Strategic Commissioning Board

Agenda

Date & Time:	Monday, 6 December 2021, 18.00-19.00
Venue:	In the Council Chamber at Bury Town Hall
Chair:	Dr C Fines

Key	A – Approval	R – Recommendation	C – Consideration	I – Information

Item	Description	Report (Re) Verbal (V)	Action	Presenter	Time
1	Welcome, Apologies & Quoracy	V	I	Chair	18.00
2	Declaration of Interests	Re	C	Chair	18.00
3	Minutes of the last Meeting and Action Log	Re	A	Chair	18.05
4	Public Questions	V	C	Chair	18.10
5	Chief Executive and Accountable Officer Update	V	C	G Little	18.15
Strategy / Policy / Proposals					
6	Northern Care Alliance - Urology Reconfiguration	Re	A	W Blandamer	18.25
7	Workforce Capacity Grant	Re	A	W Blandamer	18.35
8	Individual Funding Request (IFR) Panel Terms of Reference	Re	A	W Blandamer	18.40
9	Financial / Budget Update	Re	C	S Evans	18.45
10a	Performance Update	Re	C	W Blandamer	18.55
10b	2021-22 H2 Plan Update		A		
Close					
11	AOB and Closing Matters	V	I	Chair	19.00

Next Meetings in Public	**Strategic Commissioning Board Meeting (formal):** Monday, 10 January 2022, 4.30 p.m., Formal Public meeting at Bury Town Hall
Enquiries	Emma Kennett, Head of Corporate Affairs and Governance, Email – emma.kennett@nhs.net

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Agenda Item 2

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	06 December 2021	**Action**	Receive
Item No	2	**Confidential / Freedom of Information Status**	No
Title	Declarations of Interest Register		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr C Fines, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

- The CCG and Local Authority both have statutory responsibilities in relation to declarations of interest as part of their respective governance arrangements.
- The CCG has a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the national Health Service Act 2006 (as inserted by section 25 of the Health and Social Care Act 2012).
- The Local Authority has statutory responsibilities detailed as part of Sections 29 to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the latest Declarations of interest Register;
- Considers whether there are any interests that may impact on the business to be transacted at the meeting on the 6 December 2021; and
- Provides any further updates to existing Declarations of Interest includes within the Register.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						

Implications						
Are there any associated risks including Conflicts of Interest?	Yes	☒	No	☐	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details	Conflicts of Interest not being declared in line with statutory obligations					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Declarations of Interest

1. Register for the Strategic Commissioning Board

1.1 This report includes a copy of the latest Declarations of Interest Register for the Strategic Commissioning Board.

1.2 Strategic Commissioning Board members should ensure that they declare any relevant interests as part of the Declaration of Interest Standing item on meeting agendas or as soon as a potential conflict becomes apparent as part of meeting discussions.

1.3 There is a need for Strategic Commissioning Board Members to ensure that any changes to their existing conflicts of interest are notified to the Business Support Unit, via either the CCG Corporate Officer or Council Democratic Services team within 28 days of a change occurring to ensure that the Declarations of Interest register can be updated.

1.4 The specific management action required as a result of a conflict of interest being declared will be determined by the Chair of the Strategic Commissioning Board with an accurate record of the action being taken captured as part of the meeting minutes.

Emma Kennett
Head of Corporate Affairs and Governance
December 2021

Strategic Commissioning Board

Name	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
		Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Voting Members									
Will Blandamer, Executive Director of Strategic Commissioning - **Voting Member**	Ashton on Mersey Football Club			X	Direct	Chairman	2018	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Manchester Football Association			X	Direct	Board Champion for Safeguarding	2018	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Fiona Boyd, Governing Body Nurse - **Voting Member**	NHS England / NHS Improvement (Cheshire & Merseyside)		X		Direct	Senior Clinical Manager	Sep-21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	DWF Law		X		Direct	Medical Assessor	Aug-20	Sep-21	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Real Staffing		X		Direct	Interim Patient Safety Support	Sep-21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Peter Bury, Lay Member Quality and Performance - **Voting Member**	Labour Party		X		Direct	Member	1979	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury College		X		Direct	Member of Board of Governors	2008	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member	1974	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Clare Cummins, Bury Council, Councillor - **Voting Member**	Mental Health – Deputy Manager	X			Direct	Deputy Manager		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Johnson's Control	X			Indirect	Spouse / Civic Partner is a Regional Manager		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour party				Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Election Campaign – Ramsbottom							Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Branch & Labour Group							Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Sam Evans, Executive Director of Finance - **Voting Member**	None declared					Nil Interest	05/05/2021	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Cathy Fines, CCG Chair - **Voting Member**	Bury GP Federation	X			Direct	Practice is a member	2013	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Tower Family Health Care	X			Direct	Member practice is part of Tower Health Care	2017	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Horizon Clinical Network	X			Direct	Practice is a member	2019	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Central Manchester Foundation Trust			X	Indirect	Husband is employed		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Richard Gold, Councillor Bury Council - **Voting Member**	RIGOLD LTD	X			Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Richard Gold T/A Richard Gold Books	X			Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	GM Police, Fire & Crime Panel		X		Direct	Cabinet Appointment		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Ephemera Society		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Holy Law South Broughton Congregation Synagogue		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Yeshurun Hebrew Congregation Synagogue		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Jewish Labour Movement NW Region		X		Direct	Membership and Education		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Jewish Labour Movement		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Preswich Labour Party		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury South Consistency Labour Party			X	Direct	Sedgley Branch Delegate		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Brookvale Care Home			X	Indirect	Parent is Vice Chair of Trustees		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Howard Hughes, Clinical Director - **Voting Member**	Prestwich Pharmacy LTD	X			Indirect	Spouse is Director	1996	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Pharmacy LTD	X			Direct	Director	1996	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Greater Manchester Mental Health Foundation Trust			X	Indirect	Sister is performance Manager	2014	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hughes McCaul LTD (Dormant Company)	X			Indirect	Spouse is Director	1995	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hughes McCaul LTD (Dormant Company)	X			Direct	Director	1995	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Geoff Little, Chief Executive for Bury Council & Accountable officer Bury CCG - **Voting**	Ratio Research			X	Indirect	Close family member is an employee	Apr-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
David McCann, Lay Member - **Voting Member**	Praxis Real Estate Management LTD, Manchester	X			Direct	Director and General Legal Counsel	2011	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCL (CIP) GP LTD - Nature of Business Asset Management	X			Direct	Director	2014	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Capital LTD - Nature of Business Asset Management	X			Direct	Director and majority shareholder	2014	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Hanover Law Limited – (changed name from Praxis Law)	X			Direct	Director and 50% shareholder	2018	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	The Airfields Residential Management Company Limited	X			Direct	Director	Oct-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	The Aldermaston Estate Management Company Ltd	X			Direct	Director	Oct-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Residential Limited	X			Direct	Director	Oct-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Facilities Management Ltd	X			Direct	Director	Nov-19	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	Praxis Group Limited	X			Direct	Director	Oct-20	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	The Airfields Commercial Management Company Limited	X			Direct	Director	Feb-20	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCP III Number 2 Limited	X			Direct	Director	Mar-21	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCP III Number 1 Limited	X			Direct	Director	Mar-21	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCP III Number 4 Limited	X			Direct	Director	Apr-21	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCP III Number 3 Limited	X			Direct	Director	Apr-21	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
	PCP III Holdco Limited	X			Direct	Director	Mar-21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury Council			X	Indirect	Daughter is an employee	2012	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Charlotte Morris, Councillor Bury Council - **Voting Member**	University of Salford	X			Direct		Jun-17	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Font Communications			X	Indirect	Partner Employed	Sep-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unison		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Eamonn O'Brien, Bury Council Leader - **Voting Member**	Bury Council - Councillor	X			Direct	Councillor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Young Christian Workers – Training & Development Team	X			Direct	Development Team		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Arts College		X		Direct	Governor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury Corporate Parenting Board		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	No Barriers Foundation		X		Direct	Trustee		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Eamonn O'Brien, Bury Council Leader - **Voting Member** (cont)	CAFOD Salford		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Prestwich Methodist Youth Association		X		Direct	Trustee		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Alan Quinn, Councillor Bury Council	Bury Council	X			Direct	Councillor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	previously worked for BAE Systems - Military Aircraft	X			Direct	Skilled Aircraft Fitter		Aug-21	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Harrogate and District NHS Foundation Trust			X	Indirect	Daughter in Law employed		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Mid York NHS Trust			X	Indirect	Son employed		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Citizens Advice Bureau			X	Direct	Spouse Advisor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Greater Manchester Waste Disposal Authority		X		Direct	Member/Council Representative		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	City of Trees		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	University of Manchester		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Co-operative Party		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	North West Rivers - Floods & Coastal Committee		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	GM Green City Partnership (via the Waste Authority)		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Down Syndrome Association			X	Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Uk Government in Switzerland (permanent UK Mission to the UN Geneva)			X	Indirect	Daughter is an employee		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Tahir Rafiq, Bury Council, Councillor - **Voting Member**	Juris Solicitors	X						Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hollins Grundy Primary School		X			Governor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hollins Institute Educational Fund		X			Trustee		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Law Society (England & Wales)		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Law Society (Ireland)		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Punjab Bar Council Pakistan		X			Member/High Court Advocate		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	KM Solicitors LTD	X						Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Legal Property and Consultancy	X						Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Tamoor Tariq, Bury Council, Councillor - **Voting Member**	Bury Council - Councillor	X			Direct	Councillor	May-10	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Health Watch Oldham	X			Direct	Manager	Aug-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	The Derby High School			X	Direct	Governor	Apr-18	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Unite the Union		X		Direct	Community Member	May-12	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Tamoor Tariq, Bury Council, Councillor - **Voting Member** (cont)	Labour Party		X		Direct	Member	Jun-07	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Andrea Simpson, Councillor Bury Council - **Voting Member**	Silverdae Medical Practice	X			Direct	Practice Manager		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Parrenthorn High School			X	Direct	Governor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Ribble Drive Primary School			X	Direct	Governor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Community Union			X	Indirect	Spouse is a Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury Council	X			Direct	Councillor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Salford LMC Subcommittee			X	Direct	Neighbourhood Lead for Swinton		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Village Greens	X			Direct	Shareholder		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Medical Defence Union		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Labour Party		X		Direct	Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Joe Hague Photography			X	Indirect	Spouse is Owner		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Blackford Bridge GP Practice		X	X	Indirect	Son works for Blackford Bridge GP Practice in Hollins		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Chris Wild, Lay Member - Audit and Finance - **Voting Member**	Northern Industrial Generation Limited	X			Direct	Shareholder/Director	Jun-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Secure Generation Limited	X			Direct	Shareholder/Director	Nov-15	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Efficient Generation Limited	X			Direct	Shareholder/Director	Nov-15	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	McNally Wild Limited	X			Direct	Shareholder/Director	Jul-14	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Capitas Finance Limited	X			Direct	Shareholder/Director	May-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Lower 48 Energy Limited	X			Direct	Shareholder/Director	Jul-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Close Brothers PLC	X			Direct	Retained Advisor	Sep-14	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury College			X	Indirect	Wife Employed	Feb-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

Name	Declared Interest- (Name of organisation and nature of business)	Type of Interest			Is the Interest direct or indirect?	Nature of Interest	Date of Interest		Comments
		Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
In attendance - Non-Voting Members									
Donna Ball, Executive Director of Operations, Bury Council - **Non-voting**	Oldham Pathology (Pennine Acute)			X	Indirect	Husband is and Employee		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Catherine Jackson, Executive Nurse - **Non-voting**	NCA			X	Indirect	Partner is a Director of Patient Safety & Professional Standard at the NCA.	25.10.21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises. Also discussed with Line Manager, potential conflicts
Lesley Jones, Director of Public Health, Bury Council - **Non Voting**	Bury Social Care Provider			X	Indirect	Daughter is employed	Oct-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Nick Jones, Bury Council - **non-voting**	Arum Systems Ltd (Arum)	X				Account Director		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Elms Bank			X		Governor		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Conservative Friends of Israel			X		Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	PLC Flats Management Limited	X				Director		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Cllr Nick Jones, Bury Council - non-voting (cont)	RNLI					Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Anglo-Swedish Association					Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Friends of the British Overseas Territories					Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Bury North & South Conservative Association		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	the Conservative & Unionist Party		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Conservative Councillors Association		X			Member		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr James Mason, Councillor, Bury Council - **non-voting**	DFS Trading	X			Direct	Service Manager		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Hairdresser			X	Indirect	Self Employed - Spouse		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Serving Freemason			X				Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Radcliffe First		X		Direct	Registered Political Party		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Save Greater Manchester's Greenbelt		X		Direct			Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Cllr Michael Powell, Bury Council, Councillor - **Non-Voting**	St Thomas Primary School –	X				Teacher employed by Stockport Council	Nov-19	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Elms Bank School –	X				Spouse / civic partner: teacher employed by Oak Learning Partnership	Sep-17	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Liberal Democrats		X			Member	Jan-12	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	National Education Union (NEU)		X			Member	Sep-17	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Lynne Ridsdale, Assistant Chief Officer - **Non Voting**	Together Trust		X		Direct	Trustee	Jan-20	Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Heather Moore, Executive Officer, Bury Council - **Non-voting**	None Declared					Nil Interest		Present	General guidance to be followed in respect of declaring conflicts of interest where identified. In advance and during the meeting.
Emma Kennett, Head of Corporate Affairs and Governance - **Non-voting**	None Declared					Nil Interest		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Karen Johnston, Head of Communications, Engagement and Marketing - **Non-voting**	None Declared					Nil Interest		Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
Peter Thompson, Secondary Care Consultant - **Non Voting**	Field of obstetrics	X			Direct	Performs legal work	Jun-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Shrewsbury and Telford Hospitals ,Maternity Services	X			Direct	Work as a Consultant Obstetrician	Sep-20	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.
	Walsall Manor NHS Trust	X			Direct	Advisor on Maternity Governance	Sep-21	Present	Specific arrangements in respect of potential conflicts arising to be given further consideration when situation arises.

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Agenda Item 3

Meeting: Strategic Commissioning Board (Public)			
Meeting Date	06 December 2021	**Action**	Approve
Item No	3	**Confidential / Freedom of Information Status**	No
Title	Minutes of Last meeting and Action Log		
Presented By	Cllr E O'Brien, Co-chair of the SCB and Bury Council Leader / Dr C Fines, Co-Chair of the SCB and CCG Chair, NHS Bury CCG		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

Introduction and background

The attached minutes reflect the discussion from the Strategic Commissioning Board held on 1 November 2021.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Approve the Minutes of the Meeting held on 1 November 2021 as an accurate record; and
- Note progress in respect to agreed actions captured on the Action Log.

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

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

Implications						
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☐	No	☐	N/A	☒
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	N/A					
How do proposals align with Locality Plan?	N/A					
How do proposals align with the Commissioning Strategy?	N/A					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	N/A					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	N/A					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**

Strategic Commissioning Board Virtual Meeting

MINUTES OF MEETING
Strategic Commissioning Board Meeting 1 November 2021 16.30 – 17.45 **Chair – Cllr E O'Brien**

Voting Members	
Dr Cathy Fines	NHS Bury CCG (Chair)
Cllr Eamonn O'Brien	Leader, Finance & Growth, Bury Council (Chair)
Geoff Little	Chief Executive Bury Council & Accountable Officer NHS Bury CCG
Will Blandamer	Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG
Fiona Boyd	Registered Lay Nurse of the Governing Body, NHS Bury CCG
Sam Evans	Executive Director of Finance, Bury Council & NHS Bury CCG
Howard Hughes	Clinical Director, NHS Bury CCG
Cllr Alan Quinn	Cabinet Member, Environment, Climate Change & Operations, Bury Council
Cllr Tahir Rafiq	Cabinet Member Corporate Affairs & HR, Bury Council
Cllr Andrea Simpson	First Deputy Leader and Cabinet Member Health & Wellbeing, Bury Council
Chris Wild	Lay Member, NHS CCG Bury
Others in attendance	
Philippa Braithwaite	Principal Democratic Services Officer, Bury Council
Jacqui Dennis	Director of Law & Democratic Services, Bury Council
Cllr Nick Jones	Council Opposition Member, Bury Council
Emma Kennett	Head of Corporate Affairs and Governance, NHS Bury CCG
Cllr Michael Powell	Council Opposition Member, Bury Council

MEETING NARRATIVE & OUTCOMES

1	**Welcome, Apologies and Quoracy**
1.1	The Chair welcomed those present to the meeting and noted apologies.
1.2	The Chair advised that the quoracy had been satisfied.

ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/11/01	Decision	Noted the information.	

2	**Declarations Of Interest**
2.1	The Chair reported that the CCG and Council both have statutory responsibilities in relation to the declarations of interest as part of their respective governance arrangements.
2.2	It was reported that the CCG had a statutory requirement to keep, maintain and make publicly available a register of declarations of interest under Section 14O of the National Health Service Act 2006 (as inserted by Section 25 of the Health and Social Care Act 2012). The Local Authority has statutory responsibilities detailed as part of Sections 29

	to 31 of the Localism Act 2011 and the Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012.
2.3	The Chair reminded the CCG and Council members of their obligation to declare any interest they may have on any issues arising from agenda items which might conflict with the business of the Strategic Commissioning Board.
2.4	Declarations made by members of the Strategic Commissioning Board are listed in the CCG's Register of Interests which is presented under this agenda and is also available from the CCG's Corporate Office or via the CCG website.
	• **Declarations of interest from today's meeting**
2.5	The Cabinet Member for Environment, Climate Change and Operations advised that he was now retired, the Cabinet Member for Health and Wellbeing advised her son worked for a practice in Bury, and the Registered Lay Nurse of the Governing Body advised she had submitted a revised register of interest.
2.6	• **Declarations of Interest from the previous meeting**
	There were no declarations of interest from the previous meeting raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/02	Decision	Noted the published register of interests.	

3	Minutes of the last Meetings and Action Log
	• **Minutes**
3.1	The minutes of the Strategic Commissioning Board meeting held on 4 October 2021 were agreed as an accurate record.
	• **Action Log**
3.2	There were no updates in relation to the Action Log.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/03	Decision	Approved the minutes of the meeting held on the 6 September 2021.	

4	Public Questions
4.1	There were no public questions raised.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/04	Decision	Noted the information.	

5	Chief Executive and Accountable Officer Update
5.1	The Chief Executive, Bury Council / Accountable Officer, NHS Bury CCG provided an update on the latest CCG and Council developments. He detailed some of the health and social care pledges included in the Autumn Budget announcements, including 3.8% increase in revenue per annum for the NHS, 3% increase for Local Government in spending power (assuming an increase in Council Tax), and £5.9 billion for elective

	cases but no additional funding for general practice. He also reported that Bury had been successful with two Levelling Up funding bids of £20 million to support a new market flexi hall to strengthen Bury's town centre offer, and the development of a new civic hub in the heart of Radcliffe's town centre as discussed by the Board at their last meeting. With regards to Covid, it was noted that infection rates had fallen in nine boroughs in Greater Manchester but Bury had increased. These rates were driven by schools and was being addressed through use of facemasks and covid tests for pupils. Vaccinations, boosters, and flu jabs continued and the borough was ready to implement Plan B if necessary. It was noted that pressures remained in the health care system, with Fairfield hospital at OPEL 3 to 4, and an exceptional level of demand was being seen across Greater Manchester. Finally, it was reported that Sir Richard Leese had been appointed as the new Chair-designate of the Integrated Care Board for Greater Manchester, and that the Chief Officer interviews had taken place.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/05	Decision	Noted the update.	

