

With patients having to attend multiple cardiology (heart) appointments, there was evidence to suggest that the experience of patients could be improved by appointments and services being more coordinated. Existing pathways for patients accessing cardiology services were reviewed to establish if there were ways they could be simplified or made more efficient and convenient for patients to access, with less duplication of appointments.

Working with our commissioning manager and clinical leads, along with valued input from a patient representative on the mobilisation group, a questionnaire was developed to gain insight into the experience of patients who accessed the service for chest pain, heart failure, fainting (syncope), valve disorder or irregular / fast heart rate (atrial fibrillation). The questionnaire also asked patients if they would rather see their cardiology doctors or nurses in the community, for example at a health centre, rather than having to attend an appointment at hospital.

The questionnaire was made available through a wide range of organisations including the voluntary sector, via GP practices and their Patient Participation Groups and through the health care providers. The questionnaire was promoted in the press and media, via the CCG website and social media, and hard copies were also made available on request.

The findings of the engagement period helped to shape pathways as part of a 12 month pilot of an integrated community cardiology service which is being delivered by Pennine

Acute Hospitals NHS Trust working in partnership with Pennine Care NHS Foundation Trust.

Following a redesign of the key pathways, three new community clinics were launched for heart failure in the early part of 2018. In addition, a new one stop shop clinic for patients with valve disorders was put in place, along with the development and implementation of a new pathway to care for patients experiencing atrial fibrillation and cardiac rehab.

The new way of working offers benefits to patients and to health care staff delivering the services. The clinics offer patients more coordinated care closer to home, whilst enabling closer working between services with primary care colleagues across a range of speciality areas.

Living with and beyond cancer

Recent figures suggest there are over 1,000 new cases of cancer diagnosed every year in Bury. In 2010, there were over 5,000 people living in Bury up to 20 years after a cancer diagnosis. Many of these people are living with unmet non-clinical needs, such as financial worries or in need of employment or emotional support, and this figure is estimated to rise to 10,800 by 2030.

To address a range of unmet non-clinical needs, in partnership with Macmillan Cancer Support, we initiated a Bury living with and beyond cancer project. The overall aim was to take a co-productive approach to develop and implement a community based service to support local people affected by cancer and to reduce the unmet needs that exist.

50 patients who are affected by cancer, were involved and engaged in the project from the start, along with a range of teams, health and care services and organisations including those representing the voluntary sector, to plan and design what a future service might look like to meet the needs of people living locally.

This co-productive consultation process highlighted key themes that would be important in the success of any future service.

- Referral processes were defined including a self-referral option which would be routed through a single point of access
- Support and advice themes to focus on, for example emotional support, were scoped out, and
- Training on cancer awareness and the impact of cancer treatment for those that would be delivering the service was also built in to the proposals.

This information formed the basis of a business case, which successfully secured funding from the CCG and Macmillan Cancer Support.

The new service known as the Bury Multi-agency Cancer Service, was launched in January 2018 to offer a range of free and confidential support and advice to people that have received a cancer diagnosis (during or after treatment), as well as carers and families. The service is provided by a range of local organisations including the voluntary sector, covering themes such as financial and benefits advice, counselling

and emotional support, employment advice and support, health and lifestyle advice and complementary therapies.

Local people can self-refer to the service (or be referred by their health care professional) by calling one telephone number which is answered by an experienced key worker who will ask a range of questions in confidence, to get a better understanding of the individual's needs, so that the most appropriate professional support can be provided.

Read more about our co-productive approach, in our engaging people and communities section on page 33.

Urgent care redesign and consultation – listening to patient feedback

An earlier period of consultation in relation to urgent care was paused in light of emerging national guidance. When the new guidance was published, we reviewed this at the same time as reflecting on patient and stakeholder feedback that had been received to date.

The feedback received at the point the original consultation was paused highlighted the importance people placed on retaining access to walk-in services in the town. It was part of our original proposals to not renew the contract for Bury's two Walk-in Centre services. This important feedback directly led to a revised proposal for urgent care being developed which included the availability of walk-in services in the future through brand new 'Integrated Health and Social Care Hubs' offering a range of health and care services.

Patients and the public were invited to share their views on the revised model, which included retaining walk-in services, through a six week consultation period.

Informed by patient and stakeholder feedback, the revised model was approved by the Governing Body at its meeting in March 2018.

Work is now underway to plan the implementation of the model. It is hoped that at least one pilot site for an Integrated Health and Social Care Hub will be up and running during the autumn of 2018.

Read more about how we listened to feedback from local people and as a result changed our proposed model, in our engaging people and communities section on page 33.

Children and young people - local transformation plan

We have continued to support children and young people's emotional and mental wellbeing with the implementation of the local transformation plan. Through the plan, Bury has:

- Recruited link workers to act as the conduit between the core children and young people mental health service, to education settings and other sectors to build knowledge and providing strategies for support at an early stage.

- Commissioned the community and voluntary sector to provide alternative therapies, parenting and peer support, widening the locally available offer.
- Supported our core provider through increased investment to achieve all nationally mandated targets around access to services, as well as waiting time standards for mental health and eating disorder specific services.

General Practice Forward View

We have continued to work closely with general practice to implement the principles of the General Practice Forward View which aims to create a stable general practice workforce with time to continue to provide high quality care to all.

The continued success of extended working hours (evening and weekend appointments) enables patients to see a GP at a time convenient to them and practices are building on this collaboration to develop new models of care in local neighbourhoods.

After successful completion of the Productive General Practice programme, a scheme which aims to put in place more efficient administrative processes, a number of practices have been participating in the Time to Care programme which sees practices implement one of the 10 high impact changes designed to free up time in general practice to spend with those patients that need it most.

Working jointly with the Bury GP Federation, an education strategy for general practice has been produced designed to support all staff working in general practice to gain the skills that they need today and to upskill them for the changing world of general practice. The strategy also gives a clear steer that education and training needs to be closely linked with that provided to other primary care providers (pharmacy, optometry and dentistry) by other organisations.

The year ahead will see us working more closely with all partners in primary care to help identify the thousands of people from Bury with unidentified medical conditions such as high blood pressure, and to empower our population to self-manage any minor illnesses they may develop.

Stopping over-prescribing of people with a learning disability

Our Medicines Optimisation team worked with GP practices and Pennine Care NHS Foundation Trust to address NHS England's 'call to action' to tackle the over-prescribing of antipsychotics in patients with learning disabilities. The goal was to increase the quality of life for this group of patients by reducing unnecessary adverse effects, particularly sedation and long term cardiovascular complications and risks.

Patients with a learning disability who were prescribed antipsychotic medication for challenging behaviour were identified from GP practice registers. Each patient's case was reviewed by a learning disability specialist pharmacist, who made recommendations to each patient's GP practice with a view to agreeing individual action plans for reducing and withdrawing antipsychotic prescribing where it was considered inappropriate.

Our pharmacy technicians worked alongside GP practice pharmacists to implement action plans, with involvement from patients, carers or family members. Regular

contact with patients ensured that any concerns around reduction plans could be alleviated, reassurance could be offered and ongoing support could be provided. In addition, learning disability team nurses from Pennine Care NHS Foundation Trust provided vital support.

The scheme highlighted the importance of communication and joint working, which helped to improve communication between health care teams, it also highlighted how regular contact with patients or carers built trust and confidence. The project was highly commended at the national 'excellence in general practice' awards.

Supporting the appropriate prescribing of specialist infant formula

In recent years, the range of formulas available for infants with suspected cow's milk protein allergy has resulted in increasing costs, inappropriate prescribing and an increased demand for community paediatric dietetic services.

Our medicines optimisation team worked with Pennine Care NHS Foundation Trust's Nutrition and Dietetic Service and Paediatric Dietitian to develop and implement a new clinical pathway to support health care professionals in terms of diagnosis and ongoing management of cow's milk protein allergy.

The Medicines Optimisation team technicians reviewed all prescribed formulas, and in line with our prescribing for clinical need policy, measures were put in place to discontinue the prescribing of those formulas available over the counter (leading to prescribing of over the counter formulas reducing by 97%).

The reviews also generated referrals to the dietetic service for infants to be reviewed and families were supported with the 'milk ladder'. Most children with milk allergy will outgrow the problem, and the milk ladder supports the reintroduction of dairy products into a diet in a planned way with specialist support, when an infant is around 12 months of age.

In addition, through the scheme the team implemented national guidance regarding 'home re-challenge' which is a process to determine if a child has an allergy to the protein found in cow's milk. This involved putting on training sessions for health visitors and clinicians, supporting decision making in the diagnosis and ongoing management of cow's milk protein allergy, and leading to more appropriate referrals to the dietetic service.

The project highlighted that key to its success was joint working between the medicines optimisation team technicians, clinicians and health visitors, leading to better processes for diagnosis and ongoing management, whilst ensuring the dietetic service is available to review infants that require access to the service in a timely manner.

Challenges and risks

The healthcare system continues to face the challenge of significant and enduring financial pressure. Need for services grows faster than funding and as we continue to plan to meet the demands of our local population, we recognise the need to work differently, using new and innovative methods, through partnership with all our stakeholders, including the local population and at an increased pace.

Through the year, there have been a number of risks identified to delivery of the strategic objectives, these are listed below:

- Because of a lack of effective engagement with communities there is a risk that the public will not access preventative services or accept responsibility for own healthcare.
- Because of a lack of engagement with partners and other key stakeholders at the right time in service redesign processes there is a risk that innovative and new approaches across sector may not be considered.
- Because of a recent CQC assessment in 2016/17 at Pennine Acute Hospitals NHS Trust, there is a risk that quality and performance at the local provider does not make the required improvements in the delivery of health care services for the local population as stipulated by the CQC and other regulators and stakeholders.
- Because of a recent CQC assessment in 2016/17 at Pennine Care NHS Foundation Trust, there is a risk that quality and performance at the local provider does not make the required improvements in the delivery of health care services for the local population as stipulated by the CQC and other regulators and stakeholders.
- Because the CCG and Local Authority have different priorities and drivers, there is a risk that integrated commissioning does not progress at pace to achieve value for money, improved outcomes.
- Because of the need to work as one commissioner there is a risk that the new governance structure fails to recognise the importance of clinical decision making.
- Because of the inability to identify sufficient QIPP programmes there is a risk that we will not achieve required quality, innovation, productivity or prevention improvements.
- Because the CCG may be required to pursue short term financial balance at the expense of long term sustainability and or might not maximise a return on investment on refundable funds, there is a risk that the CCG might not make the necessary changes required for financial sustainability and optimal service provision.

The Governing Body has reviewed these risks, with assurance from the Audit Committee on a quarterly basis, and has recognised that whilst these risks have been managed in year, they will remain as we move into 2018/19.

I believe this performance report gives a fair and balanced review of our business, development, activity and performance during the year. Whilst there have been some performance challenges, we have made substantial progress in a number of key areas.

Performance analysis

There are a range of areas and indicators that we monitor on a monthly basis, looking at the performance of services and also patient outcomes, including:

- The **NHS Constitution** – this sets out what patients have a right to expect from their local health and care services, but also what their responsibilities are to look after themselves.
- The **CCG Improvement Assessment Framework** (IAF) – indicators within this are broken down into four main domains and provide assurance that we are monitoring performance in key areas. In addition to assessing the CCG across a range of Key Performance Indicators (KPIs), the IAF also draws together a view of our performance in the quality of leadership, financial and human resources management. The output of this is then explored in assurance meetings with the Greater Manchester Health and Social Care Partnership (GMHSCP), as outlined later in this section of the report.
- **NHS Operational Planning and Contracting** – sets out the main areas that we must plan for over the coming year. This includes specifying targets against which measurement will take place.
- **Local Performance Targets** – a set of key KPIs are agreed for each service we commission to ensure that providers are meeting specified standards and are securing value for money.
- **Quality Premium** – initiatives set nationally and locally designed to improve the patient experience and overall quality of health services.
- **Legislative requirements** – as set out in the Health and Social Care Act 2006 (as amended).

We have provided a more detailed update on some of these areas later in the report.

On a monthly basis, the Quality and Performance Committee receives a performance report and a quality report, which outline the performance achieved in the reporting period along with corrective actions where performance is below the required levels. These reports are then presented to the Governing Body on a bi-monthly basis.

Performance reports are also provided to clinical work streams on a monthly basis.

We are also held to account by NHS England for delivery of a number of measures and are assessed on a quarterly basis against the IAF. The IAF assesses the CCG against a number of indicators which are broken down into the following domains:

- Better health
- Better care
- Sustainability, and
- Leadership

Assessment against the IAF is supported by quarterly assurance visits from the GMHSCP. In addition to the CCG and GMHSCP being in attendance, our local partners from Bury Council, Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust, are also represented at the meetings. These assurance visits provide an opportunity to discuss performance and developments across the local health economy and to identify any additional support required from GMHSCP.

Quality Premium

The Quality Premium requires CCGs to achieve national and local standards against key targets. The targets are amended each year in order that quality improvement is continually driven forward. In addition to the national targets, the CCG sets a local target.

Achievement of the Quality Premium is linked to a financial payment which if achieved, will support us in further improving the quality of services across the borough.

To achieve the additional funding available through the Quality Premium, collaborative working between the CCG and its main providers is required. If we fail to achieve the outcome measures, the financial award is reduced. Additionally, if the national patient rights and pledges articulated within the NHS Constitution are not delivered the available monies are further reduced by 25% for each target that is not achieved.

During 2017/18 gradual improvement was seen across the main Quality Premium measures with most being achieved or forecast to be achieved by the end of the financial year and this represents improved quality of care to Bury patients. However, as performance was lower than required against the relevant NHS Constitution measures, the potential financial reward associated with Quality Premium will not be realised. Risks associated with the financial impact of this and the non-achievement of NHS Constitution measures were managed in line with the risk management strategy throughout the year.

Quality Premium performance

There were five national and one local Quality Premium targets against which the CCG was measured in 2017/18. Progress against these targets is monitored and reported to the Quality and Performance Committee on a quarterly basis. Achievement of the Quality Premium measures results in a financial award to the CCG for onward investment to support the quality agenda.

In order to receive the Quality Premium monies for achieved measures, the CCG must also demonstrate achievement against the following four NHS Constitution measures:

- Referral to treatment time: 18 week waits
- A&E: maximum 4 hour waits (Accident and Emergency)
- Cancer: 62 day wait from GP referral to treatment, and
- Ambulance Response: 8 minute for Category A incidents

Should the CCG fail against any of the above constitutional standards, the Quality Premium monies are reduced by 25% for each failed measure.

During the year we received £370,000 investment in relation to the achievements against Quality Premium Indicators for 2016/17.

For 2017/18, although progress against many of the measures is positive, any potential financial gains will be significantly reduced due to the CCG's under-performance against the constitutional standards outlined above.

Our performance during 2017/18

NHS Constitution

The NHS Constitution outlines the values, guiding principles, rights and pledges that patients have a right to expect and we recognise our obligations to patients as set out within the Constitution. Our performance against the measures outlined in the NHS Constitution is published on our website within the Governing Body papers. Performance in a number of key areas is summarised below:

A&E targets

There are two main measures which help us to understand the experience of patients when attending A&E. The first is the 4 hour A&E wait measure and the second is the 12 hour trolley wait measure.

- 4 hour A&E wait

There has been significant pressure on the delivery of this target, both locally within the borough, within Greater Manchester and nationally. As such, performance has been noted to be below the required constitutional standard each month during the financial year. Of particular note, although the standard has not been achieved at a CCG or Pennine Acute Hospitals NHS Trust level during 2017/18, performance at Fairfield General Hospital our local hospital site has been strong.

The CCG, along with its neighbouring CCGs within the North East Sector of Greater Manchester has implemented a number of urgent care and seasonal resilience programmes to support delivery of this measure. We have also worked collaboratively with colleagues at Pennine Acute Hospitals NHS Trust to develop action plans to deliver improvements and these are monitored both through the Urgent Care Partnership Board and the North East Sector Commissioning Board on a monthly basis.

In order to bring about resilience within the current system moving into the next financial year, we have been working on a redesign of urgent care services which aims to reduce confusion for patients and to ensure that those requiring urgent care are directed to the most appropriate delivery point.

- 12 hour trolley waits

As a CCG we expect there to be no patients waiting for more than 12 hours once a decision to admit the patient has been taken.

Ongoing work between the CCG and Pennine Acute Hospitals NHS Trust has ensured that the number of trolley waits exceeding 12 hours reduced significantly during 2017/18 when compared to the position in the previous year. This includes the initiation of a number of work streams across hospital sites that are designed to improve patient flow and include primary care streaming and reducing delayed transfers of care.

This work was also supported by the introduction of a new Decision to Admit policy during the year under which consistency will be applied along with ensuring the best clinical outcome for patients.

Delayed transfers of care

Linked to the pressures seen in A&E, the urgent care agenda has seen increased focus applied on delayed transfers of care during the year. Work across our main acute and mental health providers involves improving the flow of patients and ensuring the provision of sufficient suitable accommodation in the community.

Referral to treatment waiting times (18 weeks)

Referral to treatment performance has been a challenge for both the CCG and more widely across Greater Manchester and England during the year, resulting in performance below the constitutional standard in many months.

Along with other CCGs from the North East Sector of Greater Manchester, Bury applies scrutiny to Pennine Acute Hospitals NHS Trust's performance in this area via monthly Elective Care Tactical Group meetings, where those specialities where most pressure is felt are examined. This group also oversees the improvement plans put in place by the trust and ensures that these are actioned to return performance to the required standard.

In addition, during the year some pressure has been felt across other provider sites and we have monitored progress against recovery plans via the relevant lead commissioning organisations.

Diagnostic test waiting times (6 weeks)

Delivery of the 6 week diagnostic measure has proven to be a particular challenge during the year, mainly due to capacity and resource issues with the local provider, particularly for endoscopy procedures. Plans actioned to improve the position have included commissioning the services of third party providers and this has helped Pennine Acute Hospitals NHS Trust to improve performance.

Capacity issues at other providers within Greater Manchester have also contributed to the CCG's under-performance against the target, despite Pennine Acute Hospitals NHS Trust now achieving the required standard. Improvement was, however, noted towards the end of the financial year.

Cancer targets

Cancer targets are broken down into three main waiting time periods:

- Two week wait

The primary two week wait target for GP referrals for suspected cancer has seen performance below the required standard for much of the year, though some improvement was noted in Quarter 3. Demand has continued to increase during 2017/18, though at a lower rate than in the previous year.

Where a GP referral is made for patients with breast symptoms where cancer was not initially suspected, performance was below standard during the first half of the year though started to improve through Quarter 3 as workforce issues noted at Bolton NHS Foundation Trust were resolved.

- 31 day waits

There are four measures against a 31 day standard, two of which have achieved 100% performance in most months of 2017/18.

Where a patient requires subsequent surgical intervention, performance has been less consistent, although 100% achievement has been noted for several months during the year. As demand on 31 day wait pathways tends to be low, under-performance is often the result of just one or two breaches.

Following a cancer diagnosis, a patient should expect to review their first definitive treatment within 31 days of that diagnosis and the target has been achieved throughout the year.

- 62 day waits

There are two main 62 day wait measures within the NHS Constitution and performance against these has been a particular challenge this year. Improvement plans are in place for relevant specialties and scrutiny of these is carried out by the Elective Care Tactical Group. Pennine Acute Hospitals NHS Trust, as our main provider, is also working closely with the Greater Manchester Cancer programme team to ensure best practice is applied. Reasons for breaches may be attributable to the relevant provider Trust or equally to a patient cancellation or delay.

Ambulance measures

During the year, NHS Blackpool CCG was the lead commissioner for North West Ambulance Services (NWAS) on behalf of and in collaboration with all other CCGs within the North West.

In August 2017, NWAS joined the national Ambulance Response Programme following an 18 month pilot in other regions. The focus of the programme is to ensure that each patient receives the most appropriate intervention from the ambulance service. This will involve allowing staff slightly more time to assess a call in order that this can be done, with the aim of ultimately improving performance.

As part of the Ambulance Response Programme, a new set of performance standards has been devised and we will monitor progress against these once data becomes available.

Mental health

- Improving Access to Psychological Therapies (IAPT)

We commission Pennine Care NHS Foundation Trust to deliver psychological therapies for patients needing low to moderate mental health support services and treatments, we are assessed against 4 key measures.

The four IAPT measures focus on increasing access, improving recovery and reducing waiting times (6 and 18 weeks) and strong performance has been noted against each during the current year. As the access target increases in 2018/19, close monitoring against the new target will continue to ensure that this new target can also be met.

- Early Intervention in Psychosis (EIP)

Pennine Care NHS Foundation Trust also delivers the early intervention in psychosis service for Bury residents, where the target is for 50% of patients to have commenced NICE compliant treatment within two weeks of referral. Despite strong performance in the early part of the year, this standard has been much more challenging since October 2017 with under achievement noted in each month since then.

A similar picture is evident in other areas of Greater Manchester and nationally. Both the CCG and Pennine Care NHS Foundation Trust are working closely with Greater Manchester colleagues to ensure a robust improvement plan can be enacted. Additionally, we recognised the need for additional recurrent monies though recruiting into new posts has been a particular challenge for the trust.

Towards the later stages of Quarter 4, some new posts have been filled and referral processes have been reviewed which should result in fewer patients not attending. Although still beneath the 50% target, performance in March 2018 was noted to have improved when compared to previous months, and recovery is anticipated in the first half of 2018/19.

Risks

As outlined in relevant sections of this annual report, risks are identified, managed and scrutinised by appropriate CCG committees. With regard to risks associated with failing KPIs, scrutiny is mainly applied via the Quality and Performance Committee or via the clinical work streams. Where appropriate, a KPI related risk may result in a formal risk being added to the register to be manged by either the clinical work stream, or by the relevant CCG committee. For example, a risk was created and managed during 2017/18 to address performance against those Constitutional Standards that make up the quality gateway element of the Quality Premium (QP). Although performance against the specific constitutional standards is managed through the Quality and Performance Committee, under-performance against those standards related to QP also created a financial risk to the CCG, hence the inclusion in the risk register.

NHS England assurance assessment

Assurance reviews of the CCG are undertaken on a regular basis by NHS England. Such reviews take place on a quarterly basis, and in addition to the CCG and NHS England being represented, colleagues from Pennine Care NHS Foundation Trust, Pennine Acute Hospitals NHS Trust and Bury Council are also invited to attend. These meetings provide an opportunity to discuss any identified areas of concern where the CCG might be an outlier when compared to other CCGs across Greater Manchester. These meetings also provide an opportunity to discuss positive initiatives in order that best practice can be shared across the region.

The quarterly visits together with performance against the indicators within the IAF are used to provide an end of year rating for each CCG which is published on MY NHS. The most recent assessment results are for 2016/17 where we achieved an overall rating of ‘Good’. The year-end assessment result for the CCG for 2017/18 will be available from July 2018 online at: **www.nhs.uk/service-search/performance/search**

Each CCG is also assessed on the quality of the leadership shown within the organisation. Again, the results for this are published and we achieved a 'Green' rating in the latest assessment (Quarter 2, 2017/18). The Quality of Leadership indicator assessment results for 2017/18 will be available at **www.nhs.uk/service-search/scorecard/results/1175** from July 2018.

Under the IAF we are assessed against a set of indicators grouped into 'Six Clinical Priorities'. The Six Clinical Priority areas, along with the most recent ratings are shown below:

Six Clinical Priorities		
Priority area	**2015/16 baseline**	**2016/17**
Cancer	Requires Improvement	Good
Mental Health	Inadequate	Good
Dementia	Outstanding	Outstanding
Diabetes	Inadequate	Requires Improvement
Learning Disabilities	Requires Improvement	Data not yet available
Maternity	Requires Improvement	Data not yet available

For those Clinical Priorities for which an updated rating has been published, improvement is noted. The exception to this is for Dementia which retained the highest rating of 'Outstanding' following the most recent assessment.

The ratings for priority areas where data is not yet available will be confirmed during 2018/19.

Financial performance

The CCG met all of its statutory financial duties and targets for the year, including achievement of a minimum of a breakeven position. This is against a backdrop of historical underfunding and significant financial pressures in the wider health and care economy.

In addition, as set out in the 2017/18 NHS Planning Guidance, CCGs were required to hold a 0.50% reserve uncommitted from the start of the year which the CCG has released to the bottom line resulting in an additional surplus for the year of £1,259,000 plus 'Category M' prescribing costs refunded of £315,000. This additional surplus has been offset against other national cost pressures from the current financial year and will be carried forward for drawdown in future years.

The CCG has a strong financial governance framework which has been tested through internal audit. Financial performance has been scrutinised on a monthly basis through the Finance, Contracting and Procurement Committee and reported to the Governing Body.

Non-financial information

Information in respect of human rights is included with the 'Reducing health inequality - Equality, diversity and human rights' section on page 38. Information in relation to anti-corruption and anti-bribery matters is included within the 'Counter fraud arrangements section' on page 74.

Reflecting on social matters, we have made further progress during the year on our journey to become a good corporate citizen and have been exploring how the Social Development Unit tool can support us in achieving these aspirations. Our Staff and Social Engagement Committee continues to meet on a regular basis, and during the year has considered topics including healthy workplaces, recycling and volunteering opportunities.

Sustainable Development

Introduction

Sustainable development is about balancing social, economic and environmental considerations, ensuring future generations are not adversely affected by the way we live today.

We recognise that good maintenance and care of the environment contributes a great deal to the long term health of people, their social wellbeing and economic prosperity.

As a CCG, we are responsible for the planning and purchasing of high quality and sustainable health care services for the people of Bury.

As an organisation funded by public monies, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of resources and building healthy and resilient communities.

We are committed to embedding sustainability into our operations and to encourage key partners and stakeholders to do the same. We are also committed to promoting environmental sustainability and to continually improve the quality of services and their environmental performance.

Spending money wisely and considering the social and environmental impact is highlighted in the Public Services (Social Value) Act (2012). By making the most of social, environmental and economic assets, we can improve health both now and longer term.

Our commitment is documented within our Sustainable Development Management Plan (SDMP) and evidenced through our nominated executive leading on sustainability.

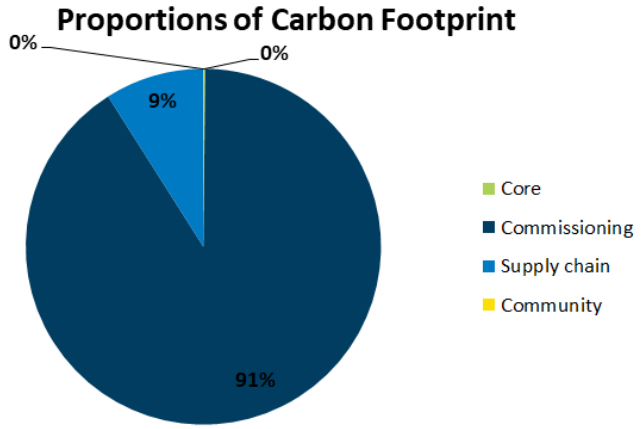
Our SDMP states:

NHS Bury CCG is responsible for the commissioning of health care across Bury. The aim of the CCG is to provide high quality sustainable health care in this region and it is committed to embedding sustainability into its operations and to

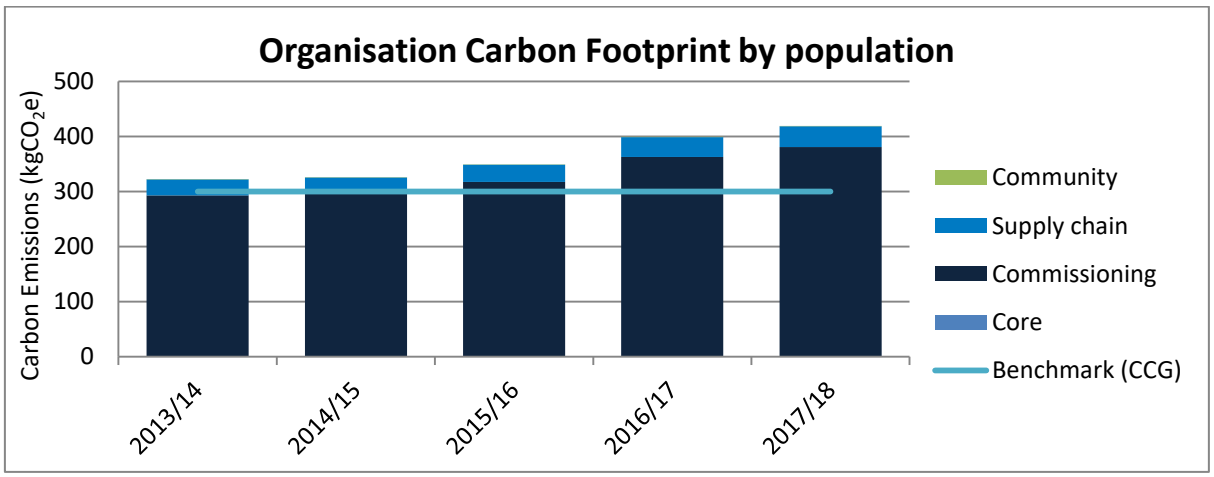
encourage key partners and stakeholders to do the same. The CCG recognises that good maintenance and care of the environment contributes a great deal to the long term health of people, their social wellbeing and economic prosperity. The CCG is committed to promoting environmental sustainability and to continually improve the quality of their services and environmental performance. At a local level, as evidenced in the Sustainable Development Management Plan, the CCG is committed to embedding sustainability into behaviours by staff and other partners in the shared estate, concentrating on reduction of paper, increased recycling and energy and carbon reduction.

Modelled Carbon Footprint

Our estimated total carbon footprint is 78,991 tonnes of carbon dioxide equivalent emissions (tCO_2e). The majority of this impact is from the services we commission.



Category	tCO_2e	% CO_2e
Core	127	0%
Commissioning	68,366	91%
Supply chain	6,753	9%
Community	26	0%



Policies

In order to embed sustainability within our business it is important to explain where in our processes and procedures sustainability features.

Area	Is sustainability considered?
Procurement (environmental & social aspects)	Yes
Suppliers' impact	No
Business Cases	No
Travel	No

One of the ways an organisation can embed sustainability is through the use of an SDMP. An update to our SDMP is required because it has not been updated or approved by the Governing Body in the last 12 months

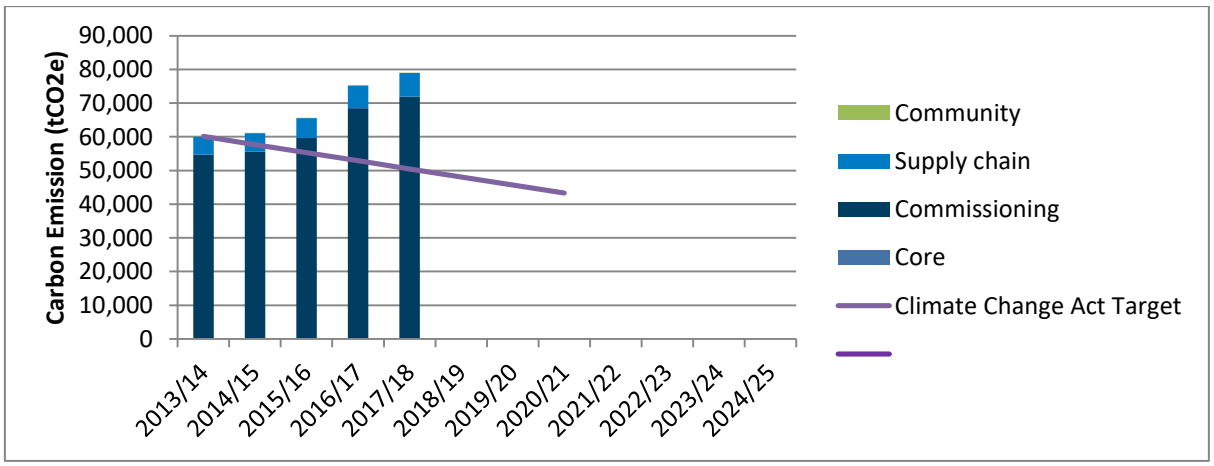
As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by raising awareness of the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health.

Examples during recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods and droughts.

The organisation has identified the need for the development of a Governing Body approved plan to include adaptation for future climate change risks affecting our area. We have not assessed the social and environmental impacts for the CCG.

Climate Change Act target



As a relatively small commissioning organisation, we do not own premises. We are committed to embedding good corporate behaviours within our organisation, concentrating on the reduction of paper, increased recycling and energy and carbon reduction.

The movement to a 'Paperless NHS' can be supported by staff reducing the use of paper, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security.

We take our environmental impact seriously and consider this within our work and contracts with our providers.

We fully support the Government's objectives to eradicate modern slavery and human trafficking, however, do not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Partnerships

As a commissioning and contracting organisation, we need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

We have not currently established any strategic partnerships. For commissioned services, below is the sustainability comparator for our main providers:

Organisation Name	SDMP	On track for 34% reduction	GCC	Healthy travel plan	Adaptation	SD Reporting score
PENNINE ACUTE HOSPITALS NHS TRUST	Yes	3. No target included in plan	No	Yes	Yes	Good
PENNINE CARE NHS FOUNDATION TRUST	Yes	3. No target included in plan	No	No	No	Excellent

More information on these measures is available **here.**

Performance

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

Commissioned activity

Organisation Name	Building energy use	Building energy use per FTE	Water	Water use per FTE	Percent high cost waste	Waste cost increase
PENNINE ACUTE HOSPITALS NHS TRUST	>10% decrease	4.3	0-20% decrease	52.4	<=75% high cost	>20% decrease
PENNINE CARE NHS FOUNDATION TRUST	>10% decrease	1.5	0-20% increase	15.6	<=75% high cost	0-20% decrease

More information on these measures is available **here**

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff, through our providers and to the patients and public that use the services we commission.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

Category	Mode	2014/15	2015/16	2016/17	2017/18
Staff commute	miles	43,228	63,401	71,114	76,849
	tCO_2e	15.88	22.93	25.70	27.38
Business Travel	miles	39,286	26,414	21,970	19,773
	tCO_2e	14.43	9.55	7.94	7.05

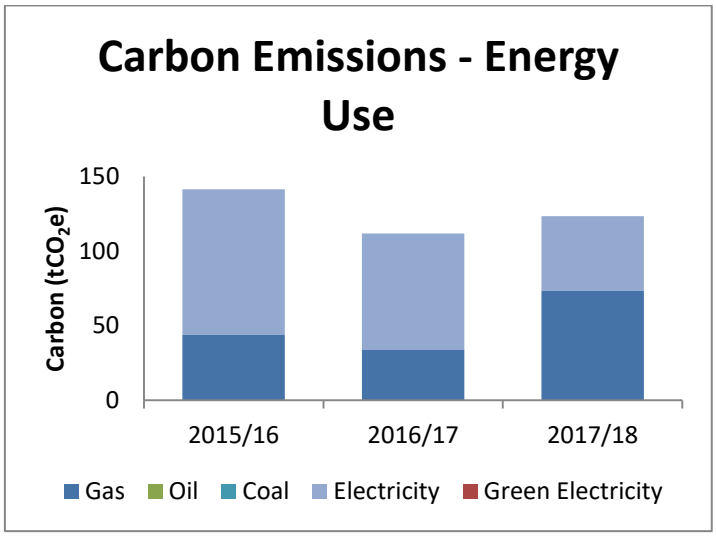
Business travel miles have been estimated for 2017/18. Business travel costs were not available to include at the time of reporting.

Energy

We spent £21,279 on energy in 2017/18, which is a 60.2% decrease on energy spend from last year.

The CCG is a tenant in an NHS Property Services building, which also accommodates staff and services not directly employed or managed by the CCG.

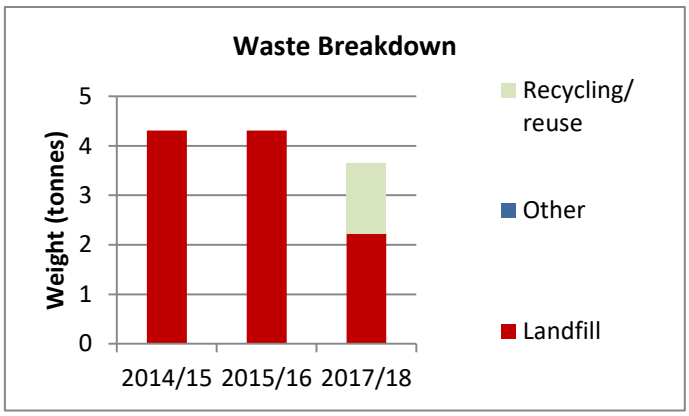
Resource		2015/16	2016/17	2017/18
Gas	Use (kWh)	209,123	161,332	346,832
	tCO_2e	44	34	74
Electricity	Use (kWh)	169,805	151,138	111,664
	tCO_2e	98	78	50
Total Energy CO_2e		141	112	123
Total Energy Spend		£66,206	£53,408	£21,279



0% of our electricity use comes from renewable sources. These figures relate to the CCG's estimated proportion of energy use from the building. Only 2015/16 to 2017/18 data is included as this is the most robust and comparable historic data available to the CCG.

Waste

Waste		2014/15	2015/16	2017/18
Recycling/ reuse	(tonnes)	0	0	1
	tCO_2e	0.00	0.00	0.03
Landfill	(tonnes)	4	4	2
	tCO_2e	1.05	1.05	0.77
Total Waste (tonnes)		4	4	4
% Recycled or Re-used		0%	0%	39%
Total Waste tCO_2e		1.05	1.05	0.80



Not all waste data was available at the time of reporting. Data for 2016/17 (the previous year) was not available.

Finite resource use – water

Water		2014/15	2015/16	2016/17	2017/18
Mains	m^3	409	9,300	7,661	1,587
	tCO_2e	0.37	8.47	6.97	1.45

Spend on water and sewage data was not available at the time of reporting.

Improvement in quality of services

NHS Bury CCG remains committed to commissioning the best possible care for the population of Bury. One of our strengths is our clinical leadership which puts safety, clinical effectiveness and patient experience at the centre of our commissioning decisions. Our Governing Body has four members with a responsibility for quality, an Executive Nurse who leads the quality and safeguarding team, a Registered Nurse of the Governing Body, a Clinical Director and a lay member who also chairs the Quality and Performance Committee.

Pressures within the NHS escalated during the year with winter proving a challenge in meeting the needs of people across the country, Bury being no exception. This year, however, there have been real improvements in the experience people have received when accessing urgent and emergency care. During the spring months particularly, the statistics have shown that access to urgent care has improved and the A&E department at Fairfield General Hospital in Bury has been amongst the best performing in the country. This has been due to the clear ambitions for improvement, leadership and collaborative working across all partners in health care, Bury Council and the private care home providers.

Our GP Member practices have been considering how they can best serve the population and offer improved services by working differently. A number of practices are looking to work more closely together to increase services for the local population, develop expertise and training of doctors and help recruit and retain experienced staff in the locality. Bury GP practices provide excellent services to our local population, with almost all of the practices rated as ‘Good’ or ‘Outstanding’ by the Care Quality Commission (CQC).

Bury is recognised as leading the way in the early diagnosis of dementia and is one of the best performing CCGs in the country. National targets require at least two thirds of people with dementia to be diagnosed, with early diagnosis being important to ensure all support can be considered for the patient and family. For patients experiencing memory impairment, a familiar setting, such as a location within their own community or a GP practice is ideal for diagnosis, treatment and ongoing management of the condition as it provides familiar reassurance. With many patients experiencing less complex cases of dementia, often with co-morbidity, GP practices were ideally placed to take a more proactive role in the diagnosis, ongoing management and care planning in the community, similar to how other long term conditions are managed.

This innovative approach to diagnosing dementia is believed to be one of the first of its kind and the project’s success was largely down to its partnership approach with organisations working together in a co-productive way.

Reducing the number of healthcare acquired infections is always a key priority. We have performed very well against a nationally set trajectory during the year for Clostridium Difficile (C Diff) and MRSA. During this year, we commenced surveillance of E.Coli infections with the ambition to reduce the numbers of people affected with this bacteria dramatically over the next five years, as we have done for MRSA and C Diff. E.Coli causes severe disease in vulnerable people and it is right that we try to reduce these infections through early detection, improved prescribing and public health messages.