6	Discharge to Assess Beds
6.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented a report which detailed the updated arrangement to maintain sufficient discharge to assess beds in the Bury system. This followed previous reports approved by the Board in October 2020 and February 2021 regarding retrospective commissioning of additional capacity in the community to release hospital capacity.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/06	Decision	Gave retrospective approval of the extension of 29 Discharge to Assess beds at Heathlands Care Home until 31st March 2022 with awareness of the financial risk.	

7.	Infection Control Grant
7.1	The Joint Executive Director of Strategic Commissioning, Bury Council & NHS Bury CCG presented the report which sought permission to disseminate an approximate combined total of £1,794,200 of Infection Control and Testing Fund monies from the Department of Health and Social Care to appropriate care providers.

ID	Type	The Strategic Commissioning Board:	Owner
D/11/07	Decision	Approved the request to disseminate the grant monies in line with Department of Health and Social Care Grant requirements.	
D/11/08	Decision	Delegated authority to the Executive Director of Strategic Commissioning to agree the dissemination of any future Infection Control and Testing fund monies in line with Department of Health and Social Care Grant requirements to ensure the strict timelines are met.	

8.	Risk Register		
8.1	The Executive Director of Finance, Bury Council & NHS Bury CCG presented the report which provided an update in respect of the five strategic risks which are captured on the CCG's Governing Body Assurance Framework (GBAF) which had been assigned to the Strategic Commissioning Board for oversight. It was noted four risks remained unchanged with one risk, Creation of GM ICS (Integrated Care System), reducing in score owing to closer partnership working arrangements.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/11/09	Decision	Received and reviewed the Strategic Commissioning Board Risk Registers.	

9	Any Other Business and Closing Matters		
9.1	The Chair summarised the main discussion points from today's meeting and thanked members for their contributions. It was noted that the timing of the next meeting be reviewed to better fit with the Shadow Locality Board meeting.		
ID	**Type**	**The Strategic Commissioning Board:**	**Owner**
D/11/10	Decision	Noted the information.	

Next Meetings in Public	**Strategic Commissioning Board Meetings:** • Monday, 6 December 2021, Formal Public meeting, time TBC (Chair: Cllr E O'Brien / Dr C Fines)
Enquiries	Emma Kennett, Head of Corporate Affairs and Governance emma.kennett@nhs.net

Strategic Commissioning Board Action Log – November 2021

Status Rating - In Progress - Completed - Not Yet Due - Overdue

Agenda Item 6

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Approve
Item No	6	**Confidential / Freedom of Information Status**	No
Title	Urology Services – Bury System 'End to End' Pathway Review		
Presented By	Ian Mello, Director of Secondary Care Commissioning, NHS Bury CCG		
Author	Mike Ryan, Head of Planning and Delivery, NCA. Catherine Tickle, Commissioning Programme Manager, NHS Bury CCG		
Clinical Lead	Howard Hughes, Clinical Director, Bury CCG Simon Minkoff, Urology Clinical Lead, Bury CCG Laurence Clarke, Consultant Urologist, NCA		
Council Lead			

Executive Summary

A report on the reconfiguration of Secondary Care Urology Services, being led by the Northern Care Alliance (NCA), was presented to the Board in May 2021 (appendix 1). The paper was received by the Board and members requested further information on the 'end to end' clinical pathway and opportunities for delivery of care in primary care and community-based services.

This paper provides Board members with an update on the collaborative work being undertaken by the CCG with NCA, as a means of assurance to the Board that the concerns raised at the previous meeting are being addressed.

A programme of work has commenced with Secondary Care Clinicians, Primary Care Clinicians, Community Services, and other stakeholders. Through a Development Group approach, Bury system partners are reviewing the 'out of hospital' elements of the Urology pathway, alongside the new Secondary Care Urology Model.

Taking an integrated system approach to developing the pathway will ensure that the right care is provided at the right time, in the right place for Bury patients and the secondary care and primary/community parts of the pathway align.

The paper provides the Board with an overview of the work undertaken to date, identifies opportunities for Rapid Action and work being undertaken to review pathways through the Urology Development Group and outlines the proposed governance arrangements through which this programme of work will be held to account.

Recommendations

It is recommended that the Strategic Commissioning Board:

- receive the update on the work undertaken to date.
- note that a further update on the work of the Development Group and pathway

review/redesign will be provided to the Board in April 2022.

- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?	Focus on prevention, place-based delivery of care and improved outcomes for patients.					
How do proposals align with Locality Plan?	Focus on system integration, prevention, place-based delivery of care, system efficiencies and improved outcomes for patients.					
How do proposals align with the Commissioning Strategy?	To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.					
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce	EIA to be completed and managed by the Development Group					

Implications						
health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
EIA to be completed and managed by the Urology Development Group						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☒	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**

Urology Services – Bury System 'End to End' Pathway Review

1. Introduction

1.1 Following the paper that went to the Board in May 2021 (appendix 1), seeking endorsement of the pan-locality Urology model of care, as part of the Northern Care Alliance (NCA) Urology reconfiguration, work has commenced locally to address the concerns raised by Board members.

1.2 The GM Model of Care (MoC) for Benign Urology was developed through the Improving Specialist Care (ISC) programme. The hub and spoke configuration for the delivery or Benign Urology services was endorsed by the Greater Manchester (GM) Joint Commissioning Board (JCB), though implementation at a GM level were delayed due to COVID-19.

1.3 The Key features of the new secondary care model are:

- A single comprehensive Benign Urology Service delivered within the NCA.
- 'Hub and Spoke' delivery model –
    - Oldham and Salford as inpatient hubs and Rochdale and Bury as spokes.
    - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
    - Single workforce within two integrated functional teams – NCA West & NCA East.
- A disaggregation of the activity from North Manchester, which will align to MFT, and the activity for Bury, Oldham, Salford and HMR which will align to the NCA.

1.4 Clinical Leads from the NCA and Bury CCG are working in partnership, along with other Bury stakeholders, to review the Urology pathway 'end to end' with a particular emphasis on integrating the provision of Urology care between primary, community, and secondary care.

1.5 A Bury system wide Urology Pathway Development Group, chaired by the Head of Planning and Delivery at NCA, has been established to deliver the pathway review and subsequent re-design of elements of the pathway, to ensure that the right care is provided at the right time, in the right place for Bury patients.

2. Purpose of the Paper

2.1 This paper is intended to assure Board members, that whilst the secondary care model is changing, the opportunity to review Bury's primary care and community elements of the pathway is being progressed alongside and aligned with the secondary care reconfiguration.

3. Background - Urology Secondary Care Reconfiguration

3.1 The NCA new model of care previously presented to Board members will allow for a single NCA wide Urology team, under a single leadership, with standardised processes and governance. Sub speciality teams will remain in place delivering MDTs across the NCA localities.

3.2 In-patient High Acuity Complex Hubs will operate at Salford Royal Hospital and Royal Oldham Hospital, both part of the Northern Care Foundation NHS Trust. The Salford 'Hub' will service the people of Bury, with Fairfield acting as a 'spoke' in the new architecture, to support high volume low acuity patients, based on a proven model at Rochdale Infirmary.

3.3 The remodelling of Urology Care at NCA, through the hub and spoke model, provides an opportunity for NCA Clinicians to work in partnership with Primary Care and Community services in Bury, to enhanced the offer into the locality and ensure greater alignment of the pathway from primary/community into secondary care.

3.4 The planned development of Urology Investigation Units (UIU) will allow for the delivery of ambulatory pathways delivered 'closer to home.' Through the Bury Urology Development Group, it is intended that Bury stakeholders, including patient representatives, will work with NCA to define the scope of the locality based UIU and explore opportunities where appropriate for delivery of care at a neighbourhood level within the Bury locality.

4. Initial Primary Care Engagement

4.1 The Consultant Urological Surgeon from NCA and the CCG Clinical Lead for Urology delivered an update to Bury Primary Care Colleagues on the reconfiguration of Urology Services at NCA and the single service model in October 2021. This took place through the Bury GP webinar chaired by the CCG Clinical Chair.

4.2 Primary Care colleagues were given the opportunity to ask questions, discuss the new model of care and explore what it means for Primary Care and Bury patients with the Urology Consultant who sits on the NCA Urology Delivery Board.

4.3 The session outcome, despite a limited number of questions from GPs, was a clear commitment made by NCA and CCG Clinical Leads to work in partnership with Primary Care and Community Services to explore the model of care required to redesign an integrated pathway.

4.4 Primary Care colleagues were invited to volunteer to be part of the Urology Development Group, where this pathway work is being undertaken.

4.5 Through the GP webinar, discussions between the Secondary Care Clinical Lead and CCG Clinical Lead, and learning from other interrelated programmes of work e.g. Phlebotomy review and NES Pathology Group, the following were identified as key areas of focus:

- Review of the Prostate Pathway and management of PSA in Primary Care
- Review of follow up pathways in primary care and secondary care
- Utilisation of lower tier services and third sector services
- Use of non - medical workforce in the Bury pathway
- To scope the requirements for a Urology Investigation Unit (UIU) to support in the identification of suitable site in the community from which to host a service
- Development of UIUs
- Access to PSA lab results for Bury GPs and other necessary pathology
- Access to Phlebotomy and Diagnostics within the pathway
- Role of Community Based Services e.g., Incontinence and District Nursing
- Exploring Bury estates for potential out of hospital delivery
- Implementing Advice &Guidance (A&G) into the pathway and Patient Initiated Follow Up (PIFU).
- Review of interrelated pathways e.g., Urology and Gynaecology and links to Gynaecology and Physiotherapy (see 5.2 below)
- Links to GM and Bury Cancer pathways (see 5.2 below)

4.6 In addition to the areas above, it was suggested at the webinar that the pathway re-design work could facilitate work to look at boundary-spanning, primary-secondary care interface roles and the possibility of identifying funding sources for a pilot of a Physician Associate for the Urology pathway work as a 'test of change.'

4.7 Through the Development Group these conversations will be extended to engage with PCN Directors and GP Federations.

5. Development Group – Overview

5.1 Terms of Reference (ToR) for the group were tabled at the first meeting and have been signed off by system partners. The first meeting provided an opportunity to review the proposed membership of the group.

5.2 Urological Oncology and gynaecology were identified as interdependencies and it was acknowledged that links will need to be made with staff from these specialities through the Development Group, as and when required. An action to seek patient input into the pathway review from the Bury Patient Involvement and Participation Group (PIP) was agreed and is being progressed.

5.3 The aims, objectives and key principles agreed by the group in the ToR reflect the request from the Board to consider the opportunity for 'place based' primary and community care. They also support the vision and ambitions set out in the Bury 'Let's Do it Strategy,' to improve the wellbeing and health outcomes of the Bury population. The pathway review will be based on codesign and accountability for shared decision making, with a focus on wellbeing, prevention and early intervention and neighbourhood working.

5.4 The Development Group meetings act as platform for stakeholders to integrate and develop relationships, define the local need and desired outcomes for Bury patients, explore opportunities, and agree transformation/re-design opportunities.

5.5 The Development Group will also oversee the implementation of a programme plan to include monitoring and evaluation.

5.6 The Urology programme of work will act as another 'test of change,' along with Orthopaedics, in the Bury system to support learning that can be scaled up across other specialties in the NCA to aid elective recovery.

6. Progress to Date

6.1 At the first meeting the Bury Community Team provided an update on the current community pathway, with clinicians from Continence and Stoma supporting this discussion. The following areas were identified as areas of opportunity from the initial discussion:

- Review of the Trial Without Catheter Pathway (TWOC) due to increasing demand
- Integration across secondary care and community services
- Review of the diagnostic pathway
- Review of community data to include patients presenting acutely with retention, post-operative referrals and referrals from A&E and cost.

6.2 An update on the secondary care pathway transformation was shared by NCA partners to ensure all group members were aware of the changes taking place. The following areas of opportunity were identified from the initial discussion:

- Realignment of ambulatory pathways
- Establishing specialist nursing workforce with presence in the Bury locality – interface roles between primary and secondary care
- Reviewing future bed capacity requirements
- Maintenance of 'Hot' Urology Lists – maximise theatre capacity
- Review of secondary care data and costs
- Learning from current Prostate Pathway in Salford
- Learning from the advanced triage pilot commenced with Salford and learning from the planned pilot of A&G in Salford
- information sharing - access to shared care records and opportunities from the NCA new Electronic Patient Referral (EPR) System

6.3 The following areas of opportunity were identified at the second meeting of the group, from a presentation of the current primary care pathway led by the CCG Clinical Lead:

- Currently Primary Care pathways are based on clinician's individual knowledge, experience, and review of published guidelines.
- Patient experience may be variable with potential inequalities arising.
- This is an opportunity to develop a more integrated and consistent service partnered between primary care, community care, and secondary care.
- New pathway will require softer boundaries, increased co-operation, less duplication of investigation, and meaningful use of Advice & Guidance and Patient Initiated Follow-Up.

- Improved referrals will identify where illness impacts on occupation or social care enabling social prescribing and signposting to lifestyle services.

7. Rapid Action Opportunities

7.1 The following 'quick wins' have been agreed by the group as the outcome of the first two meetings. Named leads have been identified to progress these at pace alongside more medium/longer term work on the wider pathway reviews:

- Review of the Prostate pathway and agreeing the optimal pathway
- Review of the TWOC pathway and agreeing the optimal pathway
- Trail of advanced triage in Bury based on the Salford pilot results.

8. Transformation Work Programme

8.1 A high level system workplan has been developed and agreed by the group as an iterative document. The plan includes the 'quick win's' and the key elements of the pathway (primary care and community) for review and redesign. Key within the action plan is alignment of new pathway with the new secondary care model of care.

8.2 The 'quick wins' and pathway reviews will be progressed in parallel. The Group Chair is meeting with named leads for each area of the plan to agree the key deliverables and milestones for the work programmes, after which the plan will be updated.

8.3 Analysis of the Urology data and finances across the pathways is being undertaken. An existing Performance and Data Group supporting the Orthopaedic Improvement work, as part of the wider Elective Care Programme, will provide the forum to bring pathway 'experts' together with BI, finance, patient representative and Public Health to agree the scope of the analysis required.

8.4 Building upon the existing group will allow the methodology developed for the analysis of inequalities in access to Orthopaedic services to be replicated for Urology, to ensure the pathways have a lens on equity and inclusion.

8.5 Named leads to attend the Planning and Data group have been agreed and an initial meeting is being arranged to scope the work. The data analysis will feed back into the Development Group.

8.6 Any impact of the secondary care reconfiguration on Bury patients and their families, such as access to care at Salford Royal, will be explored as part of the work of the Development Group. Through the pathway re-designs opportunities for 'place based' care will be a key priority.

8.7 Links will also be made with the VCFA to support the pathway work to consider support for patients and families where access to care is required outside of the Bury locality.

8.8 An Equality Impact Assessment (EIA) will be completed by the Development Group and any risks highlighted fed into the pathway redesign work to identify opportunities to mitigate the risk of inequity in access to care.

8.9 Another key principle of the re-design will be efficiencies and improved flow of patients. During the Development Group discussions, it has been acknowledged that the pathway can't be linear, and a key part of the transformation will be getting the interface between community, primary care and secondary care correct, through a blurring of organisation boundaries and ensuring the right care is provided at the right time by the right professional. It is hoped that the new pathways will allow for a more streamlined and efficient journey for patients that supports flow through the whole system.

9. Governance

9.1 The Development Group will sit within the newly proposed Bury Elective Care and Cancer governance architecture, subject to its sign off, reporting into the Elective Care and Cancer Recovery and Reform Board, due to commence in December 2021. In the short term whilst the new governance structures are being implemented the Development Group will report into the Bury Elective Care Recovery and Reform Group.

9.2 Embedding the pathway work within the Elective Care and Cancer architecture will afford it links to interrelated programmes of work e.g., diagnostics, elective improvement work, While You Wait, A&G and PIFU and the NCA led Being Well Programme that supports delivery of the NCA Recovery Strategy, which includes Elective Care.

9.3 By embedding the Urology pathway work within a robust Bury system governance framework, with clear lines of accountability, it is hoped that Board members will feel sufficiently assured that the Bury Urology pathways are being looked at in its entirety, 'end to end, 'and allow Board members the confidence to endorse the secondary care pan locality model, whilst the associated Bury pathway work is completed as a transformation programme within the Elective Care and Cancer governance.

10. Bury System Commitment

10.1 In line with the changing health and social care landscape and the transition to Integrated Care Systems (ICS), NCA and Bury CCG are committed to undertaking at pace the review and redesign of the Urology pathway as outlined in this paper.

10.2 The integrated system Development Group model, supported by NCA and Bury CCG Senior Leaders, will remove traditional divisions between hospitals and GPs, between physical and mental health, and between NHS and council led service.

10.3 Through a place based partnership approach that ensures 'systemness,' NCA and Bury CCG will deliver to the Locality Board a Urology pathway that is patient-focused and maximises the opportunities for high-quality care across the many parts of the system to maximise value for Bury residents.

11. Risks

11.1 The Board is asked to note that the Secondary Care Urology reconfiguration, overseen by the NCA Urology Board, which has senior CCG representation, is a NCA pan-locality approach. Therefore, any delays to the endorsement of the model by a locality will in turn impact upon the phased implementation across the localities, as outlined in the previous paper brough to the Board (appendix 1).

11.2 The assurances provided in this paper, with regards to the work being carried out on the pathway review and opportunities to provide care 'closer to home, 'is intended to mitigate the risk of delays to the secondary care implementation.

11.3 There is a risk that the new primary and community pathways are still in development and alignment with the new secondary care model may require unknown investment. This risk will be mitigated through the Development Group ensuring it is fully cited on the secondary care developments as they progress, and primary care and community are fully engaged with the pathway redesigns. Progress will be reported to the new Elective Care and Caner Board and risks escalated as required.

11.4 The reconfiguration of secondary care services and provision of inpatient care at SRFT for Bury patients may present a risk in terms of widening the inequalities gap. Completing an EIA, a focus on placed based care and strong links with the VFCA to support the 'end to end' pathway development will help to mitigate this risk.

11.5 Issues with the current flow of patients across the system and bed blockages in the secondary care services presents a risk to the optimal functioning of the new pathways. The close working relationships that the pathway will bring between secondary care surgical consultants and primary and secondary care clinicians, will mean that patients are only progressed for surgery where it is considered essential and where appropriate all other means of treatment have been exhausted. This will help to reduce demand in secondary care.

12. Recommendations

12.1 The Board is asked to:

- receive the update on the work undertaken to date.
- note that a further update on the work of the Development Group and pathway review/redesign will be provided to the Board in April 2022.
- endorse the NCA pan-locality delivery model for the secondary care aspect of the Urology pathway, into which the pre-secondary care locality pathway will align

Ian Mello
Director of Secondary Care Commissioning
Bury OCO
Ian.mello@nhs.net

November 2021

NHS
Bury
Clinical Commissioning Group

Meeting:			
Meeting Date	26 May 2020	**Action**	Receive
Item No.		**Confidential**	No
Title	Urology Services Across Bury, Oldham, Rochdale, and Salford		
Presented By	Ian Mello, Director of Commissioning		
Author	Mike Ryan, Head of Planning and Delivery, NCA North East Sector Commissioners		
Clinical Lead	Howard Hughes, Clinical Director		

Executive Summary

A Greater Manchester (GM) Model of Care (MoC) for Benign Urology was developed through the GM Improving Specialist Care Programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the Greater Manchester Joint Commissioning Board (JCB), though implementation has been delayed due to COVID-19.

As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local Urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve local Urology services. This work is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

This delivery model, which is designed to deliver high quality and accessible services for our patients, would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

This paper, which has been co-authored by the locality commissioners and the NCA, is seeking endorsement of the proposed pan-locality delivery model.

Recommendations

- Endorse the key design features of the pan-locality delivery model, which are fully consistent with the Greater Manchester Model of Care (MoC).
- Support a phased approach to mobilisation overseen by the Programme Board.

Links to CCG Strategic Objectives	
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐

Links to CCG Strategic Objectives	
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☐
Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:	
GBAF	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☒	No	☐	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial Implications?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☒	No	☐	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Requirements re: consultation/engagement and impact assessments being considered by the Programme Board.						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG's risk register?	Yes	☐	No	☒	N/A	☐

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Urology Services Across Bury, Oldham, Rochdale and Salford

1.0 Executive Summary

1.1 Colleagues from Bury, HMR, Oldham and Salford CCGs and the Northern Care Alliance (NCA) are jointly working together to improve Urology services. This is being overseen by a Programme Board, jointly chaired by two of the CCG Chief Clinical Officers.

1.2 There are significant service resilience issues and unwarranted variation in Urology services within Greater Manchester (GM). In response to this, the GM Improving Specialist Care (ISC) programme developed a GM-wide Model of Care (GM MoC), which was subsequently endorsed by the GM Joint Commissioning Board (JCB).

1.3 The NCA provides the majority of urological care for the populations Bury, Rochdale, Oldham and Salford. Working with local commissioners, a pan-locality delivery model has been developed which is fully aligned with GM ISC MoC.

1.4 This delivery model, which is designed to deliver high quality and accessible services for our patients, is described in more detail below but in essence would see the establishment of a hub-and spoke model – connecting Salford Royal and Royal Oldham hospitals to locality based spokes, with most care delivered through locality based Urology Investigation Units (UIs).

1.5 This paper, which has been co-authored by the locality commissioners and the NCA, is seeking endorsement of the proposed pan-locality delivery model.

2.0 Background

2.1 A GM MoC for Benign Urology was developed through the ISC programme. This hub and spoke configuration for the delivery of Benign Urology services has been endorsed by the GM JCB, though implementation has been delayed due to COVID-19.

2.2 As a result of the Pennine Acute Trust (PAT) transaction, in April 2021 responsibility for the provision of local urology services in Bury, Rochdale and Oldham now rests with Salford Royal and will, on completion of the Transaction, formally transfer to NCA.

2.3 North Manchester General Hospital (NMGH) is currently the main delivery site for inpatient (IP) Urology services for Bury, Rochdale and Oldham, though – as part of the GM MoC – in the future this site will become a spoke, with IP activity undertaken at one of designated GM hub sites (of which there are anticipated to be five), with most IP activity flowing to Royal Oldham Hospital (ROH), Salford Royal Hospital (SRH) or Manchester Royal Infirmary (MRI).[1]

2.4 Currently 1 in 5 new patient pathways ends in a procedure and a minority of these require an IP stay. Around 80% of the IP activity undertaken at NMGH is from Bury, Oldham and HMR. At SRH the vast majority of IP activity is from the Salford locality.

[1] The other two hubs in GM would be Stepping Hill Hospital (Stockport) and Bolton Hospital).

3.0 The Proposed Pan-Locality Delivery Model

3.1 The proposed pan-locality delivery model is fully aligned to the approved GM MoC and will support the delivery of a single urology service across Bury, Rochdale, Oldham and Salford.

3.2 By delivering a more integrated model of care within each locality, only a small number of patients requiring an IP stay will need to move between sites, thus improving patient experience and continuity of care, reducing inefficiencies and maximising patient safety.

3.3 Key features of the pan-locality model are:

- A single comprehensive Benign Urology Service delivered across Bury, Rochdale, Oldham and Salford.
- Hub-and-spoke delivery model –
    - ROH and SRH as inpatient hubs and Rochdale Infirmary and Fairfield General Hospital as spokes.
    - Virtual corridors running from Bury to Salford and Rochdale to Oldham.
- Single workforce within two integrated functional teams – NCA West & NCA East.
- Bury, Rochdale and Oldham IP activity currently undertaken at NMGH being aligned with the hub-and-spoke model, but recognising that patients (and their GPs) will be free to choose their service provider.
- Expansion and enhancement of clinic & diagnostic capacity at each site in the form of UIUs - increasing local access to urology services.
- A full range of sub-speciality services (e.g. stone services, andrology etc.) will be offered, in line with the GM MOC.

3.4 A phased implementation of the pan-locality model is proposed, particularly recognising the dependency on estate developments (i.e. the delivery of the agreed capital development on the ROH site and the redevelopment of NMGH site).

3.5 The final end-state is delivery of the GM MoC. This will include decommissioning of PAT IP services at NMGH and the full establishment of both ROH and SRH as hub sites. It is anticipated that the majority of patients requiring an IP episode will be cared for at ROH, with some being cared for at SRH or MRI, depending on catchment areas.

4.0 Summary of Drivers for Change

4.1 The pan-locality delivery model is fully aligned to the approved GM MoC for Benign Urology and addresses the following drivers for change:

- Risks to service sustainability, ability to meet performance requirements (exacerbated by COVID), and inequalities in access. Implementation of the first phases of the pan-locality delivery model will begin to address these issues.
- Recommendations made in the national Getting It Right First Time (GIRFT) report for Benign Urology, largely relating to the reduction of unwarranted variation in both access and outcomes, and the future development of the urological workforce. The pan-locality delivery model addresses these issues.
- If a new delivery model is not implemented, there will be increased movements of patients between providers, impacting upon continuity of care.
- MFT's long term model sees no IP surgical activity being delivered at NMGH, reinforcing the need to establish a new model that delivers more care as close to home as possible.

5.0 Impact and Benefits

5.1 The pan-locality model will deliver high quality care for urology patients, address longstanding health inequalities, make the best possible use of available capacity, utilise new ways of working and increase the amount of care that is delivered locally.

5.2 The provision of UIUs in each locality will mean that a number of daycase and diagnostic procedures, where patients currently travel to an inpatient site, will be delivered closer to home. UIUs will also increase outpatient capacity in each locality. Discussions have commenced between Bury CCG Commissioners and NCA to scope the requirements for a UIU to support in the identification of suitable site(s) in the community from which to host the service. Access to diagnostics to support urology investigations will form part of the CCGs work to develop an overarching Diagnostic Strategy for Bury.

5.3 The provision of sub-speciality services will improve patient experience and outcomes.

5.4 Working as a single NCA-wide team will address long-standing sustainability issues, improve recruitment and retention of clinical staff, increase service resilience, and allow the development of pathways that will reduce unwarranted clinical variation.

5.5 The proposed hub-and-spoke arrangements would see Bury and Salford patients that are referred into the service having their IP episode at the Salford Royal hub site. Rochdale and Oldham patients referred into the service would be cared for at the ROH hub. Patients and GPs would, of course, continue to be able to choose other providers within GM.

5.6 This would mean that some patients who currently access IP services at NMGH may have to travel further e.g. patients in the south of Bury and Rochdale, though it is anticipated that as part of the GM MoC and MFT's plans there will not be an IP service on NMGH site.

5.7 Based upon 2019/20 data the number of elective episodes of care from each CCG area undertaken at NMGH and therefore impacted by the GM MoC is as follows.

Bury CCG	HMR CCG	Oldham CCG	Salford CCG
776	822	813	No Change

6.0 Recommendations

6.1 Commissioners are asked to endorse the key design features of the pan-locality delivery model, which are fully consistent with the GM MoC, and a phased approach to mobilisation overseen by the Programme Board.

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Agenda Item 7

Bury Council

NHS Bury Clinical Commissioning Group

Strategic Commissioning Board

Meeting Date	08 December 2021	**Action**	Approve
Item No.	7	**Confidential**	Choose an item.
Title	Distribution of Adult Social Care Workforce Capacity Fund		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Matthew Logan – Strategic Lead Integrated Commissioning		
Clinical Lead			

Executive Summary

The Department of Health and Social Care have further extended the Workforce Recruitment and Retention Fund. Bury Council will soon receive a combined total of £552,981. The main purpose of the Workforce Recruitment and Retention Fund is to support local authorities address workforce capacity pressures in their geographical area this winter through recruitment and retention activity.

The core aims of this fund are to:

- support providers to maintain the provision of safe care and bolster capacity within providers to deliver more hours of care
- support timely and safe discharge from hospital to where ongoing care and support is needed
- support providers to prevent admission to hospital
- enable timely new care provision in the community
- support and boost the retention of staff within social care

The monies will be paid in two instalments, 60% (c.£332k) in November and 40% (c.£221k) in January.

Bury Council have not yet received this money, however, given the timescales involved and need to adhere to strict Department of Health and Social Care deadlines for the dissemination of money, permission is being sought to distribute the first instalment of the grant fund as outlined below.

Previous tranches of Workforce Recruitment and Retention Fund monies have had to be agreed by Urgent Decision owing to the strict timelines for disseminating funds not corresponding with SCB or Council Cabinet meeting dates. To avoid the problems in meeting Committee deadlines whilst also meeting the timelines set by the Department of Health and Social Care for the dissemination of these monies, permission is also sought for the Executive Director of Strategic Commissioning to be delegated authority to agree to the future dissemination of any Workforce Support Grants provided to support care providers during the remainder of the pandemic.

This paper seeks permission to distribute the first tranche of monies as follows:

- 45% of the Workforce Recruitment and Retention Fund to Care Homes, Supported Living Care at Home and the hospice.
- 25% of the Workforce Recruitment and Retention Fund specifically to support Nursing Homes in the borough.
- 3% to fund the pilot of the Heads Up Wellbeing and Resilience Training for those Care Homes involved.
- 27% to fund the initiatives by Workforce Hub to support large scale recruitment for Adult Social Care vacancies.

This is in line with the grant conditions set by the Department of Health and Social Care that also requires Local Authorities to disseminate the above within 20 days of receipt.

The care provider element of the fund will be apportioned out between the relevant providers based on the number of CQC registered beds in the case of Care Homes, and the number of Bury customers supported in respect of Care at Home and Supported Living.

Recommendations

- SCB approve the request to disseminate the above grant monies in line with Department of Health and Social Care Grant requirements.

- SCB approve for the Executive Director of Strategic Commissioning to be delegated authority to agree the dissemination of any future Workforce Support Grants, in line with grant conditions, provided to support care providers during the remainder of the pandemic to ensure strict timescales are met.

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

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

Implications						
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
Financial Implications - Additional expenditure as detailed below will be required from NHSE funding available to support the COVID-19 Hospital Discharge Guidance						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☐	N/A	☒
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☐	No	☐	N/A	☒
Additional details						

Governance and Reporting		
Meeting	**Date**	**Outcome**
CCMT	23/11/2021	Approved

Background

1.1 The Workforce Recruitment and Retention Fund was first introduced in January 2021. First committing an extra £120 million funding to support local authorities to manage workforce pressures, this extension of the fund allocates a further £162.5m across Local Authorities.

1.2 The core aims of this fund are to:

- Support providers to maintain the provision of safe care and bolster capacity within provider to deliver more hours of care.
- Support timely and safe discharge from hospital to where ongoing care and support is needed
- Support providers to prevent admission to hospital
- Enable timely new care provision in the community
- Support and boost the retention of staff within social care

1.3 The funding will be paid in 2 tranches. The first 60% of the fund will be paid to Local Authorities in November 2021. The remaining 40% of the fund will be paid in January 2022. All funding must be used for the measures outlined in the Appendix 1.

1.4 Subject to the grant conditions being satisfied, local authorities can choose to pass some or all of their funding to care providers within the local authority's geographical area to meet unprecedented levels of pressure on staff capacity due to winter pressures.

The allocation to care providers that Bury is proposing is based on 1844 registered CQC beds at November 2021 and includes 57 care homes and 1232 Community Care Users at October 2021, using the Capacity Tracker Service User data

2 Financial implications

2.1 Bury's total allocation of the new Workforce Recruitment and Retention Fund has just been announced with Bury receiving £552,981 in total for the period 1st November to 31st March 2022. £331,788.60 will be paid in November 2021 and £221,192.40 will be paid in January 2022.

2.2 This paper seeks permission to distribute the first tranche of the monies as follows:

- 45% of the Workforce Recruitment and Retention Fund to Care Homes, Supported Living Care at Home and the hospice. They will be able to spend this in line with the grant conditions but at their discretion. Examples of how this could be used by providers to support the recruitment and retention of staff and sustainability of service are:
    - Covering agency staff costs

  - Provider recruitment initiatives
  - Staff retention offers including:
    - Blue Light Card
    - Health Insurance
    - Life insurance
    - Childcare costs
    - Increased overtime rates

- 25% of the Workforce Recruitment and Retention Fund specifically to support Nursing Homes in the borough. They will be able to spend this in line with the grant conditions but at their discretion. Examples of how this could be used by providers to support the recruitment and retention of staff and sustainability of service are:

  - Covering nursing agency costs and allowing long term booking of agency staff
  - Pay for the transfer of agency staff to permanent
  - Staff retention offers including:
    - CPD and clinical courses
    - NMC Membership
    - Pay home office fee to support the recruitment of overseas nurses

  Rather than target individual Nursing Homes, the greater benefit and to ensure equability was to provide the additional 25% gran monies to all Bury Nursing Homes.

- 3% to fund the pilot of the Heads Up Wellbeing and Resilience Training for those Care Homes involved.

- 27% to fund the initiatives by Workforce Hub to support large scale recruitment for Adult Social Care vacancies. This will include but is not limited to:

  - Support larger scale internal recruitment model for Adult Social Care vacancies. They will test a co-ordinated large scale recruitment model in preparation for bringing in independent providers
  - Recruitment support to Integrated Neighbourhood Teams for temporary social work team capacity where needed e.g. admin
  - Scope role requirements for complex cases in Integrated Neighbourhood Teams and test out with temporary recruitment
  - Commission wellbeing and resilience support for providers
  - Recruitment event for care workers preparation
  - Streamline conversion of agency to permanent role

The below table outlines the figures that will be disseminated to each provider sector.

	Workforce Recruitment and Retention Fund			
Bury allocation 1st Tranche	£331,788.60			
Bury Split %s	45%	25%	3%	27%
Bury Split Allocation	£148,608	£83,178	£10,615	£89,387
Receiving service	Care Homes, Care at Home, Supported Living and Hospice	Nursing Homes	Heads Up Pilot	Workforce Hub

This is in-line with the grant conditions set by the Department of Health and Social Care that require Local Authorities to disseminate the above within 20 days of receipt. Bury Council is yet to receive these monies.

The percentage splits were determined based on the impact the monies would have on the particular provider sectors. £148,608 between all care providers will ensure each provider receives approx. £42 per customer/per bed. Previous allocations have resulted in lower amounts per customer/per bed, minimising the impact the monies can have on supporting providers with the recruitment and retention of staff. £83,178 between all nursing homes will ensure they receive approx. £111 per bed. This takes into account the increased costs, especially in the recruitment of agency staff, that nursing homes encounter.

3 Reporting

3.1 Local authorities must distribute the money in line with the grant circular and are required to provide 2 returns to the Department of Health and Social Care by the dates below:

- Reporting point 1: 14 January 2022
- Reporting point 2: 29 April 2022

4. Recommendations

4.1. SCB approve the request to disseminate the above grant monies in line with Department of Health and Social Care Grant requirements.

4.2. SCB approve for the Executive Director of Strategic Commissioning to be delegated authority to agree the dissemination of any future Workforce Support Grants, in line with grant conditions, provided to support care providers during the remainder of the pandemic to ensure strict timescales are met.

GOV.UK

Guidance

Annex B: grant conditions

Published 3 November 2021

Contents

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This publication is available at https://www.gov.uk/government/publications/workforce-recruitment-and-retention-fund-for-adult-social-care/annex-b-grant-conditions

Grant conditions

In this grant determination:

- ‘the department’ means the Department of Health and Social Care
- ‘grant’ means the amounts set out in the adult social care (ASC) Workforce Recruitment and Retention Fund grant determination 2021 to 2022
- ‘upper tier and unitary local authorities’ means:
  - a county council in England
  - a district council in England, other than a council for a district in a county for which there is a county council
  - a London borough council
  - the Council of the Isles of Scilly
  - the Common Council of the City of London

The main purpose of the Workforce Recruitment and Retention Fund is to support local authorities to address adult social care workforce capacity pressures in their geographical area this winter, in order to:

- support providers to maintain the provision of safe care and bolster capacity within providers to deliver more hours of care
- support timely and safe discharge from hospital to where ongoing care and support is needed
- support providers to prevent admission to hospital
- enable timely new care provision in the community
- support and boost the retention of staff within social care

This allocation of the grant must only be used to deliver measures that address local workforce capacity pressures in adult social care between 21 October 2021 and 31 March 2022 through recruitment and retention activity. We expect local authorities to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate. It will be important to retain existing staff capacity as well as encourage new and returning entrants.

Examples of this include, but are not limited to:

- supporting payments to boost the hours provided by the existing workforce – including childcare costs and overtime payments
- investment in measures to support staff and boost retention of staff within social care – including occupational health, wellbeing measures, incentive and retention payments

- the creation and maintenance of measures to secure additional or redeployed capacity from current care workers – for example:
  - shared staff banks
  - redeploying local authority staff
  - emergency support measures
  - overtime payments
- local recruitment initiatives
- activities to support hospital discharge or to prevent or address delays as a result of workforce capacity shortages (distinct from enhanced guidance on finance and contracting arrangements for H2 2021 to 2022 (https://www.england.nhs.uk/publication/guidance-on-finance-and-contracting-arrangements-for-h2-21-22/) discharge funding agreed in H2 2021 to 2022 settlement)
- activities which support the recruitment of local authority employed social care staff, or which enhance or retain the capacity of existing local authority employed social care staff
- local authorities and, where funding has been passported, providers to use the grant to cover reasonable administrative and/or set up costs they incur for new measures that deliver additional staffing capacity through recruitment and retention activity

Further examples can be found in the grant guidance.

Where local authorities and, where funding has been passported, providers are already using such approaches, the funding can be used to increase the scale of activity.