During the year our Safeguarding team continued to strengthen the quality assurance processes for nursing and residential homes by work in partnership with Bury Council. Improved communication, joint inspections and visits and education events have supported our care homes to provide improving standards of care.

The successful launch of the 'React to Red' pressure ulcer reduction programme saw attendance of managers, nurses and health care support workers from care homes and the community joining together to develop practical solutions which they can introduce into their care setting to prevent pressure ulcers.

The training programme for nurses and care staff in our nursing and residential homes has gone from strength to strength this year. The introduction of a pilot scheme facilitating clinical supervision for registered nurses in care homes has been well received with positive engagement from individuals and care providers who value the contribution that this makes to evidence for the revalidation and retention of nursing staff. Early indicators are that following evaluation, a permanent scheme facilitated by the team will be established. Additionally our acute provider at Fairfield General Hospital has been able to support training and development by opening up their training and E-learning programme to staff in the community.

There has been a significant change to the quality of services provided by our acute provider Pennine Acute Hospitals NHS Trust during the past year. An executive management team headed up by Sir David Dalton at Salford Royal NHS Foundation Trust took over the leadership of the trust in 2016 and have formed an organisation known as the Northern Care Alliance. Through this alliance, we have seen strengthened site level leadership for Fairfield General Hospital, Rochdale Infirmary, Royal Oldham Hospital and North Manchester General Hospital, which has enabled and facilitated each site to focus on improving and developing the quality of services and recruitment and retention of staff.

The CQC revisited the trust in November 2017 which has demonstrated that the management approach is showing real change. Overall Pennine Acute Hospitals NHS Trust is now assessed as 'Requires Improvement' compared to 'Inadequate' in 2016. No services have now been rated as inadequate, and for the Fairfield General Hospital site, the overall rating has improved from 'Requires Improvement' to 'Good', with 'Outstanding' in medicine, which the team are particularly proud of.

Pennine Care NHS Foundation Trust provides community and mental health services to Bury patients, covering a large footprint across Greater Manchester. The trust received a 'Requires Improvement' rating after their CQC inspection in the summer of 2016. Pennine Care NHS Foundation Trust has also seen a new Executive management team arrive to facilitate change and drive up quality.

There is a national ambition to provide better care for people with mental health conditions and we are required as a CCG to invest money into services for mental health over and above the investment into other areas of health care. Bury patients have had good access to services such as early intervention for psychosis and psychological therapies. The challenge for the coming year will be meeting the demand in the acute inpatient setting with a national shortage of mental health beds for our most unwell patients. Pennine Care NHS Foundation Trust is working with all partner organisations to develop solutions to ensure that high quality services are in place for mental health patients.

Quality deep dives have been undertaken into the wide range of services provided in both hospital and community locations. These have included maternity services, paediatric wards, A&E, complaints handling, diagnostics, Rapid Assessment Interface and Discharge (RAID) mental health services, empowering patient programmes, the newly refurbished Living Well Centre and District Nursing services, to name but a few.

Quality leads at the CCG along with members of the Patient Cabinet value visiting services and talking to front line staff and patients to ensure we have an accurate account of the care we commission.

We have many mechanisms for scrutinising the experience of local health services but we need to hear more from local people. We encourage patients to give feedback through the Friends and Family Test, directly to local services providers (Pennine Acute Hospitals NHS Trust and Pennine Care NHS Foundation Trust), and also through GP practices including through practice based Patient Participation Groups and our Quality team. All feedback, positive or negative, is warmly received, and helps to ensure that we can continue to build an accurate picture of local services and challenge and support our providers to continuously improve.

Engaging people and communities

Patient and public involvement in commissioning is about enabling people to voice their views, needs and wishes, and to contribute to plans, proposals and decisions about local services.

We have a legal duty to involve patients and the public in our work in a meaningful way to improve health and care services. This legal duty is highlighted in the National Health Service Act 2006 and amended in the Local Government and Public Involvement in Health Act 2007 and the Health and Social Care Act 2012 (section 14Z2). The legal duty is relevant to designing and planning services, decision making and proposals for changes that will impact on individuals or groups and how health services are provided to them.

Involving people in our work is a legal duty, but it is also the right thing to do. By involving and listening to people who use and access local services, our teams can better understand health needs and respond to what matters most to people.

Patients and the public can often identify innovative, effective and efficient ways of designing, delivering and joining up services and this involvement is a vital part of what is known as our commissioning cycle.

Governance and assurance

Our Patient Cabinet has continued to play an important role in ensuring that the voice of local people is influential in our decision making. Chaired by the Lay member for Patient and Public Involvement, the Patient Cabinet is a sub-committee of the Governing Body and has performed a key role in ensuring meaningful involvement and engagement with people and communities by gathering views and feedback and making sure that people have a chance to feed into and actively participate in our work.

The Patient Cabinet meets monthly to fulfil its role of ensuring that the patient and public voice is integral to our work by:

- Regularly receiving and commenting on CCG plans
- Working with clinical and commissioning colleagues on service redesign programmes including urgent care, pain and cardiology
- Gathering and feeding in views from the local community via attendance at practice-based Patient Participation Groups and forging links with local voluntary and community groups

Public participation and our commissioning cycle

The commissioning cycle describes the various steps in planning and purchasing services for local people. There are various stages where public participation can inform our work, from planning services, to commissioning (buying) them and monitoring their performance.

As part of the process of identifying people who may be affected by a proposed change, equality impact assessments are completed to ensure that all people and communities, including those with protected characteristics, are fully considered.

Our Communications and Engagement team continues to support commissioning colleagues to undertake small scale engagement with groups, some of which will encompass individuals with protected characteristics, and this is reported within our equality declaration.

We also use important data sets such as feedback from the GP patient survey, the Friends and Family Test and quality information, along with the local Joint Strategic Needs Assessment, to provide important intelligence to understand the health needs of our local population.

Different participation approaches will be appropriate, depending on the nature of the commissioning activity and the people we want to involve. Approaches may include surveys, public meetings and focus groups, along with the use of social media and the local press. When we consider co-production, approaches will be much more collaborative across the various stages of a project from concept through to implementation.

When considering participation, accessibility is very important, for example the physical accessibility of venues, and the availability of a loop system as standard, to ensure that individuals are able to participate when attending meetings or events. In addition, we have the ability to provide interpretation services if required, and to make printed materials available in alternative formats or languages where necessary.

Promoting opportunities to get involved

We encourage local people to become more involved in our work through our get involved approach. Individuals can sign up to receive regular updates via email (or by post if they don't have access to the internet). Updates include our latest news and opportunities to get involved, for example through engagement surveys or public events. We encourage people to get involved in the future through our website, the press and media, social media, through our networks including the voluntary sector and

Healthwatch, and at any public events such as our annual general meeting or other public meetings.

In addition to keeping local people and communities updated on our work regularly through the above mechanisms, we also advertise key messages on advertisement screens located in every GP surgery, and through information on the online portal known as The Bury Directory.

We have developed closer links with GP Practice Patient Participation Groups through both Patient Cabinet members and our GP Practice Managers, to create a flow of information into and out of the organisation.

During the year we have also developed closer links with Bury's vibrant Voluntary, Community and Faith Alliance. Third sector colleagues are often uniquely placed to engage with particular groups to advocate on their behalf. The support of the Alliance in reaching a wider breadth and depth of people in local communities has been valuable in supporting the CCG to increase the impact of its engagement, and we look forward to continuing to build on these relationships moving forward.

A focus on… Urgent Care and how patient feedback led to a revised future model

Testing our proposals and reflecting on them on the back of feedback from local people and stakeholders is a key part of the commissioning cycle.

In the performance section of this report at page 14 we talk about our review of urgent care services during the year. In this instance, urgent care services are services that are designed to assist patients with an illness or injury that does not appear to be an emergency, but is considered too urgent to wait for routine care.

It was part our original urgent care redesign proposals to not renew the contract for the two Walk-in Centre services located in Bury and Prestwich, however, feedback received highlighted the importance local people placed on retaining access to walk-in services in the town.

Considering this important feedback, alongside new national guidance, directly led to the CCG developing a revised proposal for urgent care. The revised proposal included the availability of walk-in services in the future through brand new 'Integrated Health and Social Care Hubs' offering a range of health and care services.

Patients and the public were invited to share their views on the revised model through a six week consultation period. All available communications and engagement mechanisms were utilised during the consultation, including a public meeting and an online survey which was also made available in hard copy format.

87% of respondents to the consultation survey said they agreed or strongly agreed with the preferred option to provide an enhanced level of access beyond the minimum level required i.e. to develop Integrated Health and Social Care Hubs in addition to an Urgent Treatment Centre (the latter being nationally mandated).

In addition, 77% of respondents agreed or strongly agreed that they believed the CCG had listened and responded to feedback about the importance people place on retaining access to walk-in services.

Integrated Hubs will be piloted later in 2018. Feedback from local people, groups and stakeholders during the pilot (before roll out across the three initial sites) will be very important in shaping these services and access to them, to ensure they meet the needs of local communities and individuals.

A focus on… living with and beyond cancer – a co-productive approach

In the performance section of this report at page 13 we talk about the living with and beyond cancer project. This was the planning and development of a new service to support people affected by cancer. Evidence tells us that many patients affected by cancer have unmet non-clinical needs including financial and employment worries and the need for emotional support. The aim of this new service was to provide advice and support to meet identified needs of individuals.

The project took a co-productive approach. Around 50 people affected by cancer, along with health and care teams, including voluntary sector organisations worked together to co-produce what the service should look like to benefit local people. This approach built trust and equal partnerships at all levels and ensured that the service was truly shaped by lived experience. By working in this way we saw new perspectives and meaningful outcomes.

Patients influenced and shaped all stages of the project from concept right through to creation, from how the service should be accessed to the range of support services that should be available, and from workforce skills needed to ensure the service was a success to what promotional materials and resources would work best. At each stage we would reflect and re-evaluate options until we identified the preferred solution together.

Local Bury resident and CCG Patient Cabinet member Jackie Roscow was closely involved in shaping this project from the start, Jackie said:

“Having witnessed cancer first hand and as a carer this service would have been a great help to myself and my husband. I’m sure the support will be extremely beneficial to cancer sufferers and their families both while they are going through treatment and after to help them come to terms with having cancer and getting over it.”

“We needed help as my husband is self-employed and were worried we would not manage while he was going through his treatment. This support would have helped in so many ways and left us to concentrate on getting better. So whatever your problems are or help you need you will be able to go to the Cancer Support Centre and be passed on to whichever organisation you may need.”

Following a successful business case, the Bury Multi-agency Cancer Service launched during the year.

Future plans

As we move towards more integrated ways of working with Bury Council, we are considering how we can ensure more meaningful involvement of local people and communities.

During the year ahead, we will be exploring how we can more effectively promote equality and diversity, look for new ways to pro-actively seek participation from people who experience health inequalities and poor health outcomes, ensure that people with lived experience enrich our conversations, and start to develop partnerships with local communities to start to have a different conversation.

We will also be improving the level of information that is included on our public facing website by making information about participation opportunities and information about the difference participation has made easier to access.

Patient contacts: enquiries, concerns, complaints and compliments

We are committed to listening to and understanding the experiences of patients, both positive and negative. We try to resolve problems and enquiries quickly and informally where we can, and in the event of a complaint being made, we ensure that a thorough investigation is undertaken into all issues raised.

During the year, 232 patient contacts were received by the CCG. This consisted of:

- 170 enquiries and informal concerns
- 45 complaints, of which 19 were investigated by the CCG and 26 were re-directed to other NHS organisations to investigate and respond accordingly
- 15 MP contacts, and
- 2 compliments

In addition, 272 requests for information were received and responded to in the year in accordance with the Freedom of Information Act.

No claims were received in the year.

Where an investigation identifies failings in the care or service that a patient has received, we ensure that appropriate action is taken to learn from the patient's experience to try and prevent this happening again. A number of service improvements have resulted from the cases that we investigated in the year. This includes the following examples:

- A referral pathway was jointly reviewed by the CCG and a hospital trust to improve and streamline processes, removing unnecessary duplication of appointments that had impacted on patient care.
- A review of the management of patients with acute shoulder pain was undertaken by a hospital trust with a view to introducing a specific referral criteria proforma for use in suspected rotator cuff injury.

We are committed to working with patients to try and achieve a successful resolution to all concerns and complaints. However, where a complainant remains unhappy with the

outcome of an investigation and chooses to escalate their complaint to the Parliamentary and Health Service Ombudsman, we will use this as an opportunity to reflect on our handling of their case and the service we have provided.

During the year we were notified that 2 complaints had been escalated to the Parliamentary and Health Service Ombudsman. The outcomes of their findings are recorded as follows:

- 1 complaint was not upheld.
- 1 complaint currently remains under investigation.

Reducing health inequality - Equality, diversity and human rights

Our commitment to promoting and advancing Equality, Diversity and Human Rights (EDHR) is central to our commitment to reduce health inequalities, in health outcomes, in access to and experience of health and social care services and in the workplace.

We recognise the diversity of the our communities in our locality, taking into consideration the needs of people based on their age, disability, gender, race, religion and belief, sexual orientation, pregnancy and maternity, marriage and civil partnership and gender reassignment. We also take into account the needs other disadvantaged group such as homeless individuals, carers, people living in poverty, long–term unemployed, people who are isolated, refugees and asylum seekers.

Each year we publish an ‘Annual Equality Publication’, setting out information on diversity within our population and our workforce, as well as the work we have undertaken throughout the year to reduce inequalities.

Some of our highlights during 2017/18 include:

- Equality Delivery System (EDS) stakeholder briefing session involving our community groups, voluntary sector and partners to help us assess our progress and also help us develop our four yearly overarching Equality Objectives and Equality and Inclusion Strategy for 2018 to 2022. A dedicated task and finish group will support us in delivering this during 2018.
- NHS Bury CCG (along with Salford and Heywood, Middleton and Rochdale CCGs) was selected as one of 28 organisations across the country to be an NHS Employers Equality and Diversity Partner for 2017/18. The Equality and Diversity Partners programme will support us to progress and develop our equality performance, as well as offering advice, guidance and examples of good practice.
- A thought provoking equality and inclusion strategy session was delivered to our Governing Body in August 2017. This moved away from the traditional focus on legislation to a more emotive scenario based session asking members to think about their work in the context of minority or disadvantaged groups.
- ADAB (Asian Development Association of Bury) as a local BME organisation and we are working on the following areas together: Mental health and wellbeing – increasing access to psychological therapies engagement (access to services), cancer screening awareness (breast, cervical and bowel) and BME community health and wellbeing engagement.
- The living with and beyond cancer recovery package, discussed earlier in this report involved extensive consultation including around 50 of Bury’s community members

who have been affected by cancer, health partners and the voluntary sector. The CCG secured additional funding from Macmillan to jointly fund, implement and deliver the project which aims to identify the unmet needs of people living with and beyond cancer.
- Reducing inappropriate antipsychotic prescribing amongst people with learning disabilities. The Medicines Optimisation team worked in collaboration with a specialist mental health pharmacist to review all antipsychotic prescribed for challenging behaviour in patients with a learning disability.
- We commission in collaboration with a neighbouring CCG an integrated model of diabetes care, bringing hospital and community based care together, providing high quality and responsive care to local people.
- Recognition at a Greater Manchester level the work that Fairfax Group Practice has done towards meeting the LGBT (lesbian, gay, bisexual and trans) 'Pride in Practice Award'.

The full publication and a range of other reports can be found on our Equality and Diversity web page.

Health and wellbeing strategy

Introduction

The CCG liaised with the Health and Wellbeing Board virtually in the creation of this summary of the work of the Board during the year. The final report will be presented to the Health and Wellbeing Board at its meeting in June.

Overview

The Chair and Chief Officer of the CCG both sit on Bury's Health and Wellbeing Board, and as such, the CCG has been a key player in the delivery of the Board's Strategy during the year.

Bury's Health and Wellbeing Board's Vision is to: *"Improve health and wellbeing through working with communities and residents to ensure that all people have a good start and enjoy a healthy, safe and fulfilling life."*

During the year, the Board has played an influential role including overseeing the development and delivery of:

- Bury's Locality Plan – which focusses on transformation of health and social care services locally
- The Director of Public Health annual report
- The Pharmaceutical Needs Assessment and associated consultation process
- Better Care Fund submission and monitoring report
- Additional funding for adult social care
- Urgent care redesign

Key achievements of the Board during the year include:

- Continuing to strengthen Health and Wellbeing Board and strategy governance arrangements
- Continuing to raise awareness about the work of the Board, its membership and strategy within the public facing Bury Directory: **www.theburydirectory.co.uk/healthandwellbeingboard**
- Promoting the work of the Board at community events
- Continued work with partners at a Greater Manchester level as well as the transformation agenda within the borough

Membership

The Health and Wellbeing Board is a statutory committee of Bury Council. It brings together senior leaders from across Bury Council and the NHS, including the CCG, with Elected Members, Healthwatch, Greater Manchester Police, Greater Manchester Fire and Rescue Service and representatives from the community and voluntary sectors, to set out a vision for improving health and wellbeing in the borough.

The Health and Wellbeing Board supports and encourages partnership arrangements to ensure that services are effectively commissioned and delivered across the NHS, social care, public health and other services. Its main purpose is to ensure improved health and wellbeing outcomes for the whole population of Bury.

All members of the Board and their deputies have successfully obtained the Royal Institute of Public Health, Understanding Health Improvement Level 2 Qualification. In addition they have received Dementia Friends training to become 'Dementia Friends' and also upskilled in the area of adult safeguarding reporting and processes.

Strategy

The Health and Wellbeing Board has a duty to ensure effective delivery of the Health and Wellbeing Strategy, priority areas during the year included:

Priority	**Matters brought to and considered by the Board during the year**
Starting well	Children - Safeguarding Annual Report Healthy Schools Programme Greater Manchester children's health and wellbeing
Living well	Public Health Annual Report Pharmaceutical Needs Assessment Joint Strategic Needs Assessment Adult - Safeguarding Annual Report System Leader, Integrated health and social care community teams Asylum Matters WIFI within GP practices Working well and the future Greater Manchester Work and Health Programme Greater Manchester Early Help model Greater Manchester Population Health Plan

Living well with a long term condition or as a carer	The Bury Directory Annual Report Help Yourself to Wellbeing Adult Autism Strategy and action plan Suicide Prevention Strategy
Ageing well	Urgent care Reducing failure demand Ground Work Ambition for Ageing
Healthy places	Locality Plan and transformation bid Single Outcomes Framework Health & Environmental Protection Annual Report

Stuart North
Accountable Officer
Date:

Accountability Report

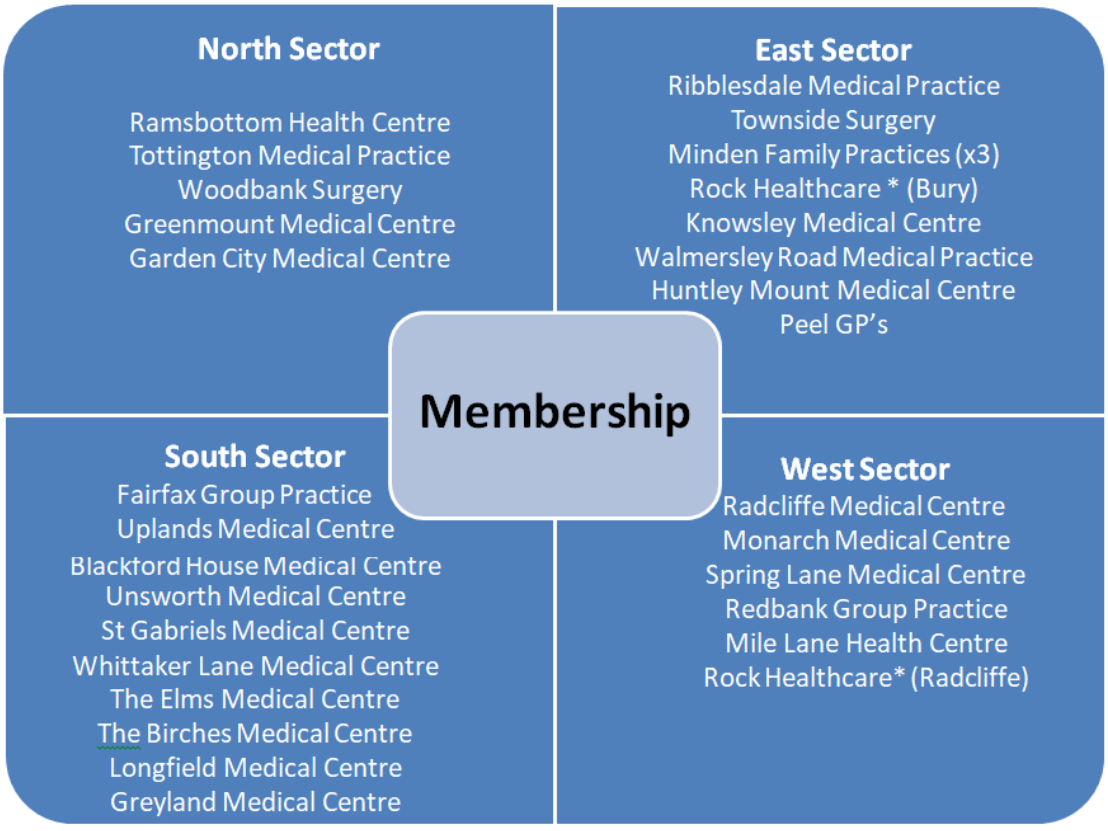
Corporate Governance Report

Members Report

NHS Bury CCG is a Member organisation, made up of the 30 GP practices in the borough of Bury, which are segmented into four sectors; North, East, South and West.

Together our Member practices make up NHS Bury CCG and they are highlighted in the table below. Each Sector is chaired by a GP known as a Sector Chair. The Sector Chairs are invited to attend the Governing Body and are key members of the Clinical Cabinet meetings to influence and shape the decision making of the Governing Body on key issues.

During the course of the 2017/18 financial year, there was an acknowledgement, that the South Sector covered a large geographical footprint which included a diverse range of health needs. To support us in meeting these diverse needs, it was felt that it would be beneficial for the South Sector to have the flexibility to be divided into two geographical sub-sections where appropriate, to ensure that the population needs are targeted in the most efficient and effective way.



*One practice over two sites.

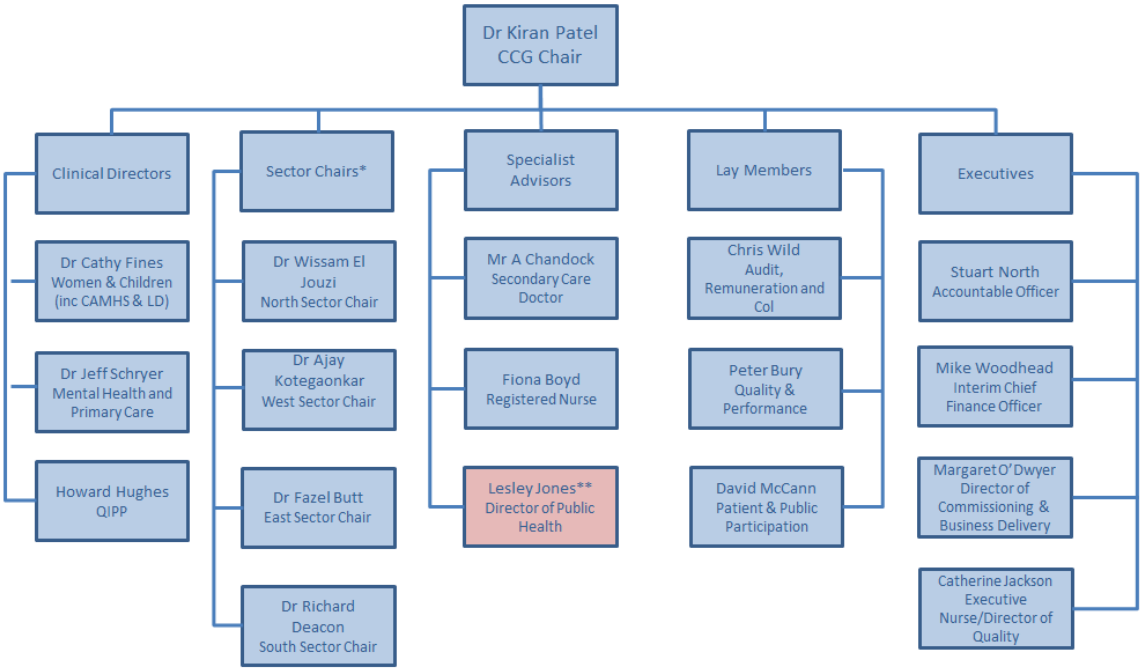
The Members hold the Governing Body to account and have delegated authority for decision making, as set out in the schedule of reservation and delegation, to the Governing Body.

More information is available on our **website**, where you can also access our Constitution. Our constitution sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for local people.

Composition of the Governing Body

NHS Bury CCG continues to be a clinically led organisation and is committed to ensuring that the Governing Body comprises a balanced membership of executive, clinical and lay members. The Governing Body strongly believes that it is essential to ensure continuity of corporate knowledge and experience in moving towards integrated commissioning arrangements with Bury Council and any revised governance arrangements this may bring. The lay members of the Governing Body bring strong, independent oversight and all lay members, the Secondary Care Consultant and Governing Body registered nurse, are considered to be independent of day to day management of the CCG.

As at 31st March 2018, NHS Bury CCG had 5 female members and 13 male members on its Governing Body as detailed in the diagram below:



*During 2017/18, the Sector Chairs have supported the Clinical Cabinet agenda and have not routinely been invited to the Governing Body, however are available as required and have voting rights as set out in the Constitution.
** The Director of Public Health is not employed by the CCG.

The Governing Body holds a minimum of 6 meetings per year in public, providing an opportunity for its discussion on business matters and decisions to be observed by members of the public.

Chair

Dr. Kiran Patel
Chair (until 31st March 2018)

Dr. Patel was the Chair of the CCG during the reporting period. A GP at Greenmount Medical Centre in Bury, Dr. Patel led the CCG as its Clinical Chair since its formation in April 2013. He graduated from the University of Manchester in 1988, and after working in a number of hospitals across the region, he came to work in Bury in 1993 and became a partner at Greenmount Medical Centre in 1996. Dr. Patel brings extensive experience of the health service both at a regional and borough level, as well as ongoing day to day experience in the delivery of primary care services to his patients.

Clinical Directors

Dr. Cathy Fines
Clinical Governing Body Member

Dr. Cathy Fines is a Clinical Director on the Governing Body, she is also the executive and GP lead for safeguarding and the clinical lead for women and children within the CCG. Cathy completed her postgraduate medical training at both North Manchester General Hospital and at Fairfield General Hospital in Bury, and did her GP training at the Uplands Medical Practice. Having worked in the south sector for the last few years, Cathy has recently moved to work in the north sector at Greenmount Medical Centre. She represents NHS Bury CCG on Bury Children Safeguarding Board, Bury Adult Safeguarding Board and Bury Corporate Parenting Panel.

Dr. Jeff Schryer
Clinical Governing Body Member (until 31st March 2018)

Dr. Jeff Schryer was a Clinical Director on the CCG Governing Body during the reporting period, in addition to being the work stream clinical lead for mental health and primary care. He qualified from Manchester University in 1986 and has a long standing interest in medical education including undergraduate and GP training. In the past, he has run the North Manchester GP Vocational Training Scheme and was previously an Associate Dean at Manchester Medical School, he has also worked in a prison providing primary care services. Dr. Schryer became Clinical Director for the CCG in October 2014, sitting on the CCG's Governing Body and taking a lead on mental health, dementia and primary care. He is also the GP Dementia Lead for the Strategic Clinical Network in Greater Manchester. Dr. Schryer is married with seven children and seven grandchildren. Dr. Schryer became the CCG Chair on 1st April 2018.

Howard Hughes
Clinical Governing Body Member

Howard Hughes is a Clinical Lead on the CCG Governing Body. His role for the CCG focuses on quality and infrastructure and he has recently taken on responsibility as clinical lead for QIPP. Howard is a community pharmacist, qualifying in 1984, he has worked in a number of pharmacy roles over the years from pharmacy manager through to being the owner of a chain of pharmacies. Since 1987 he has worked in Prestwich, currently fulfilling the role of Director and Chair of Prestwich Pharmacy Limited, and since 2006 he has been the Managing Director of another pharmacy in Burnley. In addition to his pharmaceutical interests, Howard has an interest in drug misuse and sexual health. He sat on the former Professional Executive Committee of Bury PCT until 2011 and has been Chairman of the Bury and Rochdale Local Pharmaceutical Committee for a number of years. Howard is a qualified Pharmacist Pre-Registration tutor and exam question writer.

Sector Chairs	
Dr. Wissam El-Jouzi **North Sector Chair** Dr. Wissam El-Jouzi is the North Sector Lead on the Governing Body, this sector group represents the GP practices within the North of Bury. Dr. El-Jouzi has been a GP Partner at Tottington Health Centre since 2005. He qualified in 1999 and for the first part of his career worked in London as a general surgeon and urologist. In addition to primary care, he has a special interest in minor surgery and has been an established GP trainer since 2008.	**Dr. Fazel Butt** **East Sector Chair** Dr. Fazel Butt is the East Sector GP Lead on the Governing Body, this sector group represents the GP practices within the East of Bury. Dr. Butt qualified as a GP in 2001, and before taking up his role as a GP in Bury, worked extensively in the North West as a locum and as an out-of-hours GP. He has experience of working in North West hospitals and began his current role as GP principal at Huntley Mount Medical Centre in July 2013.
Dr. Richard Deacon **South Sector Chair** Dr. Richard Deacon is the South Sector GP Lead on the Governing Body, this sector group represents the GP practices within the South of Bury. Dr. Deacon has an interest in primary care research and was previously the quality lead Board member for North Manchester CCG. Dr. Deacon has been a GP at St, Gabriel's Medical Centre in Prestwich since 2014.	**Dr. Ajay Kotegaonkar** **West Sector Chair** Dr. Ajay Kotegaonkar is the West Sector GP Lead on the Governing Body, this sector group represents the GP practices within the West of Bury. Dr. Kotegaonkar qualified as a GP in 2002 and has been a GP Partner at Spring Lane Surgery in Radcliffe since 2003. He has a special interest in palliative care and diabetes and prior to his involvement with the CCG, he was involved in the work of NHS Bury as the Practice Based Commissioning Sector Lead and Palliative Care Lead. In addition to his primary care and commissioning roles, Dr. Kotegaonkar is a hospice doctor and the Local Medical Committee representative for Radcliffe.
Lay Members	
Chris Wild **Lay Member for Audit, Remuneration and Conflicts of Interest** Chris is a Lay Member on the Governing Body. He leads on audit, remuneration and conflict of interest matters. Chris was previously the Audit Chair for NHS Bury, a role which he fulfilled from January 2011 until the CCG took over leadership of the NHS in Bury. Chris has a career in financial services, being a Chartered Accountant and holds a number of directorships in energy, finance and horticultural companies. Chris brings with him significant insight and knowledge that supports the CCG Governing Body and hopes to make a significant contribution towards Bury becoming a healthier Borough with the first class health services that it deserves.	**Peter Bury** **Lay Member Quality and Performance** Peter is the Quality and Performance Lead (Lay Member). Peter started his career in engineering then moved to work for the TUC union to promote workplace learning across the north west. He then became a parliamentary assistant working for a member of parliament and on a number of European funded projects in various EU countries and Kazakhstan. Peter was an elected member of Rochdale Council from 1982 to 1990 and a member of Bury Council until 2015. Peter has previously been Chair of the Health Overview and Scrutiny Committee for Bury Council and a member of Pennine Acute, Pennine Care and Greater Manchester scrutiny committees.

David McCann
Lay Member Patient and Public Involvement

David is the Lay Member for patient and public involvement on the Governing Body. He leads on patient and public participation matters. David's role is to Chair the Patient Cabinet which is made up of a number of patient representatives from across the borough, representing the views of local people. David is the Senior Partner at Woodcocks, Haworth and Nuttall Solicitors in Bury, he has worked from the Bury office since 1991. He has a keen interest in patient and public involvement, a role he has experience in as Non-Executive Director for Rock Healthcare (a GP Led Health Centre) in Bury.

Specialist Advisors

Mr Amarbaj Chandock
Clinical member of the Governing Body - Secondary Care Doctor

Amarbaj Chandock is a consultant Gynaecologist at the Heart of England Foundation Trust, working at Heartlands, Solihull and Good Hope Hospitals. He was trained in the West Midlands and finished his Certificate of Completion of Training in 2014. He has a special interest in gynaecology, oncology and minimal access surgery. He is lead of gynaecological oncology services at the Heart of England Foundation Trust. He has been the lead of colposcopy services in the past and is passionate about improving quality and safety for patients. He is pursuing a Global MBA degree from the London School of Economics. He has an interest in telemedicine and is currently working on providing affordable services via mobile devices which can be delivered with low-speed mobile connections, and how this can be utilised to provide multidisciplinary care for patients with cancer.

Fiona Boyd
Clinical member of the Governing Body – Registered Nurse

Fiona started her career for the NHS over 25 years ago as a Registered Nurse and a Registered Midwife. Having developed an interest in the legal aspects of healthcare, Fiona undertook a law degree, qualified as a solicitor and practised as a clinical negligence solicitor in Manchester whilst maintaining her work in nursing and midwifery. Wanting to utilise her unique skillset for the benefit of the NHS, Fiona re-entered full time NHS employment in 2006 as Corporate Quality Manager at the Royal Bolton Hospital. Whilst in post, she has maintained legal practice as a solicitor providing expert legal knowledge on a range of issues including nursing practice, risk management, clinical negligence, mental capacity act, coroner's inquests and serious incidents.

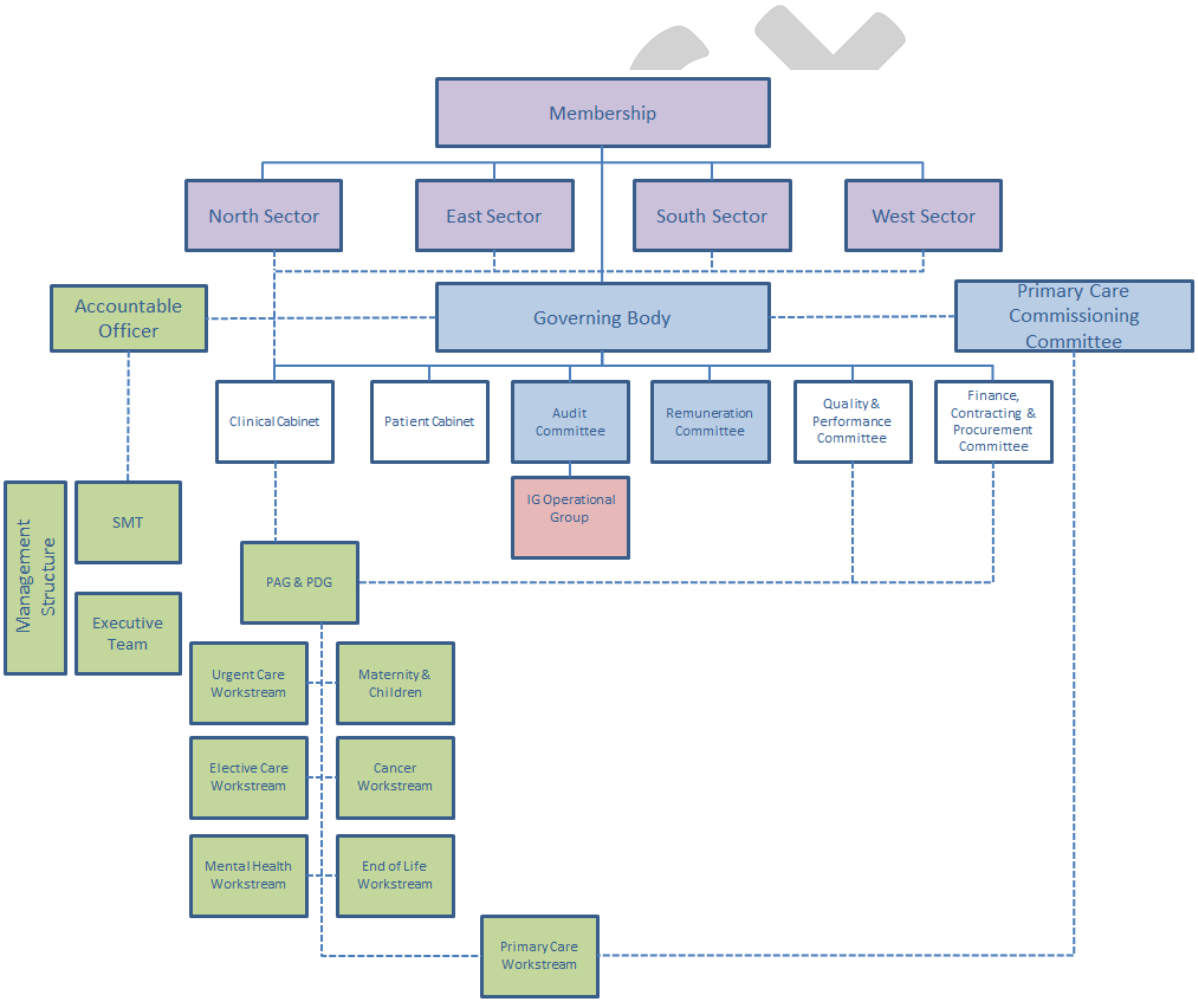
Very Senior Managers	
Stuart North **Chief Officer** Stuart North is the Chief Officer and Accountable Officer of the CCG. Stuart was previously the Director of Finance and Contracts for Bury PCT, a role which he fulfilled from August 2010 until the CCG took over leadership of the NHS in Bury. Stuart is committed to health services having worked in the NHS for over 35 years. An accountant by profession, Stuart has a wealth of experience, having previously been Director of Finance at East Cheshire NHS Trust and Associate Director of Finance at Central Manchester and Manchester Children's Hospitals NHS Trust.	**Margaret O'Dwyer** **Deputy Chief Officer / Director of Commissioning and Business Delivery** Margaret O'Dwyer is the CCG's Deputy Chief Officer and Director of Commissioning and Business Delivery. Margaret joined the CCG in May 2015. She has worked within the NHS for over 30 years and is firmly committed to the values the NHS stands for. Margaret has held various commissioning roles during her career, and has broad experience in many areas including contracting and specialised commissioning, primary care commissioning, independent funding requests, continuing health care and other primary care areas including dental and pharmacy contracts. During her time working in Salford she worked across commissioning and public health and was involved in the transfer of public health functions to the Local Authority, and in transforming community services. Margaret joined NHS England in 2013 as Deputy Director of Assurance and Delivery and became the Director in April 2014, here she developed the arrangements for CCG assurance at a time when these new organisations were forming.