We expect local authorities to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate.

Local authorities are encouraged to look at other local authority strategies and where appropriate replicate their approaches to successfully retain existing capacity or deliver additional staffing capacity through recruitment and retention activity (see Workforce Recruitment and Retention Fund guidance). This includes learning from the deployment of the Workforce Capacity Fund (https://www.gov.uk/government/publications/workforce-capacity-fund-for-adult-social-care) between January and March 2021, the national evaluation of which is available at. It is important to acknowledge that workforce capacity pressures are different now compared with those of January to March 2021. Therefore, local authorities and providers may wish to spend their Workforce Recruitment and Retention Fund allocations on different forms of allowable activity than they did with the Workforce Capacity Fund.

Additionally, local authorities are encouraged to consider where regional or joined up approaches across multiple authorities could be utilised to maximise the impact of their activity.

The grant may be used to fund alternative approaches not specified above on the condition that such measures retain existing capacity or generate additional ASC workforce capacity through recruitment and retention activity, such as employing more people, where shortages arise due to winter pressures in adult social care.

Any funding should be spent only on time-limited activity during the 21 October 2021 to 31 March 2022 period.

We expect local authorities to work closely with providers to determine how funding should best be spent, including passporting funding directly to providers where appropriate. Subject to the grant conditions being satisfied, local authorities can choose to pass some or all of their funding to care providers within the local authority's geographical area to meet pressure on staff capacity due to winter pressures.

To ensure maximum productivity of any payments to providers, local authorities should be mindful of time pressures. Therefore, if a local authority chooses to make payments to providers, where possible, they should endeavour to passport funds as early as possible during the grant period to ensure that providers have time to use the resources to maximum effect.

If the local authority chooses to make payments to providers financed by this grant they must ensure that providers will use the funding to support genuinely new expenditure that delivers additional staffing capacity or retains existing capacity through recruitment and retention activity and has not already been funded by other sources of public funding. This means the grant cannot be used on expenditure which does not produce new capacity or retains existing capacity – for example, for ensuring that staff who are isolating in line with government guidance receive their normal wages (which can instead be funded through the Infection Control and Testing Fund (https://www.gov.uk/government/publications/adult-social-care-infection-control-and-testing-fund-round-3)).

Local authorities can use funding directly to deliver measures that help all providers of adult social care in their geographical area. This includes:

- care home and domiciliary care
- care providers with which local authorities do not have contracts
- organisations providing care and support who may not be registered with the Care Quality Commission (CQC)
- day care, and short stay care services and supporting the capacity of the personal assistant workforce

However, if a local authority chooses to passport funding directly to a care provider, they should ensure funding is only given to a CQC-registered provider. A provider is legally required to register with the CQC if it carries out a regulated activity set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

If a local authority chooses to transfer funding to a CQC registered care provider they should ensure that funding is allocated on condition that:

- the local authority has in place appropriate oversight of deliverables and outputs from any amount of grant passed to a provider. This should be sufficient to ensure the funding is spent in line with the intended purpose and allow a local authority to verify or monitor the accuracy of reporting
- the local authority has due regard to their responsibilities with respect to international agreements on subsidy control

Additionally, the local authority should work constructively and collaboratively with providers receiving passported funds to ensure that it imposes conditions on the provider requiring that:

- the recipient care provider uses it for new expenditure that delivers additional staff capacity or retains existing capacity where the expenditure or activity has not already been funded by the Infection Control and Testing Fund or other sources of public funding
- the provider will return any grant amount to the local authority that is not spent on those measures
- if requested to do so, the care provider should provide the local authority or the department receipts or such other information as they request to evidence that the funding has been spent in accordance with the measures above
- if requested to do so, the care provider should provide the department or the local authority with an explanation of any matter relating to funding and its use by the recipient as they think necessary or expedient for the purposes of being assured that the money has been used in an appropriate way in respect of those measures
- the local authority must provide a final value of unspent funding and updated final spending report by no later than 30 June 2022, after which time the local authority may no longer amend this value. We expect local authorities to return unspent amounts to the department promptly after this date. In July 2022, the department will send letters to all local authorities advising them on how to return any unspent or misspent amounts. We ask that all local authorities make arrangements prior to this point to recoup any unspent amounts from providers in their local area

The grant must not be used for fee uplifts, expenditure already incurred or activities for which the local authority has earmarked or allocated expenditure or for activities which do not support the primary purpose of the Workforce Recruitment and Retention Fund which is to deliver additional staffing capacity in adult social care through recruitment and retention activity during the 21 October 2021 to 31 March 2022 period.

To be compliant with the conditions of this fund a recipient local authority must:

- only use the funding to support measures that address local workforce capacity pressures through recruitment and retention activity. This includes the measures set out above and can include passing some or all of the funding to care providers, subject to the grant conditions above being satisfied
- ensure that any payments to care providers are made on condition that it is used for measures that address local workforce capacity pressures through recruitment and retention activity. The provider should agree to report on expenditure as set out in the reporting section below and return any grant amount to the local authority that is not spent on those measures
- report on their spending as outlined in the reporting section below. This includes providing the department with a report by 14 January 2022 and subsequently on 29 April 2022
- provide the department with a return by 29 April 2022, certifying that their reported expenditure from this grant has been spent in compliance with the grant conditions (this can be found at annex E)

Local authorities may use a small amount of this funding (capped at 1% of their total Workforce Recruitment and Retention Fund allocation) for reasonable administrative costs associated with distributing and reporting on this funding.

Reporting

Local authority reporting requirements

The funding will be paid in 2 tranches. The first 60% of the fund will be paid to local authorities in November 2021. The remaining 40% of the fund will be paid in January 2022. We want local authorities to make use of this funding as quickly as possible to help increase the staffing capacity of the social care system.

We have streamlined reporting on the Workforce Recruitment and Retention Fund spend with wider reporting requirements on the Infection Control and Testing Fund Round 3.

Local authorities are required to provide the department with returns covering the information set out in annex D by the dates below.

- reporting point 1: 14 January 2022, covering expenditure from 21 October to 30 November 2021
- reporting point 2: 29 April 2022, covering expenditure for the entire whole grant period from 21 October 2021 to 31 March 2022

If local authorities have passed funding on to care providers, they must obtain the information they need from providers to complete the returns.

The second instalment will be conditional on local authorities having returned the first report to the department by 14 January 2022.

Any funding that is misspent or unspent at the close of the fund (31 March 2022) will need to be returned to the department. We will conduct an assurance process, to ensure that this funding is correctly spent by local authorities and providers.

In addition to the reporting metrics for the Infection Control and Testing Fund Round 3, we require additional reporting on:

- total funds spent directly
- total funds transferred to care providers
- list of measures or activities the fund is being used for
- funds spent on each measure or activity (including spending of transferred funding reported by providers)
- estimated total number of hours generated from the funded measures or activity since 21 October 2021
- estimated total number of hours generated from comparable local authority activities during the baseline period, September 2021
- total number of recruits generated from funded measures or activities since 21 October 2021

- total number of recruits generated from comparable local authority activities during the baseline period, September 2021
- how many staff have left care providers in the local authority area since 21 October
- how many staff left care providers in the local authority area during the baseline period, September 2021

The reporting template can be found at annex D.

We have noted local authority feedback on the Workforce Capacity Fund (which ran from January to March 2021) that the significant reporting burden reduced the effectiveness of the grant. Therefore, we have reduced the number of metrics required for reporting on this fund. However, to fully understand the impact of the fund, we will engage directly with local authorities and providers to understand in more detail how funding is being spent.

Following the closure of the fund, the department will undertake and subsequently publish an evaluation of the activities and spend conducted under the fund.

Financial management

A recipient authority and providers must maintain a sound system of internal financial controls.

Local authorities must ensure that appropriate measures are put in place to mitigate against the risk of fraud. This is particularly important for local authorities who choose to pass some or all of this funding to social care providers.

A number of different public funding streams have been made available during the pandemic. Local authorities should as far as possible put measures in place to ensure this funding is not used to support activity which has already been funded by an alternative source of public funding.

If a recipient authority has any grounds for suspecting financial irregularity in the use of any grant paid under this funding agreement or in the use of this funding, it must notify the department immediately, explain what steps are being taken to investigate the suspicion and keep the department informed about the progress of the investigation.

For these purposes ‘financial irregularity’ includes fraud or other impropriety, mismanagement, and the use of grant for purposes other than those for which it was provided. Examples of this include a provider falsely representing themselves as eligible for funding, or a provider using the funding for purposes outside of the grant conditions. The local authority must take all reasonable steps to recover the money that has been misspent.

Before passing funding on to third parties, local authorities should assure themselves that they are legitimate recipients of this funding.

Breach of conditions and recovery of grant

If the authority fails to comply with any of these conditions, or if any overpayment is made under this grant or any amount is paid in error, the Secretary of State may reduce, suspend or withhold grant payments or require the repayment of the whole or any part of the grant monies paid, as may be determined by the Secretary of State and notified in writing to the authority.

Such sum as has been notified will immediately become repayable to the Secretary of State who may set off the sum against any future amount due to the authority from central government including but not limited to the second instalment of this grant. An authority must submit returns by 14 January and 29 April 2022, as outlined above, specifying how the grant has been spent.

The template can be found at annex D.

These must be submitted to the department who may review the returns on behalf of the Secretary of State for Health and Care.

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Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Approve
Item No	8	**Confidential / Freedom of Information Status**	No
Title	Individual Funding Request (IFR) Panel Terms of Reference		
Presented By	Howard Hughes, Clinical Director		
Author	Emma Kennett, Head of Corporate Affairs and Governance		
Clinical Lead	Howard Hughes, Clinical Director		
Council Lead			

Executive Summary

This report provides an update in respect to the Terms of Reference and Membership of the Individual funding Request (IFR) Panel.

The NHS is under a statutory duty 'to promote comprehensive healthcare within the resources available'. It is not an absolute obligation to provide every treatment that a patient, or group of patients, may demand. The NHS is entitled to take into account the resources available to it and the competing demands on those resources. The precise allocation of resources and the process for prioritising the allocation of those resources is a matter of judgement.

The CCG has in place an Effective Use of Resources (EUR) Policy, which along with its underpinning frameworks, is intended to facilitate and support the decision-making process at a named individual level where their request is an exception to the commissioning policies and contracting arrangements in place.

Recommendations

It is recommended that the Strategic Commissioning Board approve the revised Terms of Reference for the Individual Funding Request (IFR) Panel.

Links to Strategic Objectives/Corporate Plan	Choose an item.
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	No
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☒	N/A	☐
Has any engagement (clinical, stakeholder	Yes	☐	No	☒	N/A	☐

Implications						
or public/patient) been undertaken in relation to this report?						
Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☒	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☐	No	☒	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☒	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☐	N/A	☐
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☐	No	☒	N/A	☐
What are the Information Governance/ Access to Information implications?						
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
If yes, has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☐	N/A	☒
If yes, please give details below:						
If no, please detail below the reason for not completing an Equality, Privacy or Quality Impact Assessment:						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk	Yes	☐	No	☐	N/A	☒

Implications						
Register?						
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**

IFR Panel

Terms of Reference

1. Introduction

1.1. This report provides an update in respect to the Terms of Reference for the Individual funding Request (IFR) Panel.

2. Background

2.1 The NHS is under a statutory duty 'to promote comprehensive healthcare within the resources available'. It is not an absolute obligation to provide every treatment that a patient, or group of patients, may demand. The NHS is entitled to take into account the resources available to it and the competing demands on those resources. The precise allocation of resources and the process for prioritising the allocation of those resources is a matter of judgement.

2.2 The CCG has in place an Effective Use of Resources (EUR) Policy, which along with its underpinning frameworks, is intended to facilitate and support the decision-making process at a named individual level where their request is an exception to the commissioning policies and contracting arrangements in place.

2.3 These arrangements, which are referred to as Individual Funding Requests are overseen by an agreed panel, which gives consideration to requests for treatment which is not routinely commissioned where it is believed that there are exceptional clinical circumstances that should be considered and providing detailed evidence of the discussions and decisions reached. The remit of the panel includes, but is not limited to:

- Where the treatment is not commissioned as the evidence base does not support commissioning on a population basis within available resource constraints, often because the treatment falls below the thresholds of clinical and / or cost effectiveness;
- Where detailed EUR recommendations exist for many procedures but exceptionality to these needs to be considered;
- Where there is no detailed policy in place in respect to the proposed procedure;
- Where the commissioner has determined that the treatment in question is a low priority for CCG resources when compared to the other health needs of the population;
- When the available evidence has not been considered by the Commissioner, so no decision has been made on whether the treatment should be made available;
- Where a condition is extremely rare, and it is unlikely there will ever be evidence of cost effectiveness at a population level for the normal commissioning process to apply;
- Where there is a contract in place with agreed criteria that must be satisfied before a procedure / treatment / drug can be commissioned; and
- Making recommendations on future policy, under the leadership of the Panel Chair who also supports the Greater Manchester Effective Use of Resources Committee.

2.4 The CCG has an IFR Panel in place, which meets on a monthly basis to consider cases that have been submitted to the CCG for consideration. The IFR Panel, and overall Effective Use of Resources approach is supported by the Greater Manchester Shared Service Effective Use of Resources Team.

2.5 A separate proposal was submitted to the SCB meeting in September 2021 in respect of funding requests to NHS Bury CCG for spot purchases.

3. Review of IFR panel Terms of Reference

3.1 The IFR panel Terms of Reference were last approved by SCB in August 2020 which included a particular request to increase the number of GPs available to support the panel and also expanding the membership to include other specialties, for example a nurse.

3.2 It was considered that the inclusion of specialties beyond General Practitioners, would not only increase the expertise available to the panel, to support the wide range of requests that are considered but will also facilitate to Panel to achieve quoracy at every meeting.

3.3 To address the concerns raised by existing panel members and to ensure the panel remained robust and able to operate, a new Terms of Reference was developed and presented for approval, with the following membership:

- IFR Chair and EUR Clinical Lead (GP)
- 2 GPs;
- 2 additional clinical members, who are not officer representatives but may be GPs;
- CCG Finance representative;
- CCG Medicines Management Representative;
- Public Health Representative;
- Lay Member representative; and
- A senior commissioning representative from the CCG.

3.4 The SCB paper in August 2020 noted a number of risks with the most significant risk relating to maintaining the current panel membership whilst recruiting to the new posts. Additionally, there was no clarity at the time on the current level of interest in the following roles:

- IFR Chair and EUR Clinical Lead (GP)
- 2 additional clinical members, who are not officer representatives;

3.5 The SCB in August 2020 supported a proposal that until the IFR Chair and EUR Clinical Lead was appointed, the interim arrangements for chairing future meetings continued, noting however that this would not fulfil the requirement for the post-holder to be a GP as set out in the Terms of Reference.

3.6 Further reflection on the Chairmanship of the panel determined that the role could be a fulfilled by a GP or any other Clinician which is a shift in what was previously approved and a recruitment process was therefore progressed.

3.7 In order to formalise the chairmanship arrangements to ensure that quoracy of Panel meetings are achieved, an amendment to the Terms of Reference is proposed to reflect that the Panel Chair will be a Clinician.

4. Recommendations

4.1 It is recommended that the revised Terms of Reference are approved.

Appendix A

TERMS OF REFERENCE
INDIVIDUAL FUNDING REQUEST
PANEL

Terms of Reference Document Control Sheet

Document Control	
Document Name	Individual Funding Request Panel Terms of Reference
Version/Revision Number	V2.7

Version Control

Version Ref	Amendment	Date Approved
v0.1	Initial draft	
V2.1	Ratified by Clinical Cabinet	May 2014
V2.2	Refresh of Terms of Reference submitted to commissioning for review	August 2019
V2.3	Feedback received from commissioning and draft ToR shared with CCG Chair and Director of Commissioning and Business Delivery	November 2019
V2.4	Updated to include feedback from Dr Schryer and IFR Team	November 2019
V2.5	Updated in respect to additional feedback from CCG Chair and Director of Commissioning and Business Delivery and shared with wider IFR Panel	February 2020
V2.6	Updated membership SCB	August 2020
V2.7	TOR updated to reflect that Chair of Panel will be a Clinician	December 2021

1.0 Introduction

1.1 The NHS is under a statutory duty 'to promote comprehensive healthcare within the resources available'. It is not an absolute obligation to provide every treatment that a patient, or group of patients, may demand. The NHS is entitled to take into account the resources available to it and the competing demands on those resources. The precise allocation of resources and the process for prioritising the allocation of those resources is a matter of judgement.

1.2 NHS Bury CCG works collaboratively with all Greater Manchester CCGs and has approved the Greater Manchester Effective Use of Resources Operational Policy in order improve the cost effectiveness of services and secure the greatest health gain from the resources available by making decisions based on evidence about clinical effectiveness balanced with known population needs.

1.3 The CCG has established an Individual Funding Request Panel (IFR), referred to in these Terms of Reference as the Panel, to review requests for funding on an individual named basis for treatments not currently covered by commissioning arrangements or for treatments excluded from those arrangements.

2.0 Membership

2.1 The IFR panel, shall comprise of the following members:

- IFR Chair and EUR Clinical Lead (GP) – *remove*
- 2 GPs;
- 2 additional clinical members, who are not officer representatives;
- CCG Finance representative;
- CCG Medicines Management Representative;
- Public Health Representative;
- Lay Member representative; and
- A senior commissioning representative from the CCG.

2.2 The Chair of the Panel shall be a Clinician – *amend from GP to Clinician*

2.3 The Vice Chair of the Panel will one of the additional clinicians who is not an officer representative and shall be determined by the Panel.

2.4 The Panel may co-opt additional members when required, particularly when specialist expertise is needed.

2.5 Where a person is to be co-opted onto the Panel for the purposes of participating in any of its meetings the decision to co-opt that individual shall be agreed in advance by the Chair and Vice Chair.

3 Quoracy

3.1 The Panel will be quorate when the following attendees are present:

- The Chair or Vice Chair;
- At least one GP and one clinical representative, who can also be the Chair or Vice Chair;
- Two other CCG representatives; and
- Either the Public Health or Lay Member representative.

3.2 A duly convened meeting of the Individual Funding Request Panel at which the quorum is present shall be competent to exercise all of any of the authorities, powers and discretions delegated to it.

3.3 Members should normally attend meetings, and it is expected that members will normally attend a minimum of 75% of meetings held per annum.

4 Deputising Arrangements

4.1 Should a member not be able to attend a Panel meeting, apologies in advance must be provided to the CCG's Corporate Office on Buccg.corporateoffice@nhs.net

4.2 Deputies can attend on behalf of non-clinical members of the Panel, however they must have the same professional expertise and must be agreed in advance with the Chair of the Panel and notified to the CCG's Corporate Office on Buccg.corporateoffice@nhs.net

4.3 Deputising arrangements will count towards the quorum, where formal representative status is confirmed, and this will be reflected within the minutes.

5 Chairs Action and Urgent Decisions

5.1 In clinically urgent situations a request may be considered in advance of the Panel using the mechanism agreed in the GM EUR Operational Policy/Standard Operating Procedures.

5.2 All emergency and urgent decisions will be reported to the Panel at its next meeting by the Chair (or vice chair) with a full explanation, regarding:

- what the decision was;
- why it was deemed and emergency or urgent decision (required to be made in the period between the scheduled meetings);
- what was the majority view of the members of the Panel; and
- how the decision was implemented.

5.3 A record of the above will form part of the minutes of the next scheduled meeting, following the emergency powers/urgent decision being made.

6 Frequency

6.1 The Panel will be scheduled to meet on a monthly basis, however where there are no cases for discussion, the panel will be stepped down. Where it is considered that there are an insufficient number of cases to be heard, cases may be deferred to the following month, subject to clinical need and / or assessment, or the panel may meet virtually via teleconferencing or other electronic communication means.

6.2 Where a panel cannot achieve quoracy and there are cases to be reviewed, the Chair of the IFR Panel, in collaboration with the GM EUR team, will determine whether it is appropriate for the cases to be deferred to the next IFR Panel meeting or agree an alternative date for the meeting, which will be convened within the same month.

7 Conduct of Meetings

7.1 The Panel will operate in accordance with the CCG's Standing Orders, Scheme of Reservation and Delegation and Standing Financial Instructions.

7.2 Meetings will be arranged, including sourcing a suitable venue, by the CCG and managed by their nominated lead officer.

7.3 Preparation of agendas and all supporting papers for consideration by the Panel is the responsibility of the GM EUR team on behalf of the CCG. These will be issued at least 5 working days in advance of the meeting.

7.4 Recording the outcomes of the meeting, taking any actions arising and ensuring letters are sent to the requesting clinician and patient within agreed timescales is the responsibility of the GM EUR team on behalf of the CCG.

7.5 Members of the IFR Panel shall respect confidentiality requirements as set out in the CCG's Constitution.

7.6 Members of the IFR Panel have a collective responsibility for the operation of the Panel. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

7.7 All emergency and urgent decisions, which are taken by the GM EUR Clinical Triage Team on behalf of the CCG's IFR panel, will be reported to the Panel at its next meeting for ratification with a full explanation, regarding:

- what the decision was;
- why it was deemed and emergency or urgent decision (required to be made in the period between the scheduled meetings);
- what was the majority view of the members of the Panel; and
- how the decision was implemented.

7.8 A record of the above will form part of the minutes of the next scheduled meeting,

following the emergency powers/urgent decision being made.

8 Conflicts of Interest

8.1 Panel Members will be expected to declare any conflicts of interests and/or an unusual interest or specialist knowledge of a particular area at all meetings and the Chair will determine how those discussions will be conducted.

9 Duties and Responsibilities

9.1 The Panel will be responsible for:

- reviewing requests for funding for treatments on an individual named basis not currently covered by commissioning arrangements or for treatments excluded from those arrangements;
- assessing the clinical effectiveness of the procedure and then the cost effectiveness of the requested treatment based on the evidence available to them at the time. For requests where a treatment is excluded from commissioning arrangements the Panel will review the evidence to determine whether or not the request under consideration is exceptional and should therefore have access to that treatment funded by the NHS.

10 Accountabilities and Decision Making

10.1 The Panel will make decisions within the bounds of its remit.

10.2 The decisions of the Panel will be binding on NHS Bury CCG.

10.3 The Panel will adopt a consensus approach to decision making where unanimous view cannot be reached on an individual request.

11 Confidentiality

11.1 All requests will be treated as highly confidential as the majority will contain sensitive and/ or clinical information.

11.2 Papers will be sent to members via the BlueTeq © system, however additional arrangements will be made to share the papers via secure e-mail e.g. NHS.net. or registered post, if required.

11.3 All confidential papers will be gathered for shredding at the end of the meeting.

12 Reviewing Terms of Reference

12.1 The Terms of Reference of the panel (including membership) shall be reviewed annually, to reflect the experience of the Panel in fulfilling its functions or sooner if there are relevant changes in legislation or local / regional or national guidance.

Agenda Item 9

Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Receive
Item No	9	**Confidential / Freedom of Information Status**	No
Title	Integrated Care Fund and Strategic Finance Group Update		
Presented By	Sam Evans, Executive Director of Finance		
Author	Simon O'Hare, Acting Deputy Chief Finance Officer, Bury CCG		
Clinical Lead			
Council Lead			

Executive Summary

The purpose of this report is to provide:

- An update on the current Bury locality system financial position in 2021/22 now that NHS allocations have been finalised:
- The current Bury locality Integrated Care Fund (ICF) position at month 7:
- An update on work that is going through the Northern Care Alliance (NCA) Chief Finance Officers Group in respect of 2022/23:
- An update on Greater Manchester (GM) work with regard to pooling and S75 agreements in 2022/23.

NHS partners financial allocations and income have been confirmed for the second half of 2021/22 and agreement to receipt of this income requires the delivery of a break even position. Delivery of break even positions for both NHS partners and the council is reliant upon non recurrent means in terms of central support or use of reserves alongside delivery of savings and efficiencies. The gap for the CCG and the council in 2021/22, bridged in this way, is £29.7m or 5.6% of income.

At month 7 the Bury ICF is forecasting a £1.9m full year overspend, against a budget of £530m. The overall budget has increased by £5.6m from month 5 and this is due to additional allocations received by the CCG in H2 to support national and local priorities, funding of pay award and back pay for contracted providers and Hospital Discharge Programme (HDP) income for quarter 2. The overspend is driven by under achievement of savings in the aligned budget of £2.3m, offset by a £0.5m underspend in the In View budget related to primary care. Whilst the pooled budget is only £0.1m overspent, it should be noted that the overspends in continuing health care and individual placements are forecast to be £1.2m at year end and this is offset by underspends in all other areas of the pooled budget.

The architecture of the NHS changes on 31st March 2022, with the dissolution of CCGs and the creation of Integrated Care Systems and with this certain areas of work will be managed at GM level and certain areas will be delegated for management at locality level. Final guidance is not currently available but NCA footprint Chief Finance Officers have drafted

how they believe budget management will fall between GM and locality, based upon the current draft guidance. This is attached as Appendix 1 for information, further work is required to resolve differences between localities and this will need to be revisited once the final guidance is published. At a national webinar on the 16th November Finance colleagues were informed 2022/23 planning guidance should be released mid to late December.

The use of the pooling arrangements within the section 75 and the reporting of aligned and in view budget, allows the locality to see the totality of performance versus budgets and support delivery of both financial balance and other strategic priorities, across all partners. The continuation of this is a key priority for 2022/23 and beyond, as it is only through system working and locality reporting that we will be able to deliver on financial balance and strategic priorities, including the Bury 2030 commitments. Through the Strategic Finance Group local partners are discussing how the reporting and delivery of a Bury Locality position is possible in 2022/23.

Aligned to this desire to continue working and reporting in an integrated way there is also a piece of work taking place across GM, which is attached as Appendix 2, that is currently progressing through existing GM governance. This paper recommends the minimum pooled budget would be the expenditure within the Better Care Fund (BCF) and the maximum could be everything that is legally permitted to be pooled. This is an evolving piece of work and does pose a number of questions and options that the Bury locality now needs to consider in terms of its current and future S75 arrangements.

Recommendations

The Strategic Commissioning Board is asked to :-

- Note system partners financial position in 2021/22 and the reliance upon non recurrent measures and savings to achieve break even.
- Note the current £1.9m overspend on the Integrated Care Fund at month 7.
- Note the current Bury Integrated Care Fund, in the context of the changing NHS architecture and the work to continue locality reporting from April 2022.
- Note the work across both the NCA footprint and GM with regard to locality budgets, pooling and section 75 arrangements in 2022/23 and the latest outputs of this work.

Links to Strategic Objectives/Corporate Plan	Yes
SO1 - To support the Borough through a robust emergency response to the Covid-19 pandemic.	☐
SO2 - To deliver our role in the Bury 2030 local industrial strategy priorities and recovery.	☐
SO3 - To deliver improved outcomes through a programme of transformation to establish the capabilities required to deliver the 2030 vision.	☒
SO4 - To secure financial sustainability through the delivery of the agreed budget strategy.	☒
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	No

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☐	No	☐	N/A	☒
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☐	N/A	☒
Have any departments/organisations who will be affected been consulted?	Yes	☒	No	☐	N/A	☐
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☐	N/A	☒
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☐	N/A	☒
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☒
How do proposals align with Health & Wellbeing Strategy?	The ICF align investment and saving plans in an integrated way to our key health and wellbeing priorities.					
How do proposals align with Locality Plan?	The ICF support the locality plan by working in an integrated way to align investment and saving plans to our key priority areas of urgent care, intermediate care, mental health and learning disabilities.					
How do proposals align with the Commissioning Strategy?	The ICF aligns to the "Lets Do It" strategy by supporting joined up health and social care services through jointly developed investment and savings plans with a single view of Council and CCG wide budgets.					
Are there any Public, Patient and Service User Implications?	Yes	☐	No	☐	N/A	☒
How do the proposals help to reduce health inequalities?	The ICF supports the targeting of resources to the areas that most need them to close the inequalities gap.					
Is there any scrutiny interest?	Yes	☐	No	☐	N/A	☒
What are the Information Governance/ Access to Information implications?	None					
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☐	N/A	☒
If yes, has an Equality, Privacy or Quality	Yes	☐	No	☐	N/A	☒

Implications						
Impact Assessment been completed?						
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐

Integrated Commissioning Fund and System Finance Group Update

1. Introduction

1.1 The purpose of this report is to provide an update on the current Bury locality system financial position in 2021/22 now that NHS allocations have been finalised, a reminder of the current Bury locality Integrated Care Fund position, an update on work that is going through the Northern Care Alliance Chief Finance Officers Group in respect of 2022/23 and an update on Greater Manchester (GM) work with regard to pooling and S75 agreements in 2022/23.

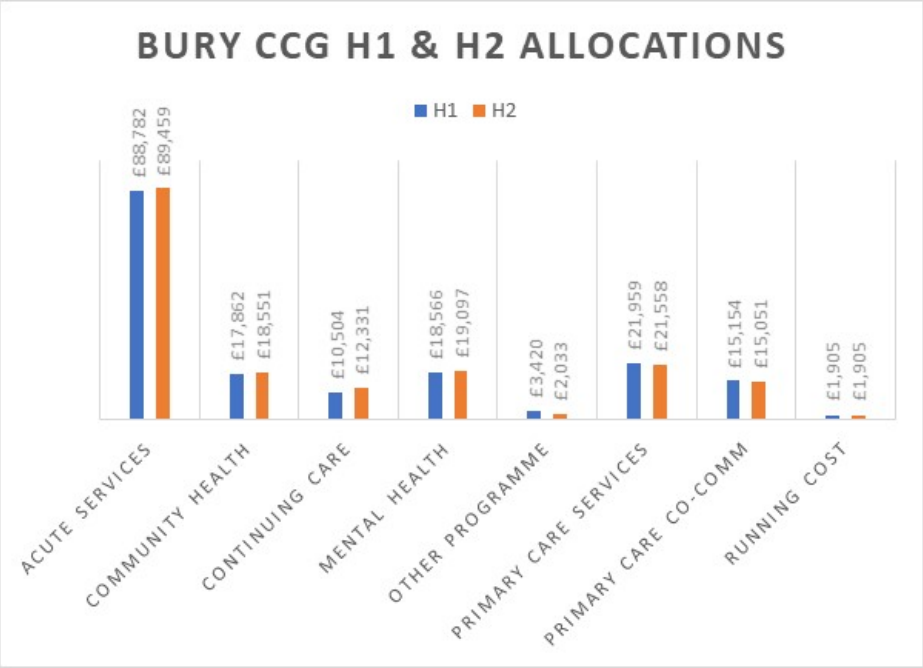
2. Bury system partners financial position in 2021/22

2.1 The NHS finance regime for 2021/22 has been delivered in 2 halves as part of the continued response to the COVID-19 pandemic. Receipt of income / allocations and confirmation of contract values between commissioners and providers has been done with the express intention that all NHS bodies break even in 2021/22 and it is to this standard that all organisations are being held.

2.2 To support delivery of this break even position, all organisations have received central non recurrent support and the remaining gap is to be made up of savings and efficiencies. Provider positions are still being collated at a GM level and an update will be brought to the locality board at a future meeting in order to provide a locality position, but the CCG position has been confirmed.

2.3 The financial regime for H2 of 2021/22 continues as in H1 with prescribed block payments to NHS providers and reimbursement of Hospital Discharge Programme (HDP) costs remaining in place until 31st March 2022. To support delivery of the required break even position the CCG has received £2.96m of GM system monies and QIPP delivery of £2.7m is required in H2 compared to £1.9m in H1. The CCG has also been funded for the 2021/22 pay award and back pay for provider staff, payable through block contracts. It should be noted that there is no funding provided for the pay award for CCG staff and this is to be managed within existing running cost allocations. This is shown overleaf in Table 1.

Table 1 – Comparison of CCG allocations for H1 & H2 of 2021/22



NB – All values in the table above are in £'000s.

2.4 The H2 budget is anticipated to increase by around £2.2m as HDP funding flows into the locality as claims are submitted and validated.

2.5 Table 2 is designed to show the level of support received and savings required to achieve break even. NHS provider partner figures are anticipated to be agreed w/c 22nd November.

Table 2 – Bury System partners financial position in 2021/22

	H1 2021/22			H2 2021/22			Full year 2021/22			
	Gap	Closed by		Gap	Closed by		Gap	Closed by		
		System monies / Use of Reserves (Council)	Savings		System monies / Use of Reserves (Council)	Savings		System monies / Use of Reserves (Council)	Savings	Gap as a % of direct income
CCG	**£3,962**	£1,889	£2,073	**£5,696**	£2,960	£2,736	**£9,658**	£4,849	£4,849	2.7%
Council							**£20,000**	£12,000	£8,000	11.6%
Manchester FT	**£0**			**£0**			**£0**	£0	£0	
Northern Care Alliance	**£0**			**£0**			**£0**	£0	£0	
Pennine Care FT	**£0**			**£0**			**£0**	£0	£0	
Total	**£3,962**	**£1,889**	**£2,073**	**£5,696**	**£2,960**	**£2,736**	**£29,658**	**£16,849**	**£12,849**	**5.6%**

2.3 As can be seen the use of non recurrent means, central support (NHS) and reserves (council), is significant and the system needs to close these gaps to minimise this reliance upon non recurrent monies as soon as is practical.

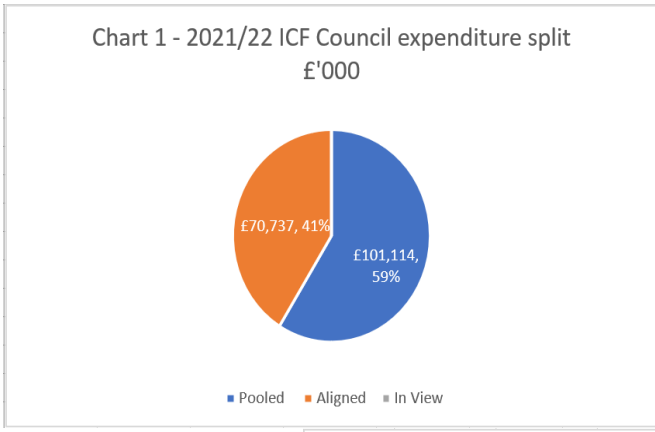
3. Bury Integrated Care Fund 2021/22

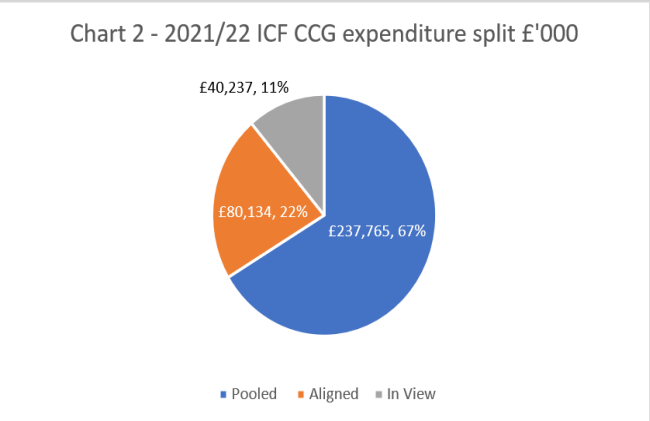
3.1 The Bury Integrated Care Fund (ICF) is a pooled budget arrangement between the council and the CCG where all appropriate and legally allowed expenditure is included within the pooled budget. This pooled budget is covered by a section 75 agreement which gives the Bury Strategic Commissioning Board (SCB) delegated decision making authority from the council and the CCG. This pooled budget arrangement

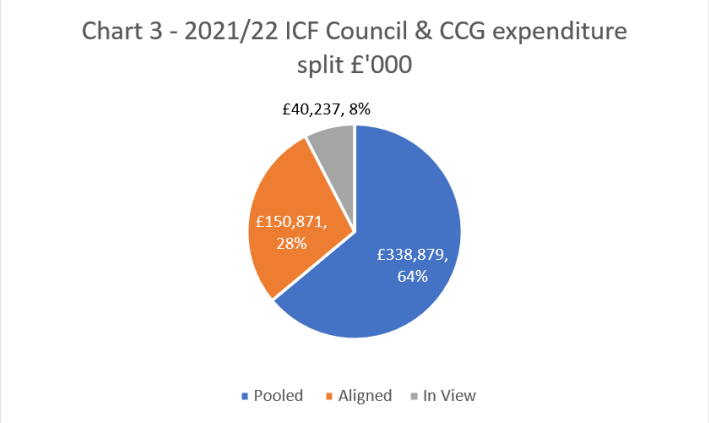
also comes with a risk share that allows partners to contribute differential amounts in any given year, as long as expenditure is made good within a 3 year period. This allows the council and the CCG to support strategic priorities which span multiple years.

3.2 Expenditure that is not legally permitted to be pooled is also shown within ICF as aligned expenditure, this is services such as cancer treatment, all surgery, treatment using lasers and other discrete exclusions. NHS expenditure where authority resides with other bodies, such as NHS England, for the treatment of Bury residents is shown as in view budget.

3.2 Charts 1, 2 and 3 below show the relative split of expenditure for 2021/22 that is pooled, aligned and in view for both the council and the CCG.