Mike Woodhead **Interim Chief Finance Officer** Mike Woodhead was appointed to the role of Acting Chief Finance Officer from 1st June 2016. Mike has worked in the NHS and public sector since 1986. Mike first joined NHS Bury CCG in the early part of 2015, taking up the role of Interim Associate Chief Finance Officer. This became a permanent role in the early part of 2016. From June 2016, Mike has stepped into the role of Acting Chief Finance Officer. During these challenging times in the NHS, Mike's main goal is to continue to strengthen the CCG's and the Bury locality financial footing as we navigate the complexities of integrated health and social care and the transformation agenda. A strong financial position is one of the foundations to delivering improved health services and outcomes to local people and Mike and his team are committed to helping make a difference.	**Catherine Jackson** **Executive Board Nurse / Director of Quality** Catherine Jackson is the Executive Nurse (Director of Nursing and Quality) for the CCG. Catherine is a member of the Governing Body. Catherine continues to work clinically as a Nurse Clinician in a general practice in Stockport for two sessions a week, specialising in long term conditions, particularly diabetes and heart disease. Additionally Catherine is a Lay Member (Non-Executive Director) on the Governing Body for Wigan Borough CCG. Catherine qualified as a nurse in 1989, and before joining general practice, she worked in a number of areas including intensive care, specialist renal (kidney) care, transplantation and general medical nursing. Catherine studied for her MSc in 1999 at Liverpool University and became a non-medical prescriber in 2003, using this knowledge and expertise in both her clinical and CCG roles. Catherine has a solid track record of advising and influencing the planning and delivery of health services, and over the five years of working for Bury CCG has developed the Quality and Safeguarding teams to ensure that the CCG delivers its constitutional standards for quality and quality improvement, listens to the needs of local people and influences the CCG on strategic commissioning to improve the health outcomes of Bury residents.
Local Authority representative	
Lesley Jones **Director of Public Health** Lesley Jones is the Director of Public Health for Bury, employed by Bury Council. As part of this role, Lesley is also a non-voting member of the Governing Body. Lesley's career in health promotion started with East Dyfed Health Authority, moving onto East Berkshire and then Bolton in 1993. Lesley dedicated the next 20 years of her career to public health in Bolton, leading to her taking on the role of Deputy Director of Public Health for Bolton. She came to work in Bury as Director of Public Health, initially on a 12 month secondment, leading to a substantive appointment in October 2014. Lesley has an interest in all aspects of improving health and reducing inequalities.	

Committee(s) including Audit Committee

The Governing Body is supported in discharging its duties through a number of committees and sub-committees.

During 2017/18, NHS Bury CCG reviewed its governance structure and arrangements, making some changes to the membership of committees and ensuring statutory duties are appropriately reflected in the terms of reference. It can be noted that governance arrangements are evolving as part of the transformation programme (health and social care) in place in Bury, with a number of key meetings now happening on a regular basis to drive this agenda forward. The current structure is outlined below.



The following table shows where our Governing Body members (employed by the CCG) are also aligned to the sub-committees of the CCG and Governing Body. It should be noted that this table does not depict the full membership of each of the committees, which is outlined in more detail in the Annual Governance Statement from page 54.

KEY

* as governing body members

** non-voting member

*** invited to attend but not a member of the committee

**** only two sector chairs hold a vote

		Governing Body	Audit Committee	Remuneration Committee	Quality Performance Committee	Finance, Contracting & Procurement Committee	Clinical Cabinet	Patient Cabinet	Primary Care Commissioning Committee
Chair									
Dr. Kiran Patel	Chair	✓		✓***		✓	✓**		✓**
Clinical Directors									
Dr. Cathy Fines	Clinical Director	✓			✓		✓		
Dr. Jeff Schryer	Clinical Director	✓					✓		✓**
Howard Hughes	Clinical Director	✓	✓***		✓	✓	✓		
Sector Chairs									
Dr. Ajay Kotegaonkar	West Sector Chair	✓****					✓		
Dr. Fazel Butt	East Sector Chair	✓****					✓		
Dr. Richard Deacon	South Sector Chair	✓****					✓		
Dr. Wissam El-Jouzi	North Sector Chair	✓****					✓		
Lay Members									
Chris Wild	Audit, Remuneration and Conflicts of Interest	✓	✓	✓		✓			
Peter Bury	Quality and Performance	✓	✓	✓	✓				✓
David McCann	Patient and Public Involvement	✓	✓	✓		✓		✓	✓
Specialist Advisors									
Mr Amarbaj Chandock	Governing Body Secondary Care Consultant	✓			✓				
Fiona Boyd	Governing Body Registered Nurse	✓							✓
Very Senior Managers									
Stuart North	Chief Officer	✓		✓***	✓***		✓**		✓
Margaret O'Dwyer	Director of Commissioning and Business Delivery	✓			✓	✓	✓		✓
Mike Woodhead	Interim Chief Finance Officer	✓	✓***			✓	✓		✓
Catherine Jackson	Executive Nurse	✓			✓				

The Audit Committee as a statutory committee within the CCG's Governance structure supports the Governing Body in ensuring a robust and appropriate system of internal control is in place and operating effectively across the CCG. The Committee is also responsible for making a recommendation to the Governing Body with regard to the approval of the annual report and accounts.

Further detail on the membership and remit of the Audit Committee can be found within the Governance Statement from page 54.

The Remuneration Report from page 78 includes details of the membership of the Remuneration Committee.

Register of interests

To ensure the integrity of the decision making delegated to our Governing Body members, all members are required to declare any actual or potential conflicts of interest which may actually or be perceived to impact upon their judgement when making decisions and the management responsibilities under which they work. Up to date declarations of interest can be viewed on our **website.**

Personal data related incidents

We recognise that the information we hold is one of our key assets. During the reporting period risks to data security have been managed through the implementation and achievement of the relevant requirements within the NHS Information Governance Toolkit.

NHS Bury CCG had no personal and confidential details (PCD) incidents to report to the Information Commissioner for the reporting period.

Statement of Disclosure to Auditors

All Directors and/or members of the Governing Body having authority or responsibility for directing or controlling the major activities of the entity during the financial year 2017/18 confirm that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

Modern Slavery Act

NHS Bury CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking, but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

Stuart North
Accountable Officer
Date:

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) (the NHS Act 2006) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of NHS Bury CCG.

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the CCG Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error
- Safeguarding the CCGs assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006), and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006

Under the NHS Act 2006, NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- Assess the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern, and

- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

To the best of my knowledge and belief, and subject to the disclosure set out below, I have properly discharged the responsibilities set out under the NHS Act 2006, Managing Public Money and in my CCG Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information, and
- The annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Stuart North
Accountable Officer
Date:

Governance Statement

Introduction and context

NHS Bury CCG is a body corporate established by NHS England on 1st April 2013 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). Our general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1st April 2017, the CCG was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

NHS Bury CCG is a Membership organisation, made up of 30 general practices across the metropolitan borough of Bury with statutory responsibility for planning and commissioning healthcare services for the local population.

Decisions are made by our Governing Body, which is led by an elected Chair, who is a GP from one of our Member practices, the Chief Officer and a team of clinical and executive leaders, alongside lay members and specialist advisors.

Decisions relating to Primary [medical] Care contracting are made through the Primary Care Commissioning Committee and notified to NHS England, in accordance with the agreed Memorandum of Understanding and also with the CCG's Governing Body.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of our policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my CCG Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively,

efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

During the reporting period covered by this Governance Statement, NHS Bury CCG has had arrangements in place to enable it to properly discharge its statutory functions. These arrangements are set out in the CCG's Constitution.

Our Constitution sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for local people. It describes the governing principles, rules and procedures that we will follow to ensure probity and accountability in our day to day running, to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its vision.

Our Constitution is supported by a number of other key documents, including an Inter Practice Agreement which sets out the relationship between the CCG and its Member practices and the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies which provide a procedural framework within which the CCG discharges its duties.

Membership

As a Membership organisation, our Members mandate the Governing Body to provide commissioning functions, performance monitoring, financial management and engagement with stakeholders on their behalf. The Members in turn commit to engaging with the CCG and abide by its Constitution and other key constitutional documents. The arrangement between the Membership and the CCG is detailed in its Inter Practice Agreement (Agreement). This Agreement explains how the Members, as individual GP practices, will contribute to the design, development and business of the CCG. The Agreement also details how the Members will work together in sector groups.

Our four sector Groups are:

- North
- South
- East
- West

During the course of the 2017/18 financial year, there was an acknowledgement, that the South Sector covered a large geographical footprint which included a diverse range of health needs. To support the CCG in meeting these diverse needs, it was felt that it would be beneficial for the South Sector to have the flexibility to be divided into two geographical sub-sections where appropriate, to ensure that the population needs are targeted in the most efficient and effective way.

Each Sector meets monthly and works to meet the needs of their geographical population, whilst supporting each other across the borough with schemes, as appropriate. Each Sector has a GP Chair who manages the governance arrangements of each Sector and provides representative responsibilities on the

Clinical Cabinet under the governance arrangements implemented at the commencement of 2017/18.

Governing Body

The Governing Body is, in the main, responsible for discharging the statutory duties and functions of the CCG.

Our Governing Body has operated effectively during the reporting period, with the required level of attendance of all members to facilitate and enable effective decision making. Six meetings have been held in public to conduct formal business, however, Governing Body members have also met on a number of other occasions throughout the year for the purposes of progressing items considered private in line with statute and national guidance and to support on-going development, education and training.

There have been no changes in the constitution of the Governing Body, however, a vacancy within the clinical membership and redirection of the GP Sector Chairs to the Clinical Cabinet from the Governing Body has introduced a level of challenge in achieving quoracy. The Governing Body is quorate with at least 9 members in attendance, of which 5 must be practicing clinicians. This has been achieved for 50% of the meetings held in public, with the CCG working under Clause 6.10.6 of the Constitution, accepting that decisions made in good faith will remain valid where there is a vacancy in the membership of the meeting, where quoracy was not achieved. Overall attendance at meetings held in public is recorded at 77%.

The main purpose of the Governing Body is to ensure that we have appropriate arrangements in place to effectively, efficiently and economically discharge our duties, in accordance with the principles of good governance.

In discharging its duties, the CCG Governing Body is responsible and accountable for delivering its financial duties, managing risk, for achieving national and local quality, productivity and service delivery targets.

Our Governing Body has been supported through the internal governance structure and the work of a range of committees and sub-committees which hold delegated responsibility for a range of functions. During this reporting period, the Governing Body was supported by the Audit Committee, Remuneration and Terms of Service Committee, Clinical Cabinet, Finance, Contracting and Procurement Committee, Quality and Risk Committee, Patient Cabinet and Primary Care Commissioning Committee.

The functions of each committee are set out in the respective terms of reference and the CCG's Standing Orders and Scheme of Reservation and Delegation.

A report from each of the established committees of the Governing Body is provided to each public meeting.

There is a shared commitment between the Governing Body members to support an effective performance culture and promote good governance across the organisation. This is evidenced through the Governing Body's commitment to

achieving the organisation's vision and values, and the successful implementation of a range of strategic objectives. These have been monitored through the performance management arrangements of the CCG and the regular review of the Governing Body Assurance Framework (GBAF). The effective use of information and good communication has also supported the Governing Body alongside the rolling programme of Governing Body development sessions.

The Governing Body is compliant with the Corporate Governance Code and has met formally on six occasions during the year ended 31st March 2018.

It is my view, that even with the transition and changes that have occurred, the Governing Body has operated effectively throughout the reporting period with the required attendance from members to facilitate decision making.

Audit Committee

The Audit Committee, which is a non-executive committee of the Governing Body, has operated throughout the financial year and has been accountable to the Governing Body for providing the organisation with an independent and objective review of their financial systems, financial information and compliance with laws, guidance, regulations and direction governing the CCG. It is also responsible for providing oversight of the effective governance across all committees and sub-committees of the Governing Body.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities.

The Committee is chaired by the Lay Member with responsibility for Audit, Finance and Conflicts of Interest.

The voting members of the Audit Committee are:
- Lay Member with responsibility for Audit, Remuneration and Conflicts of Interest
- Lay Member with responsibility for Quality and Performance, and
- Lay Member with responsibility for Patient and Public involvement

The Audit Committee is supported by the following colleagues:
- Chief Finance Officer
- Deputy Director of Business Delivery
- Representatives from the CCG's Internal Auditor
- Local Anti-Fraud Specialist, and
- Representatives from the CCG's External Auditor

During the reporting period, the Audit Committee has met on 5 occasions and has been quorate at each meeting with a 100% attendance level.

In addition to the routine business of the Audit Committee including scrutiny of the GBAF, further implementation of the risk management arrangements and ensuring compliance with the revised Conflicts of Interest guidance, there has also been a

focus on the approved Locality Plan, the development of the emerging Locality Care and One Commissioning Organisations and cyber security.

During the reporting period no material issues or internal control concerns have been raised by either the Internal or External Auditors.

No potential fraudulent concerns have been notified to the Committee.

Remuneration and Terms of Service Committee

The Committee is established to advise and where appropriate recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The Committee also advises and recommends to the Governing Body remuneration for the role of Chair, remuneration and terms of service of Clinical Members and leads and reviews any business cases for early retirement, redundancy or other matters relating to Terms and Conditions of service.

The Remuneration and Terms of Service Committee conducts its business in accordance with legal requirements, applies the Nolan Principles of public life, good staff management practice and the requirements of good corporate governance. The terms of reference and membership of the committee have been reviewed in year and now comprise the following voting members, who are all members of the Governing Body:

- Governing Body Lay member for Audit (Chair)
- Governing Body Lay member for Quality and Performance, and
- Governing Body Lay member for Patient and Public Involvement

The Chief Officer and Chair are invited to attend meetings as appropriate, however, they are not members of the Committee and are not in attendance for any discussions in respect to their remuneration.

Since April 2017, the committee has met on three occasions and has been quorate at each meeting with 100% attendance across the year. It is considered that the Committee has operated effectively within its authority to consider the following areas:

- the principles that should be applied in determining the pay award to Governing Body Members and Clinical Leads
- a review of terms and conditions of service in respect to two cases raised
- policies associated with Terms and Conditions of service, including reckonable service and on-call arrangements
- review of salaries for the Executive team, and
- assurance on the status of all HR policies, including arrangements for review and implementation

Clinical Cabinet

The Clinical Cabinet is responsible for ensuring that clinical leadership is at the heart of all decisions about patient care and services. Its members are active leaders of change, who are focused on ensuring that we commission high quality integrated services.

Work stream leads have been appointed for priority areas and they work alongside commissioning colleagues in both the CCG and Bury Council to inform and influence the clinical strategy of the CCG.

Each Clinical Work stream lead has established a clinical work stream group (either virtually or through a meeting) who are responsible for cross organisational engagement to deliver service redesign, quality improvement, health and wellbeing, QIPP, performance improvement and integration across organisations.

Membership of the Clinical Cabinet was reviewed in the previous year and comprises of the following members:

- Clinical Workstream Lead – QIPP
- Clinical Workstream Lead – Maternity and children
- Clinical Workstream Lead – Mental health
- Clinical Workstream Lead – Information, management and technology
- Clinical Workstream Lead – Urgent care
- Clinical Workstream Lead – Long term conditions
- Clinical Workstream Lead – Medicines management
- Clinical Workstream Lead – Learning disabilities
- Clinical Workstream Lead – Elective care
- Clinical Workstream Lead – Primary care
- Clinical Workstream Lead – End of life or cancer
- CCG Sector Lead – South
- CCG Sector Lead – North
- CCG Sector Lead – East
- CCG Sector Lead – West
- Practice Manager representative
- Local Authority representative
- Public Health representative
- CCG Chief Finance Officer, and
- CCG Director of Commissioning and Business Delivery

The quoracy requirements of the revised Clinical Cabinet require a minimum of 11 members present, which must include the Chair of the Committee or their appointed deputy, at least one clinical Governing Body member, the Chief Finance Officer (or their appointed representative), the Director of Commissioning and Business Delivery (or their appointed representative) and at least four additional clinical members of the Committee. There have been nine meetings held during the reporting period, all achieved quoracy with an average attendance level of 81%.

The Clinical Cabinet is also supported by clinical advisors from provider organisations including Pennine Acute Hospitals NHS Trust, Pennine Care NHS Foundation Trust and the Bury GP Federation.

The Clinical Cabinet has a robust programme of work and has reflected some of its key achievements during the reporting period below:

- Clinical contribution to several Greater Manchester effective use of resources policies
- Leading on and co-ordinating the organisational response to the national consultation on 'over the counter drugs'
- Approving and / or developing with our providers a number of improved clinical services including an integrated community cardiology service, upper and lower gastro-intestinal pathways, palliative and end of life care service, early intervention in psychosis, posture and mobility service, post-acute kidney injury care management, persistent pain pathway and the children and young people's mental health and wellbeing local transformation plan
- Contributed to internal CCG and Local Authority policies and plans such as interpretation of the 2018/19 planning guidance, the referral booking process, the Locality Plan, transformation schemes, commissioning intentions, mental health parity of esteem and provider data quality issues
- Commenting upon external organisations' plans and policies such as the draft Greater Manchester medicines strategy, renal services in Bury and Rochdale, amendments to Greater Manchester cancer 2 week wait referral templates and local sub-acute rehabilitation
- Receiving updates on previously re-designed services such as the impact of the gluten free prescribing decision, evaluation of Big White Wall online psychological therapy service, clinical pharmacist pilot, transformation schemes, Bury hospice grant allocation and lifestyle changes ahead of elective surgery
- Working with Locality Care Organisation colleagues to help consider clinical input and leadership in the emerging commissioning landscape

Finance Contracting and Procurement Committee

The Finance, Contracting and Procurement Committee provides assurance to the Governing Body with regard to the financial position of the organisation, delivery of the CCG's QIPP programme and oversight on the contracting and procurement activity of the CCG.

The committee comprises the following members and has achieved 91% attendance over the 9 meetings which have been held this year:

- Lay Member with responsibility for Audit, Remuneration and Conflicts of Interest (Chair)
- Lay Member with responsibility for Patient and Public Involvement
- Chief Finance Officer
- Director of Commissioning and Business Delivery, and
- Clinical Director

Additional expertise is co-opted as required to support contracting and procurement discussions.

In addition, the Committee has also discussed matters virtually.

During this year, the Committee has provided a significant level of scrutiny and challenge to our financial position, to ensure the management of financial risk and achievement of statutory financial duties. This has also included oversight of the QIPP programme, through regular reporting and review in order to provide assurance to the Governing Body on its delivery.

Additionally, the Finance Contracting and Procurement Committee has reviewed and recommended to the Governing Body the Investment Agreement proposals to support delivery of the Locality Plan, the finance and operational plan, the further potential opportunities identified through review of contracts and service delivery which will support achievement of the financial gap as we head into 2018/19 and has received updates on the contract negotiations and final agreement of the in year risk mitigations.

Quality and Performance Committee

The Quality and Performance Committee, is accountable to the Governing Body for monitoring the quality and performance of commissioned services and initiating performance interventions, where necessary. In accordance with the responsibilities delegated to it by the Governing Body the remit of the Committee is to:

- Monitor the quality and performance of all commissioned providers
- Undertake routine monitoring and oversight of children's and vulnerable adult protection policies
- Instigate performance intervention in line with the quality strategy and contract clauses
- Identify major quality improvement requirements and escalate, and
- Develop policies and strategies related to its area of responsibility

Chaired by the Lay Member with responsibility for Quality and Performance, the committee comprises the following members:

- Lay Member (Chair)
- Governing Body Secondary Care Doctor (Vice Chair)
- Executive Nurse
- Director of Commissioning and Business Delivery
- Two Clinical Directors, and
- Head of Safeguarding

The Committee has met on 12 occasions during the reporting period, with a 79% attendance rate and quoracy has been achieved at each meeting.

During the year, the committee has continuously reviewed and developed itself to ensure appropriate scrutiny and challenge of its areas of work and provides assurance to the Governing Body.

The Committee has been focussed on ensuring continued improvements in the quality and safety of services provided to the local population, continued development of the quality dashboard and continued development of the risk and performance reports.

The wider work programme of the Committee has also included consideration of quality within nursing homes, serious incident oversight, and outcomes of quality visits at local provider organisations, patient experience reports, deep dives into the risks associated with the work programme within its remit, receiving updates on the safeguarding agenda, including regular review of highlight reports and the annual safeguarding and looked after children reports.

Patient Cabinet

We are keen to ensure that the local patient voice is at the heart of our work. In year, the Patient Cabinet, which includes a number of local people from a range of backgrounds who themselves use local health services in its core membership, has continued to meet with the strengthened officer representation from the CCG to further embed this area of work in our activities.

The Cabinet has representatives from all parts of the Borough and members bring a breadth of experience and interest in health issues including cancer support, palliative care, long term conditions, mental health, urgent care, the BME community and primary care.

Whilst formal arrangements are in place for Patient Cabinet meetings, it is recognised that the real and added value is delivered through patient member engagement in work streams and development of pathways. Examples of this involvement include, but are not limited to:

- Involvement in the co-production of a new service known as the Bury Multi-agency Cancer Service, discussed in more detail earlier in this report, the service offers a range of free and confidential support and advice to people affected by cancer. Provided by a range of local organisations including the voluntary sector, financial and benefits advice, counselling and emotional support, employment advice and support, health and lifestyle advice and complementary therapies are examples of some of advice and support available.
- Involvement in the redesign of urgent care services in Bury. The previous urgent care system had evolved over time, was complex and there was duplication within services. A new system was needed to reduce confusion for patients in terms of which service would best meet their needs, where to access services and when.
- Supporting GP practice Patient Participation Groups within Bury in their ongoing development.