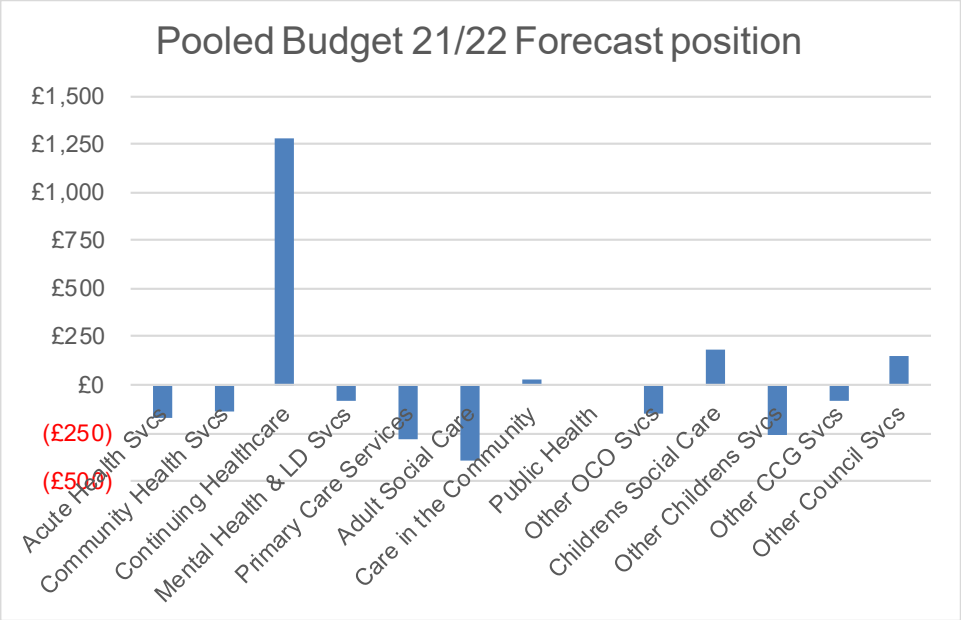


3.3 The current forecast position, based upon month 7 information, for the ICF is an overspend of £1.9m on an annual total budget of £530m. This is a reduction of £1.6m from the Month 5 position of a £3.5m overspend. There is a £0.1m overspend on services held within the section 75 pooled budget, £2.3m overspend on services within the aligned fund and £0.5m underspend on services within the in-view budget. The annual budget has increased by £5.6m from the month 5 report due to additional allocations the CCG has received to support pay awards and back pay, the finalisation of H2 core allocations, HDP income for Q2, Primary Care Improving Access monies and mental health SDF and SR funding for H2.

Summary	21/22 Contribution £'000	21/22 Forecast Expenditure £'000	21/22 Variance £'000
Section 75 Pooled Budget	(338,880)	338,964	85
Aligned Budget	(150,871)	153,161	2,290
In-View Budget	(40,237)	39,758	(479)
Integrated Commissioning Fund	**(529,987)**	**531,884**	**1,897**

3.4 The summary position of the pooled budget at month 7 is an overspend of £0.1m as set out in the table below, alongside the overspend and underspend position for service areas:

Service area	21/22 Budget £'000	21/22 Forecast £'000	21/22 Variance £'000
Acute Health Services	89,122	88,954	(168)
Community Health & Care Services	91,712	92,887	1,175
Mental Health & Learning Disabilities	39,474	39,388	(86)
Primary Care Services	42,470	42,186	(284)
Adult Social Care	16,384	15,989	(395)
Childrens Services and Social Care	14,004	13,932	(72)
Public Health	10,756	10,756	0
Other CCG & Council Services	34,959	34,873	(86)
Total Pool Expenditure	**338,880**	**338,964**	**85**
Contributions	**(338,880)**	**(338,880)**	**0**
Section 75 Pooled Budget	**0**	**85**	**85**



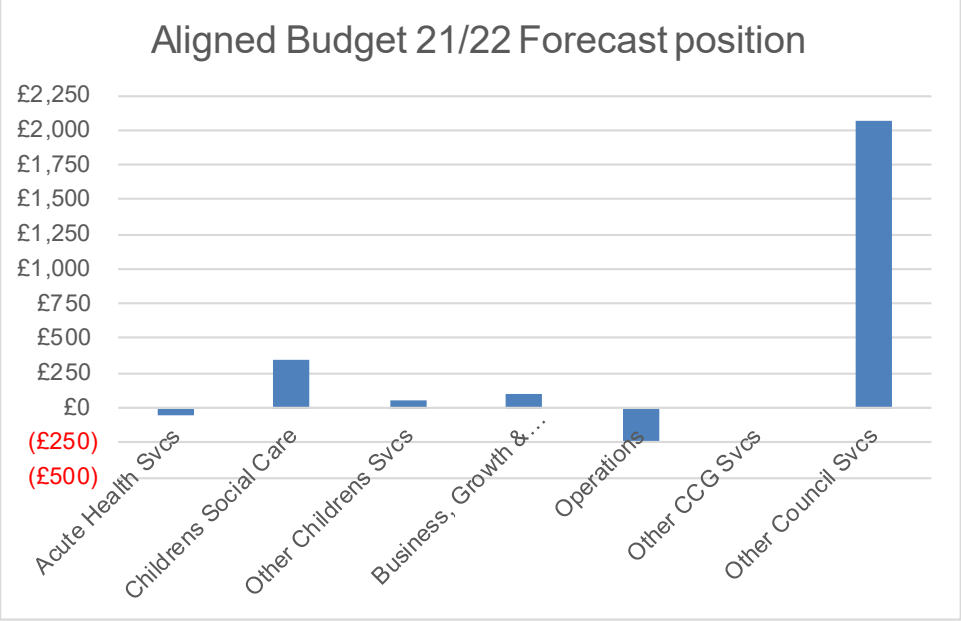
3.5 The key overspend in the pooled budget is £1.2m in community health and care services mainly attributable to a £1.3m forecast outturn overspend in continuing healthcare and individual placement budgets (CHC) offset by a £0.1m underspend in care in the community. This resulting pressure is after full reimbursement of

expenditure related to the national Hospital Discharge Programme (HDP) under which the Bury system is reimbursed for the first 4/6 weeks of care depending on date of discharge for patients discharged from hospital. Continuing Healthcare (CHC) and individual placements is still experiencing significant pressures in month seven, despite the ongoing reviews of joint funded patients, Mental Health and children's placements and further emphasises the requirement to progress the implementation of the CHC database. Given the importance of the work and absences in the CHC team, resource from across other existing CCG and Council teams, and from another GM CCG continues to be utilised.

3.6 Underspends are forecast in other CCG and Council services, £0.3m in primary care, £0.4m in Adult Social Care & smaller underspends across a number of areas.

3.7 The aligned budget is forecasting an overspend of £2.3m at month 7, as shown in the table overleaf, alongside the over and under spend position for service areas:

Service area	21/22 Budget £'000	21/22 Forecast £'000	21/22 Variance £'000
Acute Health Services	80,134	80,083	(51)
Childrens Services and Social Care	26,057	26,460	403
Operations	16,300	16,060	(240)
Other CCG & Council Services	28,380	30,557	2,178
Total Aligned Expenditure	**150,871**	**153,161**	**2,290**
Contributions	**(150,871)**	**(150,871)**	**0**
Aligned Budget	**0**	**2,290**	**2,290**



3.8 The vast majority of the over spend is driven by Other CCG & Council services and this is predominantly the under achievement of savings schemes in both 2021/22 and those brought forward from 2020/21. There is also an overspend of £0.4m in Children's Services and Social Care which is due to overspends on secure placements

(£0.7m) and additional agency costs for social workers (£0.5m), offset by debt recovery (£0.1m), vacancies (£0.1m), changes in fostering and care leaver placements (£0.2m) and use of reserves (£0.4m) to leave the current forecast overspend.

3.9 The In View budget is underspent by £0.5m and this is driven by prior year benefits in the Delegated Primary Care budget .

Service area	21/22 Budget £'000	21/22 Forecast £'000	21/22 Variance £'000
Delegated GP services	30,205	29,755	(450)
Other CCG & Council Services	10,032	10,003	(28)
Total In-View Expenditure	**40,237**	**39,758**	**(479)**
Contributions	**(40,237)**	**(40,237)**	**0**
In-View Budget	**0**	**(479)**	**(479)**

4 Integrated Funds, the ICS and Locality Reporting in 2022/23 and beyond

4.1 The architecture of the NHS changes at 31st March 2022, with the dissolution of CCGs and the creation of Integrated Care Systems. This removes the commissioner provider split and creates a statutory body at GM level and with this certain areas of work will be managed at GM level and certain areas will be delegated for management at locality level. This is still embryonic and whilst draft guidance is available, final guidance is not available as the bill is yet to have it's final reading in parliament and pass in to law. Northern Care Alliance (NCA) footprint Chief Finance Officers have drafted how they believe budget management will fall between GM and locality, based upon the current draft guidance. This is attached as Appendix 1 for information, further work is required to resolve differences between localities and this will need to be revisited once the final guidance is published

4.2 The use of the pooling arrangements within the section 75 and the reporting of aligned and in view budget, allows the locality to see the totality of performance versus budgets and support delivery of both financial balance and other strategic priorities, across all partners. The continuation of this is a key priority for 2022/23 and beyond, as it is only through system working and locality reporting that we will be able to deliver on financial balance and strategic priorities, including the Bury 2030 commitments. Through the Strategic Finance Group local partners are discussing how the delivery of a Bury Locality position is possible in 2022/23.

4.3 Aligned to this desire to continue working and reporting in an integrated way there is also a piece of work taking place across GM, which is attached as Appendix 2, that is currently progressing through existing GM governance. This paper recommends the minimum pooled budget would be the expenditure within the Better Care Fund (BCF) and the maximum would be everything that is legally permitted to be pooled.

4 Actions Required

4.1 The Strategic Commissioning Board is asked to :-

- Note system partners financial position in 2021/22 and the reliance upon non recurrent measures and savings to achieve break even.
- Note the current £1.9m overspend on the Integrated Care Fund at month 7.
- Note the Bury Integrated Care Fund, in the context of the changing NHS architecture and the work to continue locality reporting from April 2022.
- Note the work across both the NCA footprint and GM with regard to locality budgets, pooling and section 75 arrangements in 2022/23 and the latest outputs of this work.

Simon O'Hare
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November 2021

Appendix 1 – Initial Decision Making Locality vs GM Estimate

Locality	Total Budget	GM		Local	
	£m	%	£m	%	£m
Bury	£344.5	40%	£138.4	60%	£206.1
Oldham	£456.5	24%	£86.1	76%	£370.4
Salford	£503.7	67%	£339.5	33%	£164.2
HMR	£400.8	53%	£214.3	47%	£186.5
TOTAL	**£1,705.5**	**46%**	**£778.3**	**54%**	**£927.2**

The significant areas of difference are around the treatment of Urgent Care and Planned Care and the level of detail that has been used to split between GM and Locality.

This table has been completed based upon returns by the above localities as to their understanding of where decision making responsibility will lie in 2022/23. Decision making responsibility is different to how funding will flow, as the majority of funding to NHS providers will flow direct from the GM ICB / ICS, as there will not be a statutory local non provider NHS organisation for this money to flow through.

This is an initial version and each localities view and differences of approach are evident within this table. Once there is finalised national guidance, a revised version will be produced and shared. The significant current differences between localities is on how Urgent Care and Planned Care have been treated and costs allocated to GM or locality.

Appendix 2

Approach to the Adoption of Section 75 Agreements for Place Based Partnerships by the Greater Manchester Integrated Care Board

Introduction

Following the report presented to the Finance Advisory Committee (FAC) on 14 September 2021, it was agreed that a formal Section 75 Working Group would be established to:

- Identify current issues arising from the existing blend of arrangements, and conflicts with emergent Integrated Care System (ICS) design.
- Look at best practice and how this can be incorporated.
- Recommend solutions to the Finance Advisory Committee.
- Act as a link between the ICS Governance workstream, as the two areas of work are closely related.

The Working Group held its first meeting on 19 October 2021. It was agreed that the initial step would be to ascertain what current arrangements were already in place, and with the time available before the establishment of the ICS on 1 April 2022, consider the options available to ensure the safe transition of these arrangements into the new system.

This report sets out the background as well as some key considerations, before setting out an options appraisal on how best to transfer or transition these S75 agreements into the Integrated Care Board (ICB).

Background

The arrangements in each of the 10 Localities have different historical roots and have been shaped by different needs, relationships and sets of organisations. In some localities there are long-standing arrangements which have grown slowly and now encompass the maximum permissible range of NHS services and budgets, and a wide range of associated Local Authority functions.

In other cases, the arrangements have grown from the Better Care Fund over the more recent past, but are now a central part of the conversation and seen as key to integrated working.

In all localities the Section 75 arrangements are a potent symbol of the integrated working arrangements. This symbolism is sometimes in contrast to the practical successes that have, to date, been achieved through the pooling of budgets. In reviewing the current arrangements and what changes will be required to implement the new legislation we will need to:

- Ensure that we protect the integration achieved in localities.
- Ensure that the trust and relationship on which local integration is built are maintained through the move to an ICS; and

- Ensure that changes made to the legal documentation and financial arrangements do not undo that relationship-led integration.

Key Considerations

NHS England Guidance

In assessing the way forward, the most up to date guidance published by NHSE has been reviewed. It is worth noting at this stage the guidance remains very high level and open to interpretation.

Baseline Assessment

A detailed review of each of the S75 agreements was undertaken. The following areas were identified as key to enable a better understanding of the existing arrangements in order to determine the best way forward.

- Host partner
- Pooled budget value
- Flow of funds
- Expiry date for existing agreement
- Notice period required to terminate the agreement
- Notice period required for variation to the agreement
- Approach to financial risk management
- Governance and decision making point for the agreement
- VAT
- Adjacent agreements

The detailed findings of the base line assessment are presented in Appendix 1.

The key issues identified were as follows:

- The Host partner was not always identifiable in all circumstances.
- Notice to terminate the agreements varies from 3 months to 12 months.
- Tameside and Glossop CCG have served notice on their S75 agreement, therefore there will need to be an interim arrangement put into place from the 1st April 2022 for the Tameside locality which will remain the responsibility of the GM ICS.
- Financial risk share arrangements are not clear in all circumstances.
- The value of the 'Pool Budget' is not clear as this is conflated with aligned and in view budgets.
- In the main not all the 'Pooled Budgets' are formally pooled i.e. each partner manages its own income and expenditure.
- There is considerable variation in the level of services that are included under the current S75 arrangements. This ranges from the minimum requirement of the Better Care Fund to the maximum array of permissible services.
- A number of adjacent agreements have also been identified for certain localities, which will need to be considered in any future arrangements that are agreed on a PBP basis.

Legal Opinion

Legal opinion was also obtained to help understand the implications of the pending legislation and the interpretation of the guidance published to date. This advice can be divided into two categories the first with regards to the current S75 agreements and the second, in respect of ICB governance arrangements for the delegation of and / or joint exercise of ICB functions under the NHS Health Care Act 2006 and the pending proposed legislation. The legal guidance received in respect of the second point can be found in Appendix 2.

Current S75 Arrangements

Advice received in respect of the current S75 agreements is that these will automatically novate to the successor body the ICB on the 1st April 2022. A root and branch review of existing agreements has not been advocated. Where further legal assurance is required this is done a specific basis.

Future ICB Delegated Arrangements

The legal advice provided is subject to the proposed legislation being finalised. The advice outlines the potential options for the ICB to delegate its functions and also those functions delegated to it, overcoming the historical problem of double delegation. The complexities around the different forms of delegation are explored and the various aspects that would need to be considered.

In summary the legal advice is complex and there are a number of options that would be available for the delegation of ICB functions. However, given that the legislation has yet to be approved and may be subject to further amendments, a clear way forward cannot be determined. Even once the final Health Care bill has been passed it would take some time to digest the implications and then decide on the best way forward for the GM ICS. This reality has consequently been reflected in the options appraisal outlined below.

Options Appraisal

Option 1 - Adopt existing Section 75 agreements.

The first option is that all existing arrangements novate into the new system on 1 April 2022, with the ICB taking on responsibility for the existing S75s held by CCGs.

Advantages

- Current arrangements are already in place and can legally be adopted by the ICB (assuming current legislation (or proposed legislation) does not change).
- Allows the capacity that would be used on amending existing arrangements to be used for other more urgent matters relating to CCG closedown, ICB setup and transition.

- Allows time for legislation to be passed and spatial levels to be agreed, providing a clearer picture of how to implement a model framework for S75 agreements (and/or other flexibilities) across the ICS footprint.

Disadvantages

- Current S75 agreements could be at odds with agreed spatial level work (once agreed) / legislation.
- Potentially complex governance arrangements for all the agreements in place post 1 April 2022, with the ICB managing a number of different S75 arrangements in different ways.
- No guarantee there would be sufficient capacity in the initial months of the transition into the ICB to create a model framework for S75 agreements (and/or other flexibilities).
- Potential loss of expertise and corporate memory within CCGs if key members of staff leave due to uncertainty in lead up and transition into ICB arrangements, meaning review and change of current S75 agreements could be more difficult.
- S75 agreements not formally agreed between ICB and PBPs, so less legal footing / ownership and potential for less buy in / partnership working.
- Variation in S75 agreements already in place across the ICS footprint, which could result in unwanted variation of how services are delivered across the footprint going into 1 April 2022.

Option 2 – Agree model framework Section 75 agreements (and/or other flexibilities) to be adopted by all Place Based Partnerships (PBP) prior to 31st March 2022.

The second option is to agree a model framework for S75 agreements (and/or other flexibilities) across the ICS, and for each of the relevant agreements to be amended, approved and adopted to fit within this framework by each PBP in advance of the ICB's creation on 1 April 2022.

Advantages

- Having an agreed model framework would ensure clarity and consistency across the ICS footprint, providing clear governance and potentially reducing variation.
- By doing this now, this would reduce the risk of losing the relevant expertise, knowledge and corporate memory required for amending any S75 agreements.
- By doing this now, this would free up capacity for transition and transformation work post 1 April 2022.

Disadvantages

- Spatial levels yet to be determined, making it difficult to agree model framework at this stage.
- Lack of dedicated capacity at shadow ICB level to create a model framework for a S75 agreement (and/or other flexibilities) at this time.

- Capacity at local level stretched with closedown / transition and BAU work, meaning it would be difficult to review and amend any agreements to fit into a new framework.
- Lack of time to take agreements through the relevant CCG and shadow PBP / ICB governance structures before 1 April 2022.
- Some agreements have notice periods for termination which would go beyond the 31 March 2022 deadline.
- Legislation still not formally passed – although it is not likely to happen, but any changes to the proposed legislation could undo any work already done on agreeing a model framework.

Option 3 – Agree model framework Section 75 agreements (and/or other flexibilities) to be adopted by all PBPs with back stop date of 30 September 2022.

The third option is to agree a model framework for S75 agreements (and/or other flexibilities) across the ICS, and for each of the relevant agreements to be amended, approved and adopted to fit this framework by the ICB and each PBP by an agreed backstop date of 30 September 2022.

Advantages

- Having an agreed model framework would ensure clarity and consistency across the ICS footprint, providing clear governance and potentially reducing variation.
- By not having the 31 March 2022 deadline (and having in its place an agreed backstop date), this would allow CCGs and / or PBPs to amend their agreements at their own pace, determined by their own planning and available resources.
- Process would be incremental, which would enable those PBPs who progress with the process sooner to share the relevant learning with other localities.
- An incremental approach would also reduce the pressure on the ICB and its governance structures if it did not need to approve all agreements 'en masse'.
- The agreed backstop date will ensure all S75 agreements (and/or other flexibilities) fit within the agreed model framework by 1 October 2022.