The Patient Cabinet is a formal sub-committee of the Governing Body and has delegated authority as stated in its terms of reference and the scheme of delegation and reservation to:

- Provide assurance to the Governing Body that patient and the public experience and voice informs commissioning policies and activity so that patient and public involvement will be evident and auditable
- Directly contribute a public and patient perspective to CCG plans policies and commissioning decisions
- Advise and assist the CCG in meeting its duties to involve patients and the public in the planning of commissioning arrangements and in any proposed changes to services which may impact on patients in line with its statutory duties under the National Health Service Act 2006 and subsequent legislation
- Advise and assist the CCG in meeting its Public Sector Equalities Duties under the Equality Act 2010, and
- Identify and share good practice in involving and empowering patients, and also to challenge poor engagement practice

The Patient Cabinet, which is chaired by the Lay Member for Patient and Public Involvement, meets on a monthly basis through both an informal development session and formal meeting. Volunteer members of the Patient Cabinet are also representatives on other committees, groups and workstreams within the CCG.

Externally, the Patient Cabinet has developed relationships with Bury Healthwatch, local voluntary sector organisations, Bury Council, practice based patient participation groups, carers groups and BME community groups.

The Patient Cabinet has met formally on 6 occasions achieving an overall attendance level of 64%. Attendance at informal sessions is not monitored.

Patient Cabinet members have been involved in and supported a number of key areas of work during the year and the Cabinet has fulfilled its role to ensure that the patient and public voice is integral to the work of the CCG by:

- receiving and commenting on CCG strategies and plans
- working with clinical and service redesign leads and contributing to service redesign programmes including urgent care, gastro-intestinal pathways, musculoskeletal (MSK) pathways and the Bury Cancer Support Centre
- Taking an active role in engagement activities linked to NHS providers including patient involvement within the Manchester Cancer Programme, patient representation on the North East Sector Cancer Board and involvement in the Quality Improvement Programme at Pennine Acute Hospitals NHS Trust
- Gathering and feeding in views from the local community via attendance at local practice-based patient participation groups and forging links with local voluntary and community groups

The Patient Cabinet has also undertaken an effectiveness review of itself and the work it undertakes, and has committed to exploring how it can work more effectively and in partnership with Bury Council, Healthwatch, voluntary organisations and the wider population on Bury.

Primary Care Commissioning Committee

The role of the Primary Care Commissioning Committee is to carry out the functions relating to the commissioning of primary [medical] care services under section 83 of the NHS Act, except those relating to individual GP performance management which have been reserved to NHS England, and includes:

- Oversight of General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach and / or remedial notices, and removing a contract)
- Authorisation of implementation of new enhanced services ("Local Enhanced Services")
- Oversight of Directed Enhanced Services applications
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- Decision making on whether to establish new GP practices in an area
- Decision making on approving practice mergers, retirements, resignations etc, and
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes)

We have determined additional responsibilities for the Committee to oversee and have widened its non-voting membership to include representatives from primary care professional bodies, including the Local Medical Committee, Local Pharmaceutical Committee, Local Dental Committee and Local Ophthalmic Committee.

The Committee, which is chaired by the Lay Member for Quality and Performance, comprises the following membership and is considered quorate where there is a lay and executive majority with a minimum of nine members present of which 5 must be voting members. Those present must also include the Chair or vice chair, the Chief Officer of Chief Finance Officer and the Clinical Director for leading on Primary Care or the CCG Chair (both non-voting), to represent primary care.

- CCG Lay Member (Chair) (voting)
- CCG Lay Member (vice chair) (voting)
- CCG Chief Officer (voting)
- CCG Chief Finance Officer (voting)
- CCG Director of Commissioning and Business Delivery (voting)
- Director of Public Health (voting)
- Clinical member of the Governing Body – Registered Nurse (voting)
- Deputy Director of Primary Care (voting)
- CCG Chair (non-voting)
- CCG Clinical Director responsible for leading on Primary Care (non-voting)
- NHS England operational representative (non-voting)
- Patient Cabinet Representation(non-voting)
- A representative from Healthwatch (non-voting)
- A representative from the Health and Wellbeing Board (non-voting)
- A representative from the LMC (non-conflicted) (non-voting)
- A representative from the LPC (non-conflicted) (non-voting)
- A representative from the LOC (non-conflicted) (non-voting), and

- A representative from the LDC (non-conflicted) (non-voting)

The committee has met on 10 occasions, with average attendance of 72%. Each meeting has been quorate and the Committee has been effective in discharging its duties.

During the year the committee has reviewed a number of areas, including the approval of a merger of 6 General Practices within the locality onto one contract.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance, however we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code they consider to be relevant to the CCG.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, we have reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of our statutory duties.

Risk management arrangements and effectiveness

The Risk Management Strategy and Policy meets the needs of the CCG and is also reflective of current guidance on risk management best practice as provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004). The Strategy, which has reached the final year of its three year plan in relation to the implementation and delivery of risk management across the CCG, outlines the arrangements agreed by the Audit Committee and approved by the Governing Body for the identification, evaluation, management, monitoring and mitigation of risk.

The Strategy and Policy sets out our risk appetite and tolerance levels, detailing that the risk appetite will be determined on a risk-by-risk basis, with a clear focus on reducing risks to levels as low as reasonably practicable but will tolerate risks where mitigation actions are not cost effective. We are also explicit in that it has zero tolerance for regulatory breaches and fraud.

Roles and responsibilities at both an individual and committee level are clearly defined through the strategy and policy, including arrangements for review and escalation of risks.

The GBAF captures risks with the potential to impact upon the delivery of our strategic objectives, and is supported by the Corporate Risk Register which captures all organisational risks of a level 15 or above.

The practice and principles of risk management are routinely embedded within the day to day operation of the CCG through:

- Compliance with legislative and regulatory requirements
- Adherence to Prime Financial Policies and the Scheme of Reservation and Delegation
- Effective administration and operation of Committees and sub-committees of the Governing Body
- Collation, review and monitoring of the GBAF
- Regular scrutiny and reporting of the Corporate Risk Register
- Routine challenge of poor performance through internal performance management processes
- Completion of Quality, Privacy and Equality Impact assessments for all service re-design activity as part of the refreshed Project Management Office, and
- Implementation of policies and procedures

Regular reviews of each risk are undertaken, which also considers the controls and sources of assurance in place to ensure these are effective and actively working in managing the level of risk presented.

We employ a number of mechanisms to actively prevent and deter risks from arising, including the active promotion of risk prevention through incident reporting, risk assessment and the reporting of concerns through whistleblowing arrangements.

Our Constitution reflects the protection afforded by whistleblowing in line with national guidance and considered the arrangements that have been in place during the reporting period to have been effective.

We also commission internal audits of our work areas to identify gaps in systems and processes and also receive updates in relation to both reactive and pro-active work carried out by the Local Anti-Fraud Specialist in accordance with the agreed plan and national guidance or trends. During the reporting period, we have been made aware of no potential instances of fraud.

We are committed to ensuring that all stakeholders are engaged and involved as appropriate in the management of risks that may impact upon them. This is achieved through our effective communications and engagement strategy and involves providing updates on specific areas of work including the risks, holding engagement events and utilising our patients and stakeholder networks. We have undertaken a number of engagement exercises during the year and also concluded a consultation on our proposed urgent care redesign model, which was redesigned to incorporate patient feedback and concern, demonstrating this approach working in practice.

Additionally, we have focussed on the importance of Quality, Quality and Privacy Impact Assessments, embedding these through our Business Delivery Framework and QIPP agenda.

Training has been made available throughout the year to support staff members, and a concerted effort in raising awareness has been made. This reflects our commitment to pro-active risk management.

Incident reporting is encouraged in the CCG.

Capacity to Handle Risk

CCG leadership is pivotal in the management of risk. Work continues to raise the profile of risk management at both strategic and operational levels.

The Risk Management Strategy and Policy more clearly articulates the roles and responsibilities at both an individual and committee level with each Executive Director being accountable for the risks associated with their portfolio.

Governing Body members were intrinsic in articulating the principal risks to delivery of the strategic objectives for inclusion in the GBAF. Operationally, work has continued on the presentation and discussion of risks and risk registers at each meeting of the clinical work streams and sub-committees of the Governing Body, including a comprehensive programme of deep-dives into each risk that has been open on the risk register for a period of 12 months.

Scrutiny of risk also takes place through the Audit Committee which receives an update in respect to any risks identified and assessed at a level 15 or above and also on any risks proposed for closure.

Risk Owners receive regular updates and are supported in undertaking their responsibilities through dedicated resource, which was brought in-house at the start of the financial year.

Reports are prepared for discussion on a frequency relevant to the receiving committee or work stream, although risks are reviewed on a timeframe appropriate to their level and complexity as agreed by the risk lead and risk manager.

Reporting is undertaken in a timely manner, however, the approach remains dynamic and updates on key risks between reports are provided verbally to sub-committee and Governing Body as appropriate.

Recognising the responsibility of all colleagues in respect to Risk Management, training was delivered to all staff members in April 2017 to ensure that all staff members have the capabilities and knowledge of basic risk management principles, and foreseeing potential risks.

Over the last year, we have also worked closely with Governance and Risk colleagues across Greater Manchester, through a governance leads meeting and the

Greater Manchester risk workshops to ensure continued learning from others and sharing of best practice.

The Governance processes in respect to management of risk are considered robust.

Risk Assessment

We continue to embed risk management reporting and have introduced risk registers for each of the clinical workstreams. We have continued to utilise the risk management software system to capture information relating to controls, assurances and associated gaps for each identified risk and to support the production of the GBAF and Risk Registers. We also include action plans to support the delivery of identified actions to address identified gaps in control or assurance.

Risks are assessed in accordance with the organisational Risk Management Strategy and Policy and reported to the respective committee on a regular basis. Once a risk has been identified a risk assessment is undertaken and a risk rating assigned according to the severity and likelihood (using a 5 x 5 risk assessment matrix), recognising any existing controls in place. A decision is then made by the risk owner as to the most appropriate course of action for treating the risk. Risks are added to the risk register and where the risk is not appropriately controlled and the level of risk is not accepted, an action plan to treat the risk is developed.

The GBAF captures the principal risks to delivery of the Strategic Objectives and is reported to the Governing Body on a quarterly basis, following review and scrutiny by the Audit Committee. Risks have been added and removed over the course of the year, and at March 18 it contains 8 risks, each of which has been managed during the course of the year through increasing controls and sources of assurance with each risk being considered as adequately managed with an overall level of significant assurance.

A significant number of the risks managed over the year and reported through the GBAF are related to the integrated commissioning agenda, specifically the development or relationships and supporting arrangements to facilitate the one commissioner function across the CCG and Bury Council. Recognising the differing cultures and priorities, these have continued to be managed in year through the implementation of a joint leadership team and emerging governance arrangements.

Financial sustainability and delivery of a QIPP programme were also identified as risks to the CCG. Mitigations have been put in place to address short term requirements and the CCG has achieved all of its statutory duties, however, long term sustainability requires a level of change, which is articulated in the Locality Plan. Financial sustainability remains an active risk to the CCG, particularly as delays in approval of the locality's Transformation Bid and subsequent delays in the implementation of schemes have been encountered. We recognise, however, that it cannot rely on transformation alone and introduced a comprehensive review of contracts and service delivery to identify areas where further improvements or changes could be introduced to drive efficiency to help mitigate the risk. The proposals were considered by the Governing Body in March 2018 and will be progressed as we head into the next financial year.

Risks in respect to the quality of care provided by our main acute, mental health and community service providers remain on the GBAF for monitoring, however the last review saw a decrease in the level of risk presented following improved outcomes during the most recent inspections undertaken by the CQC. We continue to participate in the governance arrangements established to drive forward improvements and risk assured that the progress made is sustainable. Reports are submitted to the Quality & Performance Committee and Governing Body on a regular basis.

Operational risks in relation to performance against metrics associated with the Quality Premium, failure of the provider to complete timely serious incident investigations, delivery of the SEND (special educational needs and disabilities) agenda including improving joint commissioning, increased financial costs associated with prescribing, and risks associated with maternity services have also be brought to the attention of the Governing Body in year via the Corporate Risk Register.

During the year, each risk on the risk register and GBAF has been reviewed on a frequency relevant to its level and complexity. These reviews have challenged the appropriateness of each risk, including the risk description, assessment, controls and sources of assurance where necessary and required mitigations.

Risks identified in-year are assessed in three stages:

- Original position – the level of risk presented based on no controls or assurances being in place
- Current 'as at' position – the current level of risk presented (as at 31st March 2018) after considering existing controls and known assurances, and
- Target Risk – the level of risk presented based on completion of mitigation action plans, additional controls and increased sources of assurance

At the start of the reporting period, the Governing Body reviewed the Strategic Objectives and agreed the principal risk to delivery of these. Eight principal risks were identified under the seven strategic objectives and were assessed in relation to the current level of risk taking into account existing controls. All of these risks had been included on the GBAF from the previous year. 7 of the risks were assessed at a significant level with a risk rating of 15 and above, with the remaining 1 risk assessed as a high risk with a rating between 10 and 12.

In relation to personal health budgets, following an audit, the processes judged as limited assurance have been addressed and will be scrutinised by the Audit Committee. Furthermore, we have commenced work with Bury Council to enable the wider roll out of personal health budgets for health care using the expertise of colleagues with extensive experience in the delivery of personal health budgets for social care.

Actions were identified for each risk on the GBAF, irrespective of the assessed risk score, to further increase controls, reduce gaps in assurance, and progress each risk towards its target level.

During the reporting period, no risks have been removed from the GBAF and no new risks have been added, however at the end of the reporting period three new risks were identified and agreed for inclusion on the GBAF for 2018/19. These relate to the governance arrangements for the One Commissioning Organisation, the urgent care redesign and delivery of the transformation plan.

There has been very little movement in the level of risk over the reporting period, with only one risk reducing in score from a significant to high level, however, all risks have been managed in-year with scrutiny of the controls and assurance in place and 75% are reporting significant assurance.

In addition to the GBAF, the risk register contained 29 risks at the start of the reporting period, which are reviewed by risk leads, work streams and committees on a regular basis. Over the reporting period, 17 new risks have been added and 25 risks have been closed, leaving 21 risks open at the end of the reporting period.

The CCG was exposed to the cyber security attack on 12th of May 2017 and was required to implement its business continuity arrangements for a short period of time whilst the nature of the attack was fully understood. A small number of devices were compromised in both the CCG and within our Member practices. Since that time, a number of anti-malware products have been added to the estate to further protect the CCG and its Member practices. There is a programme of work currently being undertaken to migrate devices to Windows 10 with Advanced Threat Protection enabled to link directly into the new NHS Digital Cyber Security centre.

The Risk Management Strategy and Policy outlines specific roles and responsibilities in relation to the overarching management of risk, however, it clearly articulates that delivery and adherence to risk management arrangements is the responsibility of everyone within the CCG and every individual staff member has the responsibility to identify any potential or actual risk for service users, staff and the organisation.

In all instances where a risk is not tolerable at the current level, an action plan is drawn up to set out the steps to be taken to manage that risk, with a nominated responsible lead officer and a deadline for completion of each action.

Reporting arrangements continue to provide detailed qualitative information and analysis to accompany the risk registers with regular updates to the respective committees, or Governing Body as appropriate. Outcomes are reviewed in respect of actions taken through these arrangements and where these are not satisfactory or do not reduce the level of risk to the CCG, the risk remains open. Once desired outcomes are achieved, the risk is recommended for closure to the Audit Committee and archived as necessary.

There have been no risks to compliance with our licence to operate.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify

and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk, it can therefore only provide reasonable and not absolute assurance of effectiveness.

The System of Internal Control has been in place in the CCG for the year ended 31st March 2018 and up to the date of approval of the Annual Report and Accounts and has included:

- The CCG Constitution
- The Risk Management Strategy and Policy and wider arrangements
- The Anti-Fraud Annual Plan
- The Internal Audit Annual Plan
- The External Audit Annual Plan
- Performance monitoring of CCG providers and the CCG itself
- IG Toolkit submission
- Incident reporting and serious untoward incident monitoring
- Quality reporting
- Financial reporting
- Contract monitoring arrangements
- Policies and procedures
- Governance framework including committee and sub-committee governance structure
- Equality Delivery System 2,
- Safeguarding Annual Work Plan and Report, and
- Compliance with EPRR core standards (emergency preparedness)

The CCG assures itself on the validity on the Annual Governance Statement through a process of triangulation between the information contained in it and:

- Internal Audit reports, findings and recommendations
- The Head of Internal Audit Opinion, and
- Consultation with members of the Audit Committee, including the External Auditors, on the accuracy of the contents of this statement

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

An audit of conflicts of interest was completed following the prescribed framework issued by NHS England. Overall, we were fully complaint in 22 of the 27 key elements within each of the five scoped areas.

The following compliance levels were assigned to each scope area:

Area	Compliance Level	RAG
Governance Arrangements	Partial	●
Declarations of Gifts and Hospitality	Full	●
Register of interests, gifts and hospitality and procurement decisions	Partial	●
Decision making process and contract monitoring	Partial	●
Reporting concerns and identifying and managing breaches and contract monitoring	Full	●

We have reviewed the feedback from the audit, and is disappointed that three areas were identified as partially compliant. This has been a particular focus during the year, with specific training provided to the Governing Body to increase awareness, alongside the refresh of our CCG's policy in line with revised guidance.

We acknowledge the findings and will ensure that quarterly reviews of the electronic staff record and registers are undertaken, further information is collated in respect to General Practice staff involved in CCG business and further clarity on the responsibility of approving sponsorship and oversight of data protection and confidentially is referenced appropriately in respect of the Conflict of Interest, Gifts and Hospitality and Sponsorship policies.

Data Quality

We utilise data provided by NHS England to inform our performance and business reporting. These arrangements are reviewed through the quarterly assurance checks with GMHSCP and submitted to the Governing Body and other committees as appropriate as part of the performance management arrangements.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

The Internal Audit review of Information Governance Toolkit returned an outcome of Significant Assurance and the CCG submitted an overall return demonstrating 88%

compliance, with 16 level 3 requirements and 9 level 2 requirements. Three requirements were assessed as not applicable to the CCG.

This achievement is above the requirements set out in the NHS Operating Framework and demonstrates that the CCG has an excellent Information Governance Framework and culture in place.

There are processes in place for incident reporting and investigation of serious incidents. We continue to develop our information risk assessment and management procedures and are committed to ensuring our arrangements are fully implemented to embed an information risk culture throughout the organisation.

Business Critical Models

Over the course of the reporting period, the CCG has identified its business critical models and current arrangements for their quality assurance. Predominantly, these are provided by the Greater Manchester Shared Service, however, there are other external providers who are responsible for the administration of some Business Critical Models and other internal systems that the CCG is reliant on to deliver its core functions.

All business critical models have been identified as part of the business continuity management arrangements and included on the information asset register, with a suitably qualified information asset owner.

Where business critical models are the responsibility of an external organisation, we seek assurance on the arrangements in place for managing these. In relation to those models provided by other NHS organisations, these are subject to regular internal and external review, the outputs of which are reported to the CCG through management and service auditor reports.

Third party assurances

We commission services from Greater Manchester Shared Services. Regular reviews are undertaken and we receive assurance that roles and responsibilities delivered under these arrangements are economic, efficient and effective. The arrangements are kept under continuous review.

For the remaining services commissioned from Greater Manchester Shared Services, achievement against KPIs is routinely monitored and concerns are escalated as required. We have a high level of assurance in delivery of services in line with our requirements.

Control Issues

We declared no control issues during our month 9 review and remain assured that no issues have arisen from the submission of the month 9 declaration to the end of the reporting period.

Review of economy, efficiency and effectiveness of the use of resources

We continue to develop and strengthen internal controls and have worked with the Internal and External Auditors to progress this. The CCG's QIPP target was identified through financial modelling arrangements to support the identification and delivery of QIPP have been continually reviewed over the reporting period, taking into account the findings from the Internal Audit review and to ensure that lessons learnt are continually incorporated into day to day business. We recognise there is still much more to be delivered and have embraced the Right Care methodology to further our learning and approach.

As part of our annual assurance processes against the IAF, a review on the Quality of Leadership has been undertaken by GMHSCP. We reviewed each of the requirements in detail and submitted a self-assessed rating of green, although identified developing relationships within the local system and quality as green star areas.

Discussions throughout the year in respect to the CCG's performance demonstrated that Leadership is robust, and the CCG received confirmation that its self-assessment is an accurate reflection, with a formal rating of 'green' being awarded.

Our financial performance continues to be monitored through monthly returns, review and is reported through each Governing Body meeting with scrutiny and assurance provided by the Finance, Procurement and Contracting Committee.

The audited accounts were reviewed in detail by the Audit Committee at their meeting on 21st May 2018 before recommendation to the Governing Body which met and approved them on 23rd May 2018. The accounts are signed by the Accountable Officer and Chief Finance Officer.

Delegation of functions

We operate a scheme of delegation which sets out the powers reserved by the membership and those delegated to other components of our decision-making architecture. This scheme of delegation is open to scrutiny by both Internal Audit and External Audit colleagues.

We have not delegated functions outside of the scheme of delegation during the reporting period.

Counter fraud arrangements

The Audit Committee is responsible for seeking assurance and oversees Counter Fraud services and supports the view that fraud against the NHS will not be tolerated.

All genuine suspicions of fraud are investigated and if proven the appropriate sanctions will be sought against the perpetrators.

In addition to overseeing the anti-fraud, bribery and corruption arrangements in place with providers, the CCG also needs to ensure its own counter fraud measures are robust.

We have well established counter fraud arrangements in order to achieve the standards set out by NHS Protect.

We engage an Accredited Counter Fraud Specialist to implement an on-going programme of anti-fraud, bribery and corruption work across the whole organisation. During 2017/18, work has involved the delivery of an annual work plan which follows NHS Protects strategy to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all 4 key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

The Chief Finance Officer, as an Executive member of the Governing Body, is responsible for ensuring we take our responsibility for managing risks associated with fraud, bribery and corruption seriously.

We continue to take a very robust approach to counter fraud work, the Local Counter Fraud Specialist (LCFS) is well resourced in terms of work plan days and the Audit Committee and senior management throughout the organisation understand the importance of counter fraud work and fully support the LCFS and Chief Finance Officer in conducting that work.

The LCFS has developed key relationships across the CCG, which supports it in developing an anti-fraud culture and work has been undertaken in year to deliver awareness raising with employees, GPs, practice managers and Sector Leads.

During the reporting period, we have been made aware of no potential instances of fraud.

The Audit Committee receives the report against the standard for commissioners on an annual basis. At the meeting in March 2018, the Audit Committee approved the overall self-assessed rating of 'Green' and was assured on the levels of compliance with the requirements.

The Audit Committee is also advised on NHS Protect quality assurance recommendations and appropriate action is taken as required.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of our system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Substantial Assurance, can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

During the year, Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Patient Access: Out of Hours and 7 Day Working	Significant Assurance
Key Finance Systems	Significant Assurance
Information Governance Toolkit	Significant Assurance
Personal Health Budgets	Limited Assurance

From these reviews, a total of 11 recommendations were made on the following basis:

Level	Number	%
Critical		0%
High	4	36.4%
Medium	5	45.4%
Low	2	18.2%

All recommendations will be addressed through mitigating actions which against an agreed completion date with updates reported to the Audit Committee on a quarterly basis.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, the quality and performance committee, Internal Audit and the outcome of our review meetings against the IAF. The conclusions from each of these is positive and provides assurance that the system, processes and management of controls to effectively manage risks with the CCG is robust and embedded in core business.

Our risk management systems and processes including the GBAF and the overall governance arrangements continue to develop and enhance the delivery of robust and informed decision making in-year, alongside financial and performance information.

The Governing Body has conducted greater oversight of the GBAF and Corporate Risk Register, which have continued to be monitored and updated in line with the Risk Management Strategy and Policy supporting our systems of internal control throughout the reporting period.

In February 2018, the Internal Auditors undertook a review of the CCG's GBAF and associated risk management processes. This review found that the *Assurance Framework is structured to meet the NHS requirements and clearly reflects the risks discussed by the Governing Body but could be more visibly used by the Governing Body and its sub-committees.*

Conclusion

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways as described above. The Head of Internal Audit has also provided 'Significant Assurance' that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

My review concludes that NHS Bury CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and I confirm that no significant control issues have been identified in the reporting period.

Stuart North
Accountable Officer
Date:

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

For the period from 1st April 2017 to 31st March 2018, details of the membership of the Remuneration Committee were as follows:

- Chris Wild, Chair
- David McCann, Lay Member
- Peter Bury, Lay Member

The Remuneration Committee follows national guidance issued by the Department of Health to determine the remuneration and terms and conditions of senior managers using the national Very Senior Managers pay framework (VSM). Implementation of this framework took place following completion of the Fitness for Purpose assessment. The Remuneration Committee is also responsible for the remuneration of the clinical members. Remuneration is not performance related.

Policy on the remuneration of senior managers

The policy on the duration of senior manager contracts is in line with our Approved Standing Orders.

The performance of VSMs is assessed through the CCG's Personal Development Review system in line with NHS policy. Remuneration is not performance related. Termination of contracts, and any relevant payments, would be calculated on an individual basis, taking into account circumstances of termination, notice periods, length of service and salary. All calculations would be in line with statutory and NHS terms and conditions.

Remuneration of Very Senior Managers

There are no senior managers within the CCG who are remunerated above £150,000 per annum.

Senior manager remuneration (including salary and pension entitlements)

For each very senior manager and other members of the Governing Body who have served during the financial year 2017/18. Details of service contract, remuneration and pension benefits are shows in the tables below.

Name	Position	Unexpired term of contract (as at 31/03/18)	Notice period
Dr. Kiran Patel	Chair	1 year*	6 months
Stuart North	Chief Officer	Substantive	6 months
Mike Woodhead	Interim Chief Finance Officer	Substantive	6 months
Catherine Jackson	Executive Board Nurse / Director of Quality	Substantive	6 months
Margaret O'Dwyer	Deputy Chief Officer / Director of Commissioning and Business Delivery	Substantive	6 months
Howard Hughes	Clinical Governing Body Member	2 years**	6 months
Dr. Catherine Fines	Clinical Governing Body Member	0 years***	6 months
Dr. Jeff Schryer	Clinical Governing Body Member	1 year 6 months****	6 months
Peter Bury	Lay member for Quality and Performance	1 year 7 months	3 months
Chris Wild	Lay Member for Audit, Remuneration and Conflicts of Interest	1 year	3 months
David McCann	Lay Member for Patient and Public Involvement	1 year	3 months
Fiona Boyd	Clinical member of the Governing Body – Registered Nurse	1 year 7 months	3 months
Mr Amarbaj Chandock	Clinical Member of the Governing Body - Secondary Care Doctor	1 year 2 months	3 months

* Stood down as Chair from 1/4/18, to take up a new role.
** Re-elected to role of Clinical Director for a 3 year period commencing 1/4/2017.
*** Re-elected to role of Clinical Director for a 3 year period commencing 1/4/2018.
**** Elected to the position of CCG Chair commencing 1/4/2018.

As per the Standing Orders, elected Governing Body Members can be re-elected up to a maximum term of office of 9 years.

Full details of Governing Body including Lay Members, their roles, and the committees or sub-committees they were members of during the year can be found on page 50, and also in the Annual Governance Statement.

Remuneration package

Name and Title	2017/18				
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000
Dr. Kiran Patel Chair	95-100	-	-	-	95-100
Stuart North Chief Officer	110-115	-	-	15-17.5	125-130
Mike Woodhead Interim Chief Finance Officer	95-100	-	-	22.5-25	120-125
Catherine Jackson Executive Board Nurse / Director of Quality	70-75	-	-	10-12.5	80-85
Margaret O'Dwyer Deputy Chief Officer / Director of Commissioning and Business Delivery	100-105	-	-	15-17.5	115-120
Howard Hughes Clinical Governing Body member	50-55	-	-	5-7.5	55-60
Dr. Catherine Fines Clinical Governing Body member	65-70	-	-	42.5-45	110-115
Dr. Jeff Schryer Clinical Governing Body member	50-55	-	-	12.5-15	65-70
Mr Amarbaj Chandock Secondary Care Doctor	5-10	-	-	-	5-10
Dr. Wissam El-Jouzi	10-15	-	-	-	10-15

Name and Title	2017/18				
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000
North Sector Chair					
Dr. Fazel Butt East Sector Chair	10-15	-	-	-	10-15
Dr. Ajay Kotegaonkar West Sector Chair	10-15	-	-	-	10-15
Dr. Richard Deacon South Sector Chair	10-15	-	-	-	10-15
Peter Bury Lay Member for Quality and Performance	10-15	-	-	-	10-15
Chris Wild Lay Member for Audit, Remuneration and Conflict of Interest	10-15	-	-	-	10-15
David McCann Lay Member for Patient and Public Involvement	10-15	-	-	-	10-15
Fiona Boyd Clinical Member Governing Body / Registered Nurse	5-10	-	-	-	5-10

- There were no long term Performance Bonus schemes in operation during the year, and therefore column (d) has been excluded.
- Dr. Catherine Fines received £26,332 of her remuneration (2016/17 £26,071) in respect of services provided as the Named GP for Safeguarding.

Name and Title	2016/17				
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000
Dr. Kiran Patel Chair	95-100	-	-	-	95-100
Stuart North Chief Officer	110-115	-	-	15-17.5	125-130
Claire Wilson Chief Finance Officer	15-20	-	-	10-12.5	25-30
Mike Woodhead Interim Chief Finance Officer	90-95	-	-	20-22.5	110-115
Catherine Jackson Executive Board Nurse / Director of Quality	60-65	-	-	15-17.5	80-85
Margaret O'Dwyer Deputy Chief Officer / Director of Commissioning and Business Delivery	100-105	-	-	47.5-50	145-150
Howard Hughes Clinical Governing Body member	50-55	-	-	-	50-55
Dr. Catherine Fines Clinical Governing Body member	65-70	-	-	5-7.5	70-75
Dr. Jeff Schryer Clinical Governing Body member	50-55	-	-	2.5-5	55-60
Dr. Victoria Moyle Clinical Governing Body member	40-45	-	-	0-2.5	40-45

Name and Title	2016/17				
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000
Mr Amarbaj Chandock Secondary Care Doctor	0-5	-	-	-	0-5
Dr. Wissam El-Jouzi North Sector Chair	-	-	-	-	-
Dr. Fazel Butt East Sector Chair	-	-	-	-	-
Dr. Ajay Kotegaonkar West Sector Chair	-	-	-	-	-
Dr. Richard Deacon South Sector Chair	0-5	-	-	92.5-95	90-95
Andrew Clough Lay Member for Quality & Risk	0-5	-	-	-	0-5
Peter Bury Lay Member for Quality and Performance	0-5	-	-	-	0-5
Chris Wild Lay Member for Audit, Remuneration and Conflict of Interest	10-15	-	-	-	10-15
David McCann Lay Member for Patient and Public Involvement	10-15	-	-	-	10-15
Karen Richardson Lay Member for Primary Care Quality	0-5	-	-	-	0-5

Name and Title	2016/17				
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000
Fiona Boyd Clinical Member Governing Body / Registered Nurse	0-5	-	-	-	0-5

There were no long term Performance Bonus schemes in operation during the year, and therefore column (d) has been excluded.

Pension benefits as at 31st March 2018

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31st March 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1st April 2017	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31st March 2018	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Stuart North Chief Officer	0-2.5	2.5-5	50-55	155-160	1,118	85	1,203	-
Mike Woodhead Interim Chief Finance Officer	0-2.5	-	0-5	-	19	20	39	-
Catherine Jackson Executive Board Nurse / Director of Quality	0-2.5	2.5-5	40-45	120-125	682	31	713	-
Margaret O'Dwyer Deputy Chief Officer / Director of Commissioning and Business Delivery	0-2.5	2.5-5	45-50	140-145	957	82	1,039	-
Dr. Catherine Fines Clinical Governing Body member	2.5-5	0-2.5	15-20	40-45	246	39	284	-
Dr. Jeff Schryer Clinical Governing Body member	0-2.5	2.5-5	10-15	30-35	207	23	230	-
Howard Hughes Clinical Governing Body member	0-2.5	-	0-5	-	-	5	5	-
Dr. Richard Deacon South Sector Chair	0-2.5	0-2.5	25-27.5	70-75	436	11	447	-

Notes: KPMG under the terms of the audit has audited the above figures showing the senior managers pension entitlement. Inflation assumed to be 1% for 2017/18.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement for loss of office

There were no payments in relation to compensation on early retirement for loss of office during 2017/18**.**

Payments to past members

There were no payments to past members during 2017/18.

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/Member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director/Member in NHS Bury CCG in the financial year 2017/18 was £165k - £170k (2016/17 was £160k - £165k). This was 4 times (2016/17 was 4 times) the median remuneration of the workforce, which was £42k (2016/17 was £41k).

In 2017/18, no employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £15k to £166k (2016/17 was £15k to £165k).

Total remuneration includes salary, non-consolidated performance-related pay where relevant, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

We recognise that our staff are one of our most important attributes, and ensuring that staff have a positive experience working at the CCG, and feel motivated and supported, is a key priority for the CCG's leadership.

During the year we have sought to develop and enhance our workforce in a number of ways, including:

- Consultation with staff on a number of new and revised policies including in relation to:
  - Leave of Absence
  - Flexible Working
  - Attendance Management
  - Grievance
  - Managing Work performance
  - Whistleblowing
  - Conflicts of Interest, and
  - Gifts and Hospitality

- Supporting staff to participate in a range of leadership development opportunities, including the introduction to leadership and advanced leadership development programmes.
- Continuing to support staff compliance with mandatory training covering the areas of equality and diversity, information governance, safeguarding adults and children, infection prevention, manual handling, fire safety, health and safety and fraud awareness, via a new online e-learning portal.

Number of senior managers

Senior managers are categorised using the definitions provided by the Information Centre's Occupational Code Manual as follows:

- Very Senior Managers – Chief Executive, Director of Finance and other executive directors who are voting members of the organisation
- Senior Managers – who directly report to the executive team and have responsibility for budgets, staff, assets or significant areas of work.

Senior officers of the CCG are remunerated under the 'local very senior manager' (LVSM) pay arrangements with remuneration for other Governing Body members also agreed outside of Agenda for Change and reported as follows:

	Pay Band	**M**	**F**	**Total**
Governing Body	LVSM / outside of AfC	13	4	17
Other Senior Managers	Agenda for Change	-	6	6

Staff numbers and costs

We directly employed 110 members of staff as at 31st March 2018 to support the delivery of our functions. Most are based at our Headquarters on Silver Street, Bury. During the year, 82 staff were permanently employed with the CCG. 48 staff were employed on other arrangements (including fixed term contracts and inward and outward secondments).

Staff costs are included in accordance with note 4 to the statutory accounts, where full remuneration details can also be found.

The average number of employees during 2017/18 was 95.39 whole time equivalent, which is also calculated in accordance with note 4 to the statutory accounts, where full remuneration details can also be found. In addition we also commission services from Greater Manchester Shared Service, for example contracting, human resources and organisational development support and share a number of posts with our neighbouring CCGs within the North East Sector of Greater Manchester including Continuing Health Care resources.

Staff composition

Our staff composition as at 31st March 2018 is reported as follows and is presented as numbers of individuals employed directly by the CCG and also under memorandums of understanding with other neighbouring CCGs. The figures exclude any resources commissioned under service level agreement from Greater Manchester Shared Service and have also been categorised based on the guidance provided through the Information Centre's Occupation Codes and supporting information.

	Male	**Female**	**Total**
Chair and Non Executives	4	0	4
Governing Body Members	3	2	5
Clinical	14	6	20
Senior Managers	3	7	10
Managers	4	11	15
Nursing Professionals	2	18	20
Clerical and Administrative	14	42	56
Totals	**44**	**86**	**130**

The above figures take account of inward and outward secondments.

Sickness absence data

Sickness absence figures for the calendar year ended 31st December 2017 are as follows:

Total full time equivalent days lost: 350 (as per the Cabinet Office definition).
Average working days lost: 4.6.

Sickness absence is reported at an organisational level each month to the senior management team as part of the workforce performance report. This report provides data on the 'in month' and cumulative ('financial year to date') percentage sickness rates, the cost of sickness, whether the sickness is long or short term, benchmarked data from the Health and Social Care Information Centre's data warehouse comparing the CCG to the average sickness rate for CCGs in the North West of England and the reasons for sickness.

Monthly reports at individual employee level are shared with line managers and our Human Resources Advisor works closely with managers to proactively manage sickness cases in line with the Sickness Absence policy.

Staff policies - Equality, diversity and human rights

We have a range of employment policies which support equality, diversity and human rights including Dignity at Work, Equality, Diversity and Human Rights, Flexible Working, Disability Policy, Shared Parental Leave. All HR policies are regularly reviewed and updated to reflect changes in legislation and best practice.

Additionally, Equality Analyses are undertaken as part of the development and review process to ensure polices are fair and equitable to all employees and any potential adverse impacts are identified and addressed.

Reasonable adjustments are made for staff who consider themselves to have a disability at the time of recruitment or who have become a disabled person during the period when they are employed by the CCG. This is discussed on a case by case basis with the employees line manager and HR support where necessary, to ensure that these staff are supported in their day to day roles and in their development.

In line with our Public Sector Equality Duty our Annual Equality Publication and the Equality Workforce Report Published in January 2018 outlines our approach to equality and diversity including how this relates to our workforce.

The full publication and a range of other reports can be found on our Equality and Diversity web page.

We are committed to maintaining effective employee relations with our staff and their union representatives, and consider that good employee relations are an important factor in achieving our values and objectives. We are committed to securing and promoting staff engagement and involvement.

Consultation with staff

We value the opinions and views of staff and recognise that all members of staff are able to contribute more effectively when they know their duties and responsibilities, obligations, rights and have an opportunity of making their views known on issues that affect them.

Established processes are in place for staff to be engaged and consulted with on a range of issues. Monthly staff briefings are in place along with a write up of discussions which is shared with staff, benefiting those unable to attend in person.

A mechanism for involving and engaging with staff on matters affecting them including the consideration of and feedback on draft human resources policies and procedures in advance of them being approved and implemented is also in place.

Consultation and the introduction of new policies is ongoing to ensure that we have policies and procedures that are fit for purpose.

During the year, the Staff and Social Engagement Committee became more established. A member or representative from each department or team attends the monthly meetings to ensure that the views of all staff from all teams are captured and represented on a range of issues affecting them.

During the year for the benefit of staff we continued to offer an Employee Assistance Programme. The programme aims to provide support with any personal or professional issues which could be impacting on a member of staff's general health and wellbeing.

Whilst the CCG does not have any trade union representatives, it would be supportive of staff wanting to explore taking on this role.

Expenditure on consultancy

As at the 31st March 2018 we spent £61,000 on consultancy.

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31st March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31st March 2018	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0

for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

All off-payroll engagements have been subject to a risk based assessment and all assurances have been sought regarding compliance to current tax legislation.

All off-payroll engagements have ceased as at 31st March with the exception of one where the CCG has confirmed that the worker is on an agency run payroll.

Table 2: New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1st April 2017 and 31st March 2018, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2017 and 31st March 2018	2
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	2
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1st April 2017 and 31st March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	1 *
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	17 **

*The Director of Public Health is not employed by NHS Bury CCG.

**This figure also includes the Sector Chairs, who during 2017/18 have supported the Clinical Cabinet agenda and have not routinely been invited to the Governing Body, however, are available as required and have voting rights as set out in the Constitution.

Exit packages, including special (non-contractual) payments

There were no exit packages or other departures during 2017/18.

Stuart North
Accountable Officer
Date:

Parliamentary Accountability and Audit Report

NHS Bury CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Annual Accounts.