Disadvantages

- Spatial levels yet to be determined, making it difficult to agree model framework at this stage.
- Lack of dedicated capacity to create a model framework for S75 agreements (and/or other flexibilities) at this time.
- Legislation still not formally passed – although not likely to happen, but any changes to the proposed legislation could undo any work already done on agreeing a model framework.
- Variable governance structures will be in place across the 10 localities, making it challenging for the ICB to bring all agreements in line with the agreed model framework.

Option 4 – Adopt all existing Section 75 agreements, but with some harmonisation.

The fourth option is that all existing arrangements novate into the new system with the ICB taking on responsibility for the existing S75 agreements held by CCGs, but that the following elements are harmonised (by mutual agreement) / identified prior to 1 April 2022:

- Harmonise termination notice periods.
- Identify any existing conflicts between current arrangements and spatial level framework (once agreed).
- Ensure hosting arrangements are in line with the overall GM ICS approach.
- Ensure there is full clarity on the financial risk arrangements in place for each locality and how this risk would be manged by the locality under the new system arrangements.

Advantages

- Current arrangements already in place and can legally be adopted by the ICB (assuming current legislation (or proposed legislation) does not change).
- Allows the capacity that would be used on extensively amending existing arrangements to be used for other more urgent matters relating to CCG closedown, ICB setup and transition.
- Allows time for legislation to be passed and spatial levels to be agreed, providing a clearer picture of how to implement a model framework for S75 agreements (and/or other flexibilities) across the ICS footprint.
- Financial risk management arrangements will be identified and there will be a clear understanding on the how the locality will contain this risk within the new system without having to be subsidised over and above its allocated financial resources.
- Harmonisation of the termination notice periods will ensure that all existing agreements will need to be amended to adhere to the agreed model framework by the agreed backstop date.
- Identification of any existing conflicts between the current arrangements and the spatial level framework will help the system understand how these could potentially be managed.
- Hosting arrangements will be consistent across the ICS footprint.

Disadvantages

- Current S75 agreements could be at odds with agreed spatial level work (once agreed) / legislation.
- Potentially complex governance arrangements for all the agreements in place post 1 April 2022, with the ICB managing a number of different S75 arrangements in different ways.
- Capacity required to conduct harmonisation, and tight timescales for getting these agreed via the local governance structures.
- Potential loss of expertise and corporate memory within CCGs if key members of staff leave due to uncertainty in lead up to and transition into the ICB arrangements, meaning review and change of current S75 agreements could be more difficult.

- S75 agreements not formally agreed between ICB and PBPs, so less legal footing / ownership and potential for less buy in / partnership working.
- Variation in S75 agreements already in place across the ICS footprint, which could result in unwanted variation of how services are delivered across the footprint going into 1 April 2022.

Option 5 – Adopt a 'minimum legal requirement' approach.

The fifth option is to pursue a 'minimum legal requirement' approach, with all Section 75 agreements to be amended to include the Better Care Fund (BCF) and Improved Better Care Fund (IBCF) elements only.

Advantages

- This option would ensure harmonisation of agreements across the ICB footprint, providing clearer governance, reducing variation, and reducing the risk to the ICB of taking these on.

Disadvantages

- This approach would be contrary to the objectives and the spirit in which the ICS legislation is hoped to be implemented, which is to:
    - Ensure that we protect the integration achieved in localities.
    - Ensure that the trust and relationship on which local integration is built are maintained through the move to an ICS; and
    - Ensure that changes made to the legal documentation and financial arrangements do not undo that relationship-led integration

Recommendation

The Finance Advisory Committee are recommended to:

1. Approve Option 4, which is to adopt all existing Section 75 agreements but with some harmonisation (as set out in the report), with a view to implementing Option 3, agree model framework Section 75 agreements (and/or other flexibilities) to be adopted by all PBPs with a back stop date of 30 September 2022, once legislation has been formally passed and the spatial level framework agreed.

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NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Receive
Item No.	10a	**Confidential**	No
Title	Performance Report		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The CCG, alongside other CCGs in Greater Manchester (GM), has challenges in achieving the national Constitutional Standards in a number of key areas. This report sets out the current position against a number of the main CCG Performance Indicators along with an overview of the impact to these during the current response to the COVID-19 pandemic. A further, more detailed, report setting out the position on all the indicators is presented to the Quality and Performance sub-committee on a monthly basis and to the Governing Body every two months.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives this performance update, noting the areas of challenge and action being taken.

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

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

Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

Introduction

1.1. The purpose of this report is to provide an overview of performance in the key areas of urgent, elective, cancer and childrens and adults mental health care along with an overview of the impact of the COVID-19 response to these areas as the locality moves through the COVID recovery phases.

2. Background

2.1. This paper is a summary of the information prepared for the CCG's Quality and Performance Committee in November 2021 which related to the published position as at August 2021. However, where later data has since been published, this too is referenced within the report.

2.2. A summary of NHS Bury CCG's performance against key NHS Constitution standards is shown at Appendix A and this includes a comparison with the GM, North West and England averages. The period to which the data relates is included for each metric. This varies across the metrics due to data being published at different times and to some data collections having been paused as part of the COVID-19 response.

3. NHS System Oversight Framework

3.1 The NHS System Oversight Framework (NHS SOF) was implemented during 2021-22. Data is published in a national dashboard and a summary of performance against key metrics will be presented to relevant Committees on a quarterly basis. Under the NHS SOF, assurance visits to localities are expected to take place on a periodic basis.

4. Constitutional Standards and COVID-19 Impact Review

COVID-19 Update

4.1 Following several weeks of increasing case numbers, the latest weekly data shows a decrease. Higher case numbers related primarily to school-aged children following the new term start in September with subsequent household transmission also a factor. If the most recent reduction relates to fewer children mixing during the half-term break in October then there could be a further increase in the coming weeks.

4.2 There has also been an increase in the number of COVID-19 positive inpatient at the Fairfield General Hospital (FGH) site. The number started to increase from mid-June and reached a peak of 49 on 2nd November though has reduced in recent days and stands at 23 at 15th November. Peaks during previous waves were 132 in November 2020 and 79 in January 2021.

4.3 Operational planning for the period October 2021 to March 2022 (H2) has recently concluded and a separate paper outlining NHS Bury CCG's plan has been prepared for this Board.

Planned (Elective) Care

4.4 In terms of the waiting list position, there were 23993 incomplete pathways at the end of September and this marks a 27.3% (5140 pathways) increase in waiting list size

when compared to March 2021. The target now across the H2 period is to stabilise the waiting list at the September 2021 level.

4.5 In the Year to Date (YTD) to September, the most significant increases have occurred in Ear Nose and Throat (ENT) (+66%), ophthalmology (+52%), dermatology (+46%) and cardiology (+89%). Although the waiting list for gastroenterology remains significant, there was some improvement during September.

4.6 Despite the waiting list growth referenced above, the number of 52+ week waits remained very similar to the August position, standing at 1190 in September and representing a 30% (-507 pathways) reduction when compared to March 2021. The biggest specialty decrease remains in orthopaedics where there has been a 45% decrease (-166 pathways) during this period.

4.7 Despite the reduction in the 52+ week waiting list, September saw a further increase in the number of pathways exceeding 104+ weeks with most attributed to general surgery, ENT and gynaecology. For the first time, September saw such breaches in orthopaedics too. A requirement of H2 planning is to eliminate 104+ week waits though the Northern Care Alliance (NCA) plan shows such waits remaining at year-end. The impact of this for Bury patients will be reviewed.

4.8 The CCG continues to work with system-wide partners through the Elective Care Recovery and Transformation Group to progress the development and implementation of a transformation plan for elective care with focus initially on orthopaedics. Linked to this, the GM While You Wait framework was launched in Bury on 11th October alongside the Bury-specific information via the Bury Directory, with dedicated Orthopaedics information currently being finalised. The GM specialty specific resources will focus initially on children's surgery, orthopaedics and gastroenterology.

4.9 This work complements the efficiencies work being undertaken by the NCA that includes waiting list validation and maximising theatre utilisation. The NCA is also embarking on a consolidation programme split into four areas: Being Well, Deciding Well, Waiting Well and Recovering Well. The Deciding Well programme is being led by the Bury Care Organisation (BCO) and this includes the expansion of Specialist Advice for which an H2 target has been set of there being 12 specialist advice requests for every 100 first outpatient attendances. A task and finish group has been established to take this forward that ensures primary care engagement too.

4.10 A new Elective and Cancer Care Recovery and Reform Programme Board is currently being established in Bury and this will result in a single integrated plan being put in place across the locality to take all developments forward.

4.11 With regards to diagnostics, performance has deteriorated for Bury patients across recent months with the latest data for September showing 40.6% of patients waiting longer than six weeks to be seen, against a target of <1.0%. There remains a significant variance between Bury and Pennine Acute Hospital Trust (PAHT) performance and that of both GM and England, though the variance has stabilised in recent months.

4.12 Significant diagnostics pressures remain at the NCA, particularly in endoscopy and echocardiography. The GM modular endoscopy unit remains in situ at the FGH site with a proposal to extend the facility until the end of the financial year supported by the GM Elective Care Recovery and Reform Programme Board in October. The Board

set a requirement for utilisation to be maximised and for trusts to plan replacing this capacity from April 2022 onwards.

4.13 Planning for the Community Diagnostic Hub (CDH) programme continues with the NCA business case having been submitted for inclusion as part of the GM-wide strategy. Alongside the CDH scheme, work to develop a diagnostics strategy for the Bury locality continues also.

Cancer Care

4.14 Suspected cancer referrals (2WW) in Bury in the YTD to September remain higher than in the same period of 2019-20 (+27.8%). Variation between tumour groups remains with the most marked increase in this period noted for gastroenterology (+105%) whilst the most significant decrease in this period can be seen in lung (-12%).

4.15 That said, the operational plan for April to September 2021 (H1) set an expectation for additional outpatient capacity to be put in place to manage the shortfall seen in 2020-21 but to the end of August, there were 13% fewer Bury patients seen than had been planned.

4.16 Due to the impact of Lower GI on cancer waiting lists, an improvement week took place in late-August across GM and is designed to act as a catalyst for change. As with other local reviews, this showed the most significant factor being the time taken to initial diagnosis and this therefore is the focus of improvement plans.

4.17 Although the priorities in H2 remain the same as in H1, a particular focus is to be placed on ensuring that all available capacity is maximised, including via hub models and the independent sector, ensure sufficient diagnostic and treatment capacity to meet increased referral levels and to accelerate the development of Rapid Diagnostic Centre (RDC) pathways for those pathways most challenged by COVID-19.

4.18 In terms of performance against the NHS Constitution standards, the Quarter 2 outturn shows a slight improvement when compared to Quarter 1 with a slightly lower number of breaches noted. For the main 62-day wait standard following a GP referral, however, Quarter 2 performance was below that of Quarter 1 though improvement is evident in September data.

4.19 2WW performance continues to be affected primarily by dermatology where ongoing pressure is evident, not only at the NCA but also across GM with two Consultants recently retired at Wrightington Wigan and Leigh (WWL) FT. Referrals for Bury patients had settled during Quarter 1 to the 2019 level though referrals in Quarter 2 were 24.8% higher than in the same period of 2019. The NCA continues to progress the specialty level improvement plan which includes future expansion of one-stop clinics and the implementation of a 2WW dermatology Referral Assessment Service (RAS) pilot which went live during October 2021 for Salford GPs and which will be rolled out to Bury and other localities in the near future.

Urgent Care

4.20 H2 planning guidance sets an overarching requirement to transform community and urgent and emergency care to prevent inappropriate attendances at emergency

departments (ED), improve timely admission and reduce length of stay. To support this, post-discharge recovery placements will continue to be funded for up to four weeks for the remainder of the financial year.

4.21 At PAHT, performance in September remained below target for the 4 hour wait standard though reduced performance is reflected across other GM adult sites too. When looking at all A&E activity, PAHT had the second worst performance in GM in Quarter 2. However, when considering Type 1 activity only, the FGH site remains amongst the best performing in GM.

4.22 A&E attendance figures at FGH remain just below the level seen in 2019-20 though the aggregate trust position shows a slight increase due to activity levels at the Royal Oldham hospital site. The FGH position, however, is in the context of ED streaming and other deflection schemes being in place without which there would have been a significant increase in attendances during 2021-22.

4.23 Following the visit to FGH by the NHS Emergency Care Improvement Support Team (ECIST) during September, a programme of work is being developed that complements existing schemes and which will be incorporated into the overall improvement plan. Subsequent to the ECIST feedback, ten task and finish groups have been established which sit under Site Management, Discharge Processes and Ward Routines. Progress will be reported into the regular implementation group meeting with updates provided to the monthly Bury-locality Urgent and Emergency Care Board.

4.24 A dip in performance for stranded and super-stranded measures (length of stay of 14 or more and 21 or more days, respectively) is noted with the NCA having the highest proportion of each in GM in Quarter 3 to mid-November. This is in the context of both the FGH and Salford Royal sites having clinical pathways that necessitate longer stays.

4.25 Urgent care issues over recent months are reflected in deteriorated ambulance performance in terms of both response times and the number of handover delays. Such increased pressure is reflected nationally too.

4.26 Winter planning remains ongoing in Bury with a winter sub-group established and all required actions to date complete. An operational plan to cover the Christmas and new year period will be completed during early December once staffing and on-call arrangements across the borough are confirmed.

4.27 Officers from Bury's Integrated Delivery Collaborative team working with CCG colleagues and others continue to lead the implementation of the urgent care redesign programme. A potential new-build Urgent Treatment Centre (UTC) is not included in capital plans at NCA for this year. Over recent months, however, the existing facility has been expanded and now has a robust waiting area and several clinic rooms. During Quarter 3, the UTC at the FGH site will undergo formal assessment for UTC accreditation and work will continue to resolve the current digital issues. Although it is likely the unit will receive the required accreditation, retention of the existing space would act as a barrier to the Bury ambition in terms of expansion for community pathways.

Maternity and Childrens Performance Measures

4.28 Pressures reported previously by Pennine Care Foundation Trust (PCFT) continue and business continuity arrangements remain in place. Within the child and adolescent mental health service (CAMHS), there is a national shortage of inpatient beds and this is resulting in longer waits for those requiring admission. PCFT also reports an increase in staff absence contributing to the pressures. Referrals into the HYM service continue to be significantly higher in 2021-22 than in 2019-20 (approximately 50% higher to September).

4.29 Recruitment to newly CCG funded posts within the PCFT Tier 2 service is underway and the service expects to be at full staffing establishment by January 2022, subject to recruitment progressing as planned.

4.30 The Strategic Commissioning Board (SCB) in September had also approved funding for additional third sector posts with November start dates having been agreed for new recruits. The additional funding includes community based Emotional Health and Wellbeing practitioners and additional bereavement support.

4.31 Children and Young Peoples (CYP) Access remains strong with a 12-month rolling average of 49.5% against a target of 35%. As in previous years, access across Quarter 1 was very high with lower numbers seen in Quarter 2.

Mental Health

4.32 The dementia diagnosis standard continues to be achieved for Bury patients and the re-establishment of the GP-led Cognitive Impairment Model is complete with associated training to primary care colleagues having been delivered too. PCFT performance for the assessment of patients in the memory assessment service deteriorated during the period of increased referrals and this will continue to be below the standard until the backlog is cleared.

4.33 The Early Intervention in Psychosis (EIP) standard also continues to be fairly consistently achieved though PCFT has highlighted pressures within the service which may impact on performance in future months. Future developments around EIP services to ensure compliance with the Long Term Plan include ensuring that NICE concordant packages of care can be delivered and this will require recruitment to specific roles.

4.34 As referenced in the above section of this report, business continuity arrangements remain in place at PCFT and relate mainly to increased demand and staff absence. Pressure is reported most acutely around inpatient services though some community services are affected too, particularly by increased staff absence.

4.35 Recruitment is underway to the additional Community Mental Health Team (CMHT) posts approved by the SCB in September is underway as is recruitment to new Mental Health Practitioner posts as part of the Additional Roles Reimbursement Scheme (ARRS). There will be one such post in each of Bury's five Integrated Neighbourhood Teams.

4.36 There have been positive interim evaluation reports of both the PCFT Urgent and Emergency Care by Appointment (UECA) assessment service and the Bury Involvement Group (BIG) peer-led community crisis service. Each of these services is

in place for an initial 12 months and papers are currently being prepared with a view to securing funding to allow ongoing commissioning.

4.37 With regard to the Improving Access to Psychological Therapies (IAPT) measures, indicative Quarter 2 data (to August) shows a continuing pattern with the IAPT Recovery standard expected to achieve whilst under-performance continues for the access and waiting times standards. Within the Bury locality, regular system meetings continue with PCFT to review and progress IAPT developments, including a review of the current significant waiting lists. A briefing paper is currently in development to consider options to address the current waiting list and pathway redesign.

5. Actions Required

5.1 The audience of this report is asked to:

- Receive this report.

Susan Sawbridge
Head of Performance
November 2021

Appendix A: Greater Manchester Constitutional Standards Summary

Measure Name	Standard	Latest Dat	GM	Bury	North West	England
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95.0%	Sep-21	67.4%	64.9%	71.8%	75.2%
A&E 12 Hour Trolley Wait	0	Sep-21	370	250	990	5025
Delayed Transfers of Care - Bed Days *(FAHT)*	200	Feb-20	428	35.1	917.1	5371.8
Delayed Transfers of Care - Bed Days *(PCFT)*				30.1		
Delayed Transfers of Care - Per 100,000	Null	Feb-20	19.2	12.2	15.6	12.4
Stranded Patients (LOS 7+ Days)	2196	Sep-21	2662	291	6645	43762
Super-Stranded Patients (LOS 21+ Days)	Null	Sep-21	1038	96	2657	16022
Referral To Treatment - 18 Weeks	92.0%	Sep-21	60.9%	60.0%	64.9%	66.5%
Referral To Treatment - 52+ Weeks	0	Sep-21	21728	1190	43075	302057
Diagnostics Tests Waiting Times	1.0%	Sep-21	31.8%	40.6%	27.9%	26.1%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	Sep-21	86.5%	77.1%	88.5%	84.1%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	Sep-21	77.9%	50.0%	84.8%	83.7%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	Sep-21	94.6%	95.1%	94.0%	92.6%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	Sep-21	94.1%	94.7%	86.3%	83.7%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	Sep-21	99.6%	100.0%	99.3%	98.9%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	Sep-21	99.7%	100.0%	99.9%	95.0%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	Sep-21	69.5%	64.5%	70.2%	68.0%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90.0%	Sep-21	66.7%	66.7%	63.2%	70.8%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	Sep-21	75.5%	72.4%	77.8%	78.2%
Cancer - 104-Day Wait	0.0%	Sep-21	53	6	151	3156
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Mar-21	60.6%	71.8%	59.4%	61.4%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Mar-21	68.5%	71.2%	70.0%	70.7%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Jul-21	68.8%	71.4%	70.1%	69.1%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Jul-21	74.2%	74.5%	74.2%	75.1%
MRSA	0.0%	Sep-21	6	0	8	53
E.Coli	Null	Sep-21	152	9	366	3221
Estimated Diagnosis Rate for People with Dementia	66.7%	Sep-21	68.5%	74.1%	66.1%	62.0%
Improving Access to Psychological Therapies Access Rate	5.3%	Aug-21	4.85%	2.78%	4.24%	5.02%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Aug-21	48.4%	51.7%	49.0%	50.8%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Aug-21	81.0%	39.3%	85.4%	91.8%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Aug-21	98.8%	89.3%	98.1%	98.8%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Aug-21	80.0%	79.0%	42.2%	62.4%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Aug-21	94.3%	100.0%	87.9%	59.7%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Aug-21	92.3%	93.9%	65.2%	62.3%
Access Rate to Children and Young People's Mental Health Services	34.0%	Aug-21	48.3%	49.4%		
CPA follow up within 7 days	95.0%	Dec-19	96.2%	98.1%	96.6%	95.5%
Mixed Sex Accommodation	0.0%	Feb-20	1.9	1.5	1.3	3.00
Cancelled Operations	Null	Dec-19	1.7%	2.0%	1.3%	1.1%
Ambulance: Category 1 Average Response Time	420	Sep-21	08:09	08:50	09:12	09:01
Ambulance: Category 1 90th Percentile	900	Sep-21	13:17	14:16	15:35	15:56
Ambulance: Category 2 Average Response Time	1080	Sep-21	55:18	56:20	57:12	45:30
Ambulance: Category 2 90th Percentile	2400	Sep-21	1:56:44	1:54:00	2:06:26	01:38:03
Ambulance: Handover Delays (>60 Mins)	Null	Sep-21	5.5%	9.3%	4.5%	7.0%
Cancer Patient Experience	Null	Apr-18	8.88	8.72	8.87	8.80
General Practice Extended Access	Null	Mar-19	100.0%	100.0%		

As per GM Tableau on 09/11/2021. Assurance>Greater Mancheser Constitutional Standards Summary/Constitutional Standards Summary

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NHS
Bury
Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	06 December 2021	**Action**	Receive
Item No.	10b	**Confidential**	No
Title	2021-22 H2 Plan Update		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

As part of the NHS planning process, the CCG formulates an activity and performance plan. This is submitted to the Greater Manchester Health and Social Care Partnership (GMHSCP) which combines submissions from all GM commissioners and providers into a single GM system-wide plan.