Financial Performance

We are pleased to report all of our statutory financial duties in 2017/18 have been achieved.

Achievement of operational financial balance

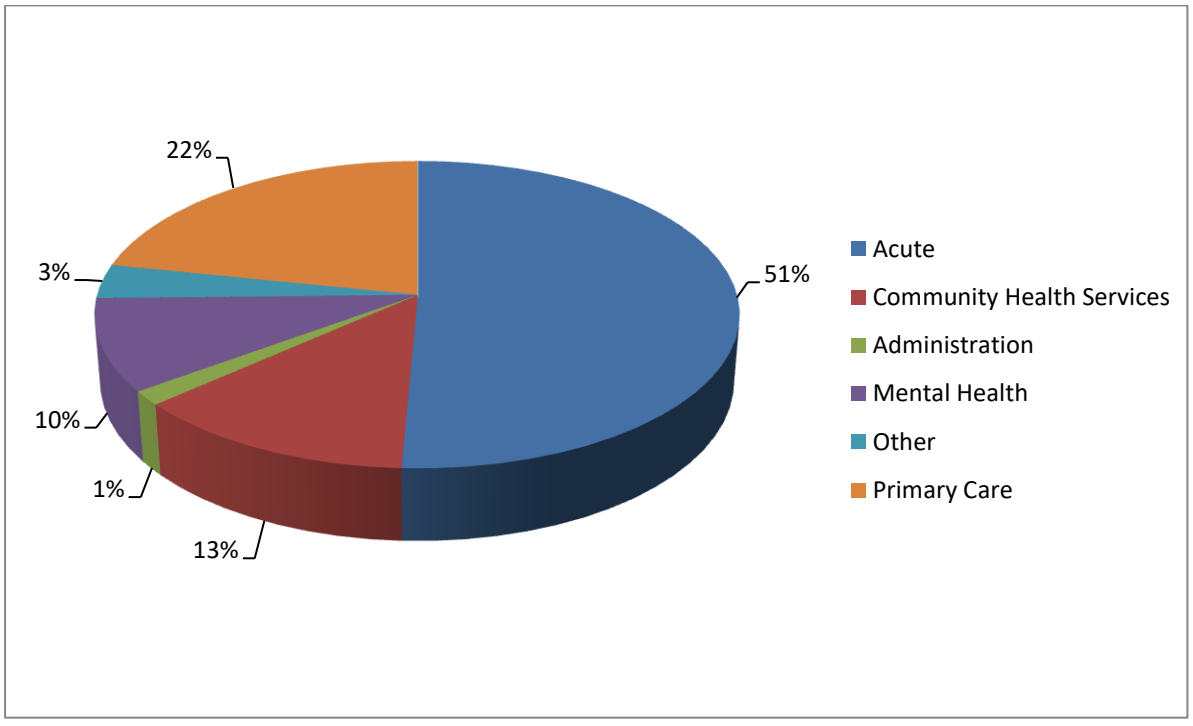
NHS Bury CCG achieved the 'operational financial balance' and reported a revenue surplus of £6,954,000.

Financing limit

The CCG should operate within a defined level of cash for each year. This was achieved in 2017/18.

Analysis of our funding and expenditure

We received £292.7 million of parliamentary revenue funding in 2017/18. We carried £1.7 million of this forward for future years investment in healthcare services increasing our cumulative surplus to £6.9 million as at 31 March 2018. We spent the remaining £291 million as follows:



Acute healthcare - represents the cost of contracts we have with hospitals to provide services for the residents in our community. Examples of these services are A&E, maternity and general and acute (hospital) services.

Primary care - costs mainly represent the cost of drugs prescribed by GPs. Costs also include other services provided from GPs and primary care contractors (e.g. GP

out of hours services) and also for Delegated Co-Commissioning Primary Care Costs.

Mental health – represents the cost of contracts we have with providers of mental health services.

Community healthcare - this is the cost of the services provided in a community setting. Examples of these services are district nursing, physiotherapy and community clinics. It also includes the cost of providing long-term packages of care for people at home and in nursing and residential homes. By understanding the needs of our community, we strive to obtain high quality and value services. We also ensure the management of those contracts throughout the lifecycle of a service is of the highest possible standard.

Administration - represents the departments that support the process of commissioning the healthcare services described above and this includes the services commissioned from the Greater Manchester Shared Service.

Other programme - mainly consists of non-acute services and healthcare estates costs.

The summary statements show the key financials for the CCG.

Financial Summary Statements - overview

The following Summary Financial Statements are a summary of information contained in NHS Bury CCG's Annual Accounts 2017/18.

These statements do not contain sufficient information to allow for a full understanding of the results and state of affairs of the CCG, and its policies as would be provided by the full Annual Accounts.

Copies of the CCG's Annual Accounts 2017/18 can be accessed via www.buryccg.nhs.uk or requested from Mike Woodhead, Interim Chief Finance Officer, NHS Bury CCG, First Floor, 21 Silver Street, Bury, BL9 0EN.

Statement of Comprehensive Net Expenditure for the year ended 31st March 2018

This statement shows our total net expenditure split between direct health care spend (programme) and administration spend.

	31st March 18			31st March 17		
	£000	£000	£000	£000	£000	£000
	Programme	Admin	Total	Programme	Admin	Total
Other operating income	(4,582)	-	(4,582)	(3,528)	(61)	(3,589)
Staff costs	1,984	2,380	4,364	1,505	2,827	4,332
Other Operating Expenditure	289,224	1,966	291,190	274,702	1,826	276,528
Total Operating Expenditure	**291,208**	**4,346**	**295,554**	**276,207**	**4,653**	**280,860**
Net Operating Expenditure	**286,626**	**4,346**	**290,972**	**272,679**	**4,592**	**277,271**

Statement of Financial Position as at 31st March 2018

The Statement of Financial Position provides a snapshot of the CCG's assets and liabilities at 31st March 2018.

	2017/18	2016/17
	£000	£000
Current assets:		
Trade and other receivables	2,410	1,510
Cash and cash equivalents	128	76
Total current assets	**2,537**	**1,586**
Total assets	**2,537**	**1,586**
Current liabilities		
Trade and other payables	(20,466)	(18,211)
Provisions	-	(109)
Total current liabilities	**(20,466)**	**(18,320)**
Non-Current Assets plus/less Net Current Assets/Liabilities	**(17,929)**	**(16,734)**
Assets less Liabilities	**(17,929)**	**(16,734)**
Financed by Taxpayers' Equity		
General fund	(17,929)	(16,734)
Total taxpayers' equity:	**(17,929)**	**(16,734)**

Statement of Changes in Taxpayers Equity for the year ended 31st March 2018

This statement reflects any of our gains or losses that have not been reflected in the Operating Cost Statement.

	Total reserves
	£000
Changes in taxpayers' equity for 2017/18	
Balance at 1st April 2017	(16,734)
Net operating costs for the financial year	(290,972)
Net funding	289,778
Balance at 31st March 2018	**(17,928)**

Statement of Cash Flows for the year ended 31st March 2018

This statement explains the movements in cash balances during the financial year.

	31st March 18	31st March 17
	£000	£000
Cash Flows from Operating Activities		
Net operating costs for the financial year	(290,972)	(277,271)
(Increase)/decrease in trade & other receivables	(900)	690
Increase/(decrease) in trade & other payables	2,255	5,026
Provisions utilised	-	(48)
Increase/(decrease) in provisions	(109)	(12)
Net Cash Inflow (Outflow) from Operating Activities	**(289,726)**	**(271,614)**
Cash Flows from Investing Activities	-	-
Net Cash Inflow (Outflow) before Financing	**(289,726)**	**(271,614)**
Cash Flows from Financing Activities		
Net funding received	289,778	271,523
Net Increase (Decrease) in Cash & Cash Equivalents	**52**	**(91)**
Cash & Cash Equivalents at the Beginning of the Financial Year	**76**	**167**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**128**	**76**

Summary of Results of the CCG Annual Accounts for the year ended 31st March 2018

Achieving the Better Payment Practice Code Target (BPPC)

The CCG exceeded the 'Better Payment Practice Code' (BPPC) Target.

Better Payment Practice Code

The CCG is a signatory to the Better Payment Practice Code. The Better Payment Practice Code is a payment initiative developed by Government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and help small businesses.

Measure of compliance

The Better Payment Practice code is summarised as follows:

a. **Target**: Pay all creditors, both NHS and Non-NHS, within 30 days of receipt of goods or services or a valid invoice (whichever is later), unless other payment terms have been agreed.

b. **Compliance**: authorise payable order schedules to take money from the CCG's bank account within 30 days (or date and issue cheque within that period).

The notional target set for the CCG is to achieve 95% in each category.

Measure of compliance	**2017/18**		**2016/17**	
	Number	**£000**	**Number**	**£000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	15,468	69,688	15,040	70,301
Total Non-NHS Trade Invoices paid within target	15,390	69,506	14,916	69,939
Percentage of Non-NHS Trade invoices paid within target	**99.50%**	**99.74%**	**99.18%**	**99.49%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,717	190,540	2,541	176,332
Total NHS Trade Invoices Paid within target	2,704	190,404	2,517	175,977
Percentage of NHS Trade Invoices paid within target	**99.52%**	**99.93%**	**99.06%**	**99.80%**

Related Party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party
	£000	**£000**	**£000**
ABL HEALTH LTD	91	-	-
ASSOCIATION OF GM CLINICAL COMMISSIONING GROUP	-	-	-
BARDOC	1,804	-	73
BIRCHES MEDICAL PRACTICE	450	-	1
BUPA - ANYTIME HEALTHCARE	-	-	-
BURY & ROCHDALE LMC	-	-	-
BURY COUNCIL	15,505	-5,431	146
BURY GP PRACTICES LTD	2,111	-	-
ELMS MEDICAL CENTRE WHITEFIELD	750	-	1
ESSENTIAL COMMUNICATION BURY	15	-	-
FUSILLIERS MUSEUM BURY	4	-	1
GORDON BURNS PARTNERSHIP BURY	-	-	-
GREENMOUNT MEDICAL CENTRE	1,268	-	1
HERSHEL WEISS SURE START	-	-	-

CENTRE			
HOLLYBANK NURSING HOME	59	-	-
HUGHES MCCAUL LTD	-	-	-
HUNTLEY MOUNT MEDICAL CENTRE	391	-	-
KEIRBY HEALTHCARE LTD (BURNLEY)	-	-	-
LASERASE BOLTON LTD	-	-	-
LOCALITY CARE ORGANISATION LCO ALLIANCE BOARD	-	-	-
OAK LODGE NURSING HOME	241	-	-
ORAS LOCUM LTD	-	-	-
PCL (CIP) GP Ltd	-	-	-
PRAXIS CAPITAL LTD	-	-	-
PRAXIS REAL ESTATE	-	-	-
PRESTWICH PHARMACY	-	-	-
ROCK HEALTHCARE	1,290	-	-
SPRING LANE SURGERY	-	-	-
ST GABRIEL'S MEDICAL PRACTICE	908	-	-
ST PETERS PHARMACY (BURNLEY) LTD	-	-	-
TOTTINGTON MEDICAL PRACTICE	1,414	-	1
TOWER FAMILY HEALTHCARE	-	-	-
UNIVERSITY OF MANCHESTER	-	-	-
UPLANDS MEDICAL PRACTICE	120	-	1
WHITTAKER LANE MEDICAL CENTRE	784	-	1
WOODCOCK SOLICITORS BURY	-	-	-

In addition, the CCG has had a number of material transactions with other government Departments and other central and local government bodies.

Most of these transactions have been with Bury Metropolitan Borough Council for £15,505,347.

For all other related party interest disclosures other than the Governing Body members above, please refer to the website **www.buryccg.nhs.uk**

Full commentary on sickness absence can be found within the Staff Report from page 89.

Stuart North
Accountable Officer
Date:

Glossary of terms

Term	Description
2 week wait	The maximum waiting time for suspected cancer is two weeks from the day an appointment is booked through the NHS e-Referral Service, or when the hospital or service receives your referral letter.
12 hour trolley wait measure	A target relating to no patient having to wait more than 12 hours once a decision to admit the patient has been taken.
A&E 4 hour target	Relates to patients attending A&E being treated, admitted or transferred within 4 hours.
Ambulance Category A incident	Category 1 (Red) calls, which relate to life threatening situations.
Atrial fibrillation	A heart condition that causes an irregular and often abnormally fast heart rate.
Bury Directory	Online one stop information point for advice, support and activities in Bury.
Bury GP Federation	A co-operative of local GP Practices.
Cardiology services	Heart services.
Clinical Commissioning Group (CCG)	Clinically-led statutory NHS organisations responsible for the planning and commissioning of health care services for their local area.
Clinicians	Doctors, nurses and other healthcare professionals.
Commission / Commissioning	The process of assessing needs, planning, prioritising, purchasing and monitoring health services to secure the best health outcomes.
Constitution (the CCG's)	Sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for local people.
Co-production	A way of working which focusses on equal partnerships, with services and organisations working together with patients, carers, families and service users to co-design care and support.
Delayed transfers of care	Occurs when a patient is ready to leave a hospital or similar care provider, but is still occupying a bed.
Devolution	The transfer of certain powers and responsibilities from national government to a particular region.
Diagnostic tests	To help with the diagnosis of an illness or other problems.
Dietetic	Relating to diet and nutrition.
EPRR	Relates to Organisational Emergency Preparedness, Resilience and Response.
Gastrointestinal services	Care for conditions affecting the digestive system.
Governing Body	Ensure that CCGs have appropriate arrangements in place to exercise their functions effectively, efficiently and economically, in accordance with any generally accepted principles of good governance that are relevant to it.

GP online services	Enabling people to book and cancel appointments, order repeat prescriptions and access part of their GP medial record via the internet.
Home re-challenge	A process to determine if a child has an allergy to the protein found in cow's milk.
Hospice at Home Team	Providing hospice care to patients in their own home.
Improvement Assessment Framework	Helps CCGs to improve and change in a number of key areas.
Inter Practice Agreement (the CCG's)	Sets out the basis of the relationship between member practices.
LDC	Local Dental Committee (represents dentists in the area)
LMC	Local Medical Committee (represents GP practices in the area)
LOC	Local Ophthalmic Committee (represents opticians in the area)
Locality Care Organisation	Local providers of services who have come together to deliver transformational changes to health and social care services.
Locality Plan	Plan to transform health and social care services by 2021.
LPC	Local Pharmaceutical Committee (represents pharmacists in the area)
Milk ladder	Supports the reintroduction of dairy products into a diet in a planned way with specialist support, when an infant is around 12 months of age.
MY NHS	Contains performance information about health and social care services.
NHS Constitution	Sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.
NICE	National Institute for Health and Care Excellence: Improving health and social care through evidence-based guidance.
Palliative care	Care for people living with a terminal illness where a cure is no longer possible.
Prescribing for Clinical Need (CCG)	Ensures that only treatments that are clinically effective and provide a clear health benefit to patients should be prescribed on NHS prescriptions.
Primary care	Primary health care is the first point of contact for health care for most people. It is mainly provided by general practitioners and their teams, however, community pharmacists, opticians and dentists are also primary health care providers.
Primary care streaming	A 'streaming' system at A&E to direct patients to the most appropriate service to meet their needs.
Productive General	A scheme which aims to put in place more efficient

Practice	administrative processes in GP practices.
QIPP	Relates to quality, innovation, productivity and prevention work.
Quality Premium	Local and national targets with a focus on quality improvement and additional investment.
React to Red	A pressure ulcer prevention campaign.
Referral to treatment	The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment.
Schedule of reservation and delegation (the CCG's)	Defines those powers which are reserved to the Governing Body while at the same time having the ability to delegate the detailed application of policies and procedures.
SEND	Special Educational Needs and Disabilities.
Single / One integrated commissioning function / organisation	The CCG and Bury Council working more closely and making decisions together to plan and purchase health and social care services.
Social care	Providing assistance with activities of daily living, maintaining independence and social interaction.
Social media	Websites and applications that enable users to create and share content or participate in social networking.
Statutory duties	The key statutory duties of CCGs are the 'must dos' that CCGs will be legally responsible for delivering.
Third sector	Non-governmental and non-profit-making organisations or associations, including charities, voluntary and community groups.
Time to Care programme	A scheme to free up time in general practice to spend with those patients that need it most.
Urgent care	Refers to services that are designed to assist patients with an illness or injury that does not appear to be an emergency, but is considered too urgent to wait for routine care.

Get in touch

We hope you have enjoyed reading our Annual Report and that it has given you some insight into our work.

If you would like this report in another format or language please contact us. If you have any comments on the report, or questions on the information contained within it, we'd really like to hear from you.

You can reach us in a number of ways:

- The 'We're here to help' section of our website **www.buryccg.nhs.uk**
- You can email us at buccg.communications@nhs.net
- You can give us a call on 0161 762 3106
- Or via our Twitter account at www.twitter.com/NHSBURYCCG

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Bury Health and Wellbeing Board

Title of the Report	JSNA 2017/18
Date	13th June 2018
Contact Officer	Jon Hobday Michelle Foxcroft
HWB Lead in this area	Chair (Cllr Simpson)

1. Executive Summary

Is this report for?	Information ✓	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	The Chair and members have requested on update on the JSNA progress.		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	The report relates to all Health and Wellbeing Strategy priorities as it is providing an update on the new JSNA which underpins the Health and Wellbeing Strategy in its entirety.		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	The report is providing an update on the JSNA and therefore links to all priorities in the JSNA.		
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	To note the contents of the report on updates to the JSNA and approve the ongoing and proposed developments including the proposed changes to the aesthetics and structure of the JSNA moving forward in 2018/2019.		
What requirement is there for internal or external communication around this area?	Board members are asked to share the proposed changes with their teams and key officers where appropriate.		
Assurance and tracking process – Has the			

report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders....please provide details.	The JSNA progress is routinely reported to the Health and Wellbeing Board. This has not been to any other meeting.

2. Introduction / Background

This report provides an overview of the developments over the last 12 months and a summary of the proposed improvements to the Bury JSNA.

A brief background to the history of the JSNA can be found below:

- The Bury JSNA was launched at Bury Wider Leadership Group in August 2016.
- Further proposals were made in 2017 to develop the JSNA to become more flexible and fit for purpose to reflect the changing requirements of commissioners and for the residents of Bury.

3. key issues for the Board to Consider

Recent Developments:

Since the JSNA last came to the HWBB in 2017 the following pieces of work have been carried out and added to the website

- Health Protection Annual Report
- Children and young people health needs assessment
- Dementia data and information
- The pharmacy needs assessment
- National Child Measurement Programme work, maps and information
- Update briefing for Public Health Outcome Framework
- Oral Health data and information
- Dental Health Profiles update
- Survey of Adult Carers Summary

Following the launch of the JSNA back in August 2016, a work plan focusing on the specific areas of the JSNA was developed.

There is a work plan that is regularly reviewed which acts as the guide for what work needs to be prioritised, completed and added to the JSNA.

As well as the new documents being added to the JSNA there has also been a number of behind the scenes developments including

- Training of new staff,
- Alignment of work with the sister website (The Bury Directory) which contains the assets in the Borough,

- Development of structural and presentation ideas of how the Bury JSNA can be more user friendly

Proposed Developments 2018/19:

As well as a full refresh/update of the existing documents contained within the work plan, changes to the website are proposed. These are contained below:

- A move for the JSNA to fit more to the life course. There will be 3 main level summaries which will be categorised into Starting Well, Living Well and Aging Well.
- Following consultation there will be a revision of the categories via the revival of the JSNA Operations Group. Further details will be circulated in around 6 months' time as more information is refreshed and the operations group is re-established.
- The engagement and training of staff around the JSNA will take place utilising a list of contacts, but also via joint open sessions with The Bury Directory Team.

4. Recommendations for action

Health and Wellbeing Board to note the content of the report and approve the ongoing developments to the JSNA.

5. Financial and legal implications (if any) If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

None at this point – as this report is an information update only.

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

Not applicable at this stage but an Equality Analysis will be completed at an appropriate point in the phase 2 development of the JSNA.

CONTACT DETAILS:

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Date: 21/05/2018

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Date: 21/05/2018