In 2021-22, the planning process has been split into two parts, the first covering the period April to September 2021 (H1) as reported to this Board during June, and the second covering the period October 2021 to March 2022 (H2). This report relates to the H2 plan.

On this occasion, providers submitted draft plans during October 2021 with final plans being submitted to GMHSCP on 5th November in advance of the national deadline of 16th November. This gap allowed time for GM to analyse plans and request further refinement if this is required.

National guidance requires specific activity and performance levels to be achieved during the year and it is also essential that plans are aligned across GM between providers and CCGs and that each organisation's plan also aligns to the locality finance plan.

In formulating the plan for H2 2021-22, the CCG liaised closely with the Northern Care Alliance (NCA), other North East Sector (NES) CCG colleagues and Bury's own Clinical Leads to ensure plans were as aligned and realistic as possible.

In addition to taking note of the plan content and methodology applied, the SCB is asked to grant retrospective authority to the Executive Director of Strategic Commissioning to approve Bury's H2 plan.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives the updates relating to 2021-22 planning contained within this report; and
- Grant retrospective authority to the Executive Director of Strategic Commissioning to approve the H2 plan.

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

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐
Have any departments/organisations who will be affected been consulted?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**

N/A		

1. Introduction

1.1. The purpose of this report is to provide an overview of the content of NHS Bury CCG's activity and performance plan for the period October 2021 to March 2022 (H2).

2. Background

2.1 Each year, NHS organisations are asked to submit operational plans for the next financial year, hereon in referred to as the 'planning round'.

2.2 For 2021-22, planning guidance was split into two periods: April to September 2021 (H1) and October 2021 to March 2022 (H2). The priorities of the H2 guidance remain as per H1:

- Support staff health and wellbeing, taking action on recruitment and retention;
- Deliver the COVID vaccination programme and continue to meet the needs of patients with COVID-19;
- Build on what has been learned to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services;
- Expand primary care capacity to improve access, local health outcomes and address health inequalities;
- Transform community, urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay; and
- Work collaboratively across systems to deliver on these priorities.

2.3 Plan submissions for H2 were at an Integrated Care System (ICS) level with input from both providers and CCGs. Providers submitted data for both point of delivery (POD) activity levels, eg outpatient attendance totals, and performance metrics whilst CCGs were required only to submit plans for a subset of mandatory metrics on this occasion.

2.4 Where necessary, the CCG sought advice and further guidance from GMHSCP to ensure maximum clarity of requirements. Liaison with the NCA, Bury's main acute provider, also took place to ensure alignment, where possible, in plans.

2.5 The CCG plan was submitted to GMHSPC on 5th November in advance of the national deadline of 16th November which was subsequently extended to 17th November. Following submission of the plan, the CCG did not receive any follow-up queries from the GM team.

2.1. The following section of this report summarises the key requirements set out within the H2 planning guidance for each POD. This is followed by a summary of the plan submitted for Bury with further detail included at Appendix A.

3. Key Requirements for H2

3.1 For the elements within this section of the report, acute providers submitted a plan though this was not a requirement for CCGs.

- **Outpatients**

3.2 There is an expectation that 25% of all outpatient attendances will take place remotely, for example via telephone or video.

3.3 For every 100 first outpatient attendances there should be 12 specialist advice requests. This includes pre-referral requests, eg advice and guidance, and post-referral requests such as via a Referral Assessment Service (RAS).

3.4 Patient Initiated Follow-up (PIFU) is to be rolled out across five specialties and 1.5% of outpatient attendances are expected to become PIFU by December 2021, followed by 2% by March 2022.

- **Elective and Cancer Care**

3.5 Providers were asked to focus on several elective specialties that have shown poor levels of recovery in the pandemic period to date. These are neurosurgery, cardiology, cardiac surgery, vascular surgery, neurology and solid organ transplant.

3.6 The overall waiting list size and number of 52+ week waits are expected to be stabilised at the September 2021 position whilst 104+ week waits are expected to be eliminated by March 2022, except where a patient chooses to defer treatment. The NCA plan shows 104+ week waits remaining at the end of the year. The impact of this for Bury patients is currently under review.

3.7 For cancer, there remains a focus in H2 on restoring outpatient and first treatment activity following a suspected cancer referral alongside a requirement to return the number of people waiting more than 62 days for treatment to pre-pandemic levels. There is also an expectation that the 28-day Faster Diagnosis Standard (FDS) is achieved from Quarter 3 onwards.

- **Urgent Care**

3.8 The overarching requirement is to transform community and urgent and emergency care to prevent inappropriate A&E attendances, improve timely admission and reduce length of stay. To support this, the first four weeks of post-discharge recovery funding will continue until 31st March at which point the scheme will end.

3.9 During the H2 period there are requirements for 12-hour A&E waits to be eliminated, for 2-hour community crisis response teams to operate from 8am until 8pm, seven days a week by April 2022, and for the volume and duration of ambulance handover delays to be reduced.

4. NHS Bury CCG's H2 Plan

4.1 For CCGs, the H2 plan consisted of performance and activity trajectories for the remainder of 2021-22 against the measures outlined in the following paragraphs.

- **NHS 111 Referrals to Same Day Emergency Care (SDEC):**

4.2 The aim is to increase the number of referrals from NHS 111 or the GM Clinical Assessment Service (CAS) to SDEC as an alternative to attending an Emergency Department (ED).

4.3 National data is yet to be published for this metric. However, at a GM level there is an expectation in H2 that there will be 55 such referrals per day. The Bury plan was based on a population share (6.5%) of the GM aspiration and this equated to 3.6 referrals per day (107 per month) across the H2 period.

- **Learning Disability Metrics:**

4.4 The target in 2021-22 is for an annual health check (AHC) to be completed for 70% of patients on the GP Learning Disability Register thus creating a target of 782 health checks for Bury based on a register size of 1112.

4.5 In keeping with previous years, the plan has been back-loaded, ie significantly more AHC to be completed in Quarters 3 and 4. This sets a requirement for 198 AHC in Quarter 3 and 470 in Quarter 4. To support this, the CCG's Clinical Lead for Learning Disability services has carried out training events for primary care colleagues around AHC completion and is also engaged with colleagues via learning disability network meetings.

4.6 Plans are also required for the number of CCG-commissioned and NHSE-commissioned learning disability patients occupying inpatient beds.

4.7 During the pandemic, increased demand resulted in the number of both CCG and NHSE-commissioned inpatients exceeding the planned level set under the Long Term Plan (LTP). For CCG-commissioned patients, there had been an increase to five such inpatients by the end of Quarter 2. Discharge planning arrangements are progressing for three of these patients with at least one expected to be discharged early in 2022, thus resulting in a plan of four such admissions in Quarter 4.

4.8 Similarly, for NHS England commissioned patients there had been an increase in admissions during the COVID-19 period. At the start of Quarter 3, there were four such inpatients and this is expected to remain the case for the remainder of the financial year. All four admissions are complex cases for which discharge planning has commenced.

4.9 It is possible that the CCG may receive challenge to the submitted plan for these inpatient numbers though it is noted that they are based on robust local knowledge from within the Continuing Healthcare team which provides case management to such complex cases.

- **Appointments in General Practice:**

4.10 The LTP set a target for there to be 50 million more appointments in general practice by 2024 and the requirement for 2021-22 is for systems to demonstrate restoration to the 2019-20 baseline. The CCG's H2 plan reflects the requirement though there is a caveat in that Ask My GP data is not currently included within published data meaning that 'actual' activity will remain below the planned position until this national issue is resolved. Work is underway in Bury to understand the volume of contacts via Ask My GP so that local monitoring of this can occur.

- **Cancer Activity:**

4.11 There are two elements in 2021-22 H2 for which CCG plans were required. The first, EB30, relates to outpatient appointments following a suspected cancer referral whilst the second, EB31, relates to the number of first treatments required following such a referral. In both cases, the requirement is for activity to be restored to the 2019-20 baseline level in addition to addressing the shortfall of activity seen during 2020-21.

4.12 As CCG performance is heavily dependent upon trust performance, the NCA methodology of applying a 2% increase to the H1 outturn was adopted by the CCG. For EB30, this results in an increase of 16.4% in H2 compared to the same period of 2019-20 and +1.5% for EB31 when comparing the same periods.

5. Conclusion

5.1 The CCG submitted its final H2 2021-22 plan by the GM deadline of 5th November 2021. Where appropriate, the activity plan was aligned as closely as possible with that of the NCA and other North East Sector (NES) CCGs and also received input from CCG Clinical Leads, as appropriate.

5.2 The CCG's plan is largely in keeping with the spirit of the planning guidance. However, as provider plans cover a wider remit, for example POD activity levels and waiting lists, the impact for Bury patients may deviate from the guidance where provider plans

5.3 There was an opportunity for GM to provide feedback to CCGs and providers between the GM deadline of 5th November and the national deadline of 16th November. The CCG plan was not challenged between these dates.

5.4 Ordinarily, planning guidance for the following financial year would be received around December and it is therefore expected that guidance for 2022-23 will be issued soon.

6 Actions Required

6.1 The audience of this report is asked to:

- Receive this report; and
- Provide retrospective authority to Executive Director of Strategic Commissioning to approve the H2 plan.

Susan Sawbridge
Head of Performance
November 2021

Appendix A: Methodology for NHS Bury CCG H2 Plan Calculations

<table>
<tr><td>Urgent and emergency care</td><td>

E.M.28: NHS 111 referrals to SDEC (as an alternative to ED)

Aim: To increase the number of calls to NHS111 that result in a referral to Same Day Emergency Care (SDEC) as an option to attendance at an Emergency Department (ED).

This was a new plan metric in H1 and as data to support this was not available, plan figures were generated by GM for each locality. For Bury, this resulted in an H1 plan of 306 referrals (51 per month).

Data remains unavailable for H2 planning though an update from GM states that 55 SDEC referrals from NHS111 per day are expected across the ICS. As Bury's population is approximately 6.5% of the total GM population, this equates to 3.6 such referrals per day (107 per month). This has been shared with NCA colleagues who confirm that this H2 plan appears realistic. This is based on the fact that the Fairfield General Hospital (FGH) site sees between 15 and 25 SDEC patients per day (approx. 9-15 per day from Bury) and that a proportion of these will be via NHS111 referrals.

NB: Some Bury patients would be referred to SDEC at the North Manchester General Hospital (NMGH) and the 3.6 per day therefore refers to Bury patients across all sites.

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<tr><td rowspan="2">Learning disabilities and autism</td><td>

E.K.1a: Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by CCGs

Aim: To reduce the number of CCG-commissioned adults who have a learning disability and/or autism and who are in inpatient care for a mental disorder.

Under the Long Term Plan (LTP), Bury had a maximum number of 2 CCG commissioned inpatients by the end of each year. However, demand increased during the COVID period and the plan was therefore increased to 3 during 2020-21.

Increased demand has continued and at the start of Q3 2021-22 there are 5 CCG-commissioned inpatients. Plans are progressing for three of these patients with at least one expected to be discharged early in 2022. Individual person specifications are currently being formulated for the remaining two to support discharge planning.

	Q1	Q2	Q3	Q4
CCG Commissioned	3	3	5	4

The H2 plan figures above are subject to no further admissions occurring and have been proposed and agreed by Catherine Jackson, Director of Nursing and Quality Improvement, and Dawn Parker, Lead Nurse for Mental Health and Complex Cases.

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<tr><td>

E.K.1b: Reliance on inpatient care for people with a learning disability and/or autism - Care commissioned by NHS England

Aim: To reduce the number of NHSE-commissioned adults who have a learning disability

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</table>

and/or autism and who are in inpatient care for a mental disorder.

Under the LTP, the number of NHSE Commissioned inpatients was expected to reduce to 2 during 2021-22 though increased to 4 due to increased demand during the COVID period. In line with the H1 plan, there remain 4 NHSE-commissioned inpatients at the mid-year point and feedback from Catherine Jackson, Director of Nursing and Quality Improvement, predicts this will be the case for the remainder of the financial year. All four are complex cases for which discharge planning has commenced.

	Q1	Q2	Q3	Q4
NHSE Commissioned	4	4	4	4

The H2 plan figures above are subject to no further admissions occurring and have been proposed and agreed by Catherine Jackson, Director of Nursing and Quality Improvement, and Dawn Parker, Lead Nurse for Mental Health and Complex Cases.

E.K.3: Learning disability registers and annual health checks delivered by GPs

Aim: To improve uptake of the annual health checks (AHC) in primary care for people with a learning disability in order to help to tackle the causes of morbidity and preventable deaths in people with a learning disability and/or autism.

For 2021-22, the target is for 70% of patients on the GP LD register to receive an AHC. The H1 plan showed 227 patients receiving their AHC, however, actual data shows just under half of this number actually receiving their AHC.

Completion of the AHC tends to be heavily weighted to the latter half of the year, and in particular to Q4, and this was certainly the case in both 2019-20 and 2020-21 (row A below). AHC completion in H1 has been below the planned level and this variance has then been applied to quarters 3 and 4 of H2 to show the annual target being achieved.

Ref		Q1	Q2	Q3	Q4	Total	LD Register size (QOF)	% of LD register
A	2020/21 Actuals	28	65	180	452	**725**	1112	**65.2%**
B	2021/22 Actuals & H2 plan	55	59	198	470	**782**	1112	**70.3%**

The proposed plan has been shared with Nigget Saleem, Medicines Optimisation and Learning Disabilities Clinical Lead, who confirmed agreement to submit the above figures whilst acknowledging that they (particularly Q4) are very optimistic. Nigget is in the process of delivering training on health checks (two undertaken in October and more scheduled for November) and plans to join a couple of networks during their LD QOF meetings with the aim of helping to boost the number of health checks undertaken.

NB: Population figure of 1112 is taken from the non-functional template. Had previously taken 1146 from QOF files. Amended Q4 plan figure to reflect lower population estimate.

Primary Care

E.D.19: Appointments in general practice

Aim: Under the LTP, the national aim is to provide 50 million more appointments in general practice by 2024.

The CCG's plan for 2021-22 shows restoration to the 2019-20 level. However, as General Practice contacts generated through the AskMyGP software are not currently captured within the published appointment data, this will have an impact on the actual activity reported in 2021-22 in advance of this being resolved.

As expected, actual data for H1 shows activity below the planned level due to AskMyGP appointments not currently being included. The proposal therefore is to retain the original plan figures for H2 which shows restoration to the 2019-20 level.

E.D.19: Planned number of General Practice appointments			Apr 2019-Feb 2020	Apr 2021-Mar 2022	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
E.D.19 (H1)	Count	Planned number of General Practice appointments	1142785	1234548	97593	92713	107352	107352	102472	107352	102472	107352	102472	97593	97593	112232
E.D.19 (H2)	Count	Planned number of General Practice appointments	1142785	1067687	65217	57716	74989	68685	64814	107352	102472	107352	102472	97593	97593	112232

NB: Baseline figures are reached by following the calculation provided to account for those practices for which there is no reported data. There is a national programme of work underway to increase the quality and completeness of this data.

Cancer

E.B.30: Urgent cancer referrals
E.B.31: Cancer treatment volumes

Aim: to accelerate the restoration of cancer care by delivering sufficient outpatient and treatment capacity to return to 2019-20 levels with additional activity planned to meet the shortfall experienced during the pandemic.

In H1 planning, the Northern Care Alliance (NCA) shared its methodology and this was reflected in the CCG plan. The calculated shortfall was applied in equal 1/12 across the year. Actual activity during the H1 period was below the planned level for both metrics and the initial proposal was to retain the original plan figures and reapportion activity across the remaining months, with seasonal adjustment applied, as per feedback from Dr Liane Harris, CCG Clinical Lead for cancer.

However, NCA methodology for H2 has since been shared and in order to achieve alignment, the CCG proposed plan has been amended.

The NCA has confirmed that for each measure, it is applying a 2% increase to their H1 outturn. The impact of applying this methodology to the CCG's H1 data is:

- EB30: Urgent Cancer Referrals: this delivers activity above the 2019-20 baseline (+16.4% in H2 and +9.6% across the financial year) and ensures alignment with NCA methodology.
- EB31: Cancer Treatment Volumes: this delivers activity a little below the 2019-20 baseline for H2 (-2.5%) though +1.5% across the financial year and ensures alignment with NCA methodology.

Row 2 of each table below shows the proposed CCG plan based on alignment with the NCA methodology and with newly available 'actuals' for September taken into account.

E.B.30: Urgent Cancer Referrals (first outpatient appointments)			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
E.B.30 (H2 Plan NCA methodology applied)	Count	All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	819	858	819	780	780	897	4953
E.B.30 (19/20 Actual)	Count	All patients urgently referred with suspected cancer by any source of referral excluding from a National Screening Programme who received a first outpatient appointment in the given month.	780	789	682	664	676	663	4254

E.B.31: Cancer Treatment Volumes			Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
E.B.31 (H2 Plan NCA methodology applied)	Count	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).	93	98	93	89	89	102	564
E.B.31 (19/20 Actual)	Count	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).	112	102	84	91	74	113	576