Chair: Dr C Munro
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NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group Governing Body
Public
11 August 2021
A G E N D A

The next meeting of the NHS Stockport Clinical Commissioning Group Governing Body will be held virtually via Microsoft Teams at 10:00am.

	Agenda item	Report	Action	Lead	Time
1	Apologies		To Note	Chair	10:00
2	Notification of items for AOB		To Note		
3	Declarations of Interest		To Note		
4	Minutes of the meeting held on 16 June 2021	Attached	To Approve		
5	Actions arising	Attached	For Assurance		
STANDING ITEMS					
6	Report of the Chair	Verbal	For Assurance	C Munro	10:05
7	Report of the Chief Accountable Officer	Verbal	For Assurance	A Green	10:15
STRATEGIC ITEMS					
8	Greater Manchester Public Services - Race Commitment for Change 2021	Attached	To Approve	A Green	10:30
GOVERNANCE					
9	Greater Manchester Choice and Equity Policy (CHC)	Attached	For Assurance	A Rolfe	10:45
10	Governing Body Assurance Framework – Quarter 1 Review 2021/22	Attached	For Assurance	P Lewis-Grundy	10:55
PERFORMANCE					
11	Finance Report (including Procurement)	Attached	For Assurance	M Cullen	11:05
12	Integrated Performance and Delivery Report Month	Attached	For Assurance	L McLean	11:20
FOR INFORMATION					
13	Report from Committees: a. Audit Committee report for the period to August 2021	Attached	For Assurance	P Winrow	11:40
	b. Primary Care Commissioning Committee	N/A	For Assurance	P Riley	

Quoracy: a minimum of one third of the total membership of the Governing Body (4), of which there should be at least: the Accountable Officer or the Chief Financial Officer, a Lay Member; and two General Practice Representatives (Of which at least one must be a GP)

	report – N/A c. Finance, Performance and Delivery Committee report for the period to August 2021 d. Planning & Commissioning Committee report for the period to August 2021 e. Quality and Governance Committee report for the period to August 2021	 Attached Attached Attached	 For Assurance For Assurance For Assurance	 P Riley P Winrow J Jolly	
14	Any Other Business		To Note	C Munro	11:50
15	Questions from Members of the Public		To Respond	C Munro	11:55
DATE, TIME AND VENUE OF NEXT MEETING					
The next NHS Stockport Clinical Commissioning Group Governing Body (public) meeting will be held on: **Wednesday 13 October 2021** Potential agenda items should be notified to eve.anderson1@nhs.net					

SUPPORTING INFORMATION PACK
1. Greater Manchester Choice and Equity Policy **(Item 9)** 2. Governing Body Assurance Framework spreadsheet **(Item 10)** 3. Integrated Performance and Delivery Report **(Item 12)**

Quoracy: a minimum of one third of the total membership of the Governing Body (4), of which there should be at least: the Accountable Officer or the Chief Financial Officer, a Lay Member; and two General Practice Representatives (Of which at least one must be a GP)

NHS
Stockport
Clinical Commissioning Group

PUBLIC – Governing Body Meeting
DRAFT MINUTES of the meeting held on Weds 16 June 2021
MS Teams

Present:

Dr C Briggs	GP Clinical Chair (Chair) **(CB)**
Mr M Cullen	Interim Chief Finance Officer, Stockport CCG **(MC)**
Ms A Green	Chief Accountable Officer, Stockport CCG **(AG)**
Dr A Johnson	General Practice Representative **(AJ)**
Dr John Jolly	Secondary Care Specialist **(JJ)**
Mr D Phillips	Lay Member for Patient & Public Involvement **(DP)**
Mr P Riley	Lay Member for Primary Care Commissioning **(PR)**
Dr M Valluri	General Practice Representative **(MV)**
Mr P Winrow	Lay Member for Audit & Governance **(PW)**
Mrs A Rolfe	Executive Nurse (**AR**)

In attendance:

Ms E Anderson	Business Administrator (**Minutes)**
Ms S Carroll	Healthwatch **(SC)**
Ms J Connolly	Director of Public Health, Stockport Metropolitan Borough Council (**JC**)
Ms E Ince	Director of Integrated Commissioning **(EI)**
Mr P Lewis Grundy	Deputy Director of Corporate Affairs **(PLG)**
Ms L McLean	Performance and Delivery **(LM)**
Ms G Miller	Associate Director of Commissioning **(GM),** (for minute item 13)
Mr P Stevens	LMC, Representative (**PS**)
Mr S Woodworth	Medical Director (**SW**)

Apologies

Dr M Richardson	General Practice Representative **(MR)**
Ms K Fortune	General Practice Representative **(KF)**

1. Welcome & Apologies	
The Chair welcomed members to the meeting; apologies were noted as listed above.	
2. Declarations of Interest	
The Chair asked members of the Governing Body to declare any interests held that would impact on the business conducted by the Governing Body today.	
3. Notification of Items of Any Other Business	
There were no items of any other business notified.	
4. Minutes of the meeting held on 14 April 2021	
The minutes of the meeting of the Governing Body held on 14 April 2021 were received and agreed as an accurate record. **RESOLVED:** **That the minutes of the Governing Board held on 14 April 2021 be approved and signed as a correct record.**	

5. Matters Arising / Actions from previous meeting	
The Chair presented the action log and the following updates were given at the meeting: MA130 – DP to meet with JC & AH in order to share evidence of the engagement. DP received a report on Engagement on the ONE Stockport Borough Plan. **Action to close.** MA142 - Updated JSNA to be brought back to future Governing Body Meeting including plans for addressing inequalities. This was covered under item 8 on the Agenda and in the minute below. **Action to Close.** **RESOLVED:** **That the actions arising from previous meetings and the assurance given, including the updates provided at the meeting and outlined above, be noted.**	
6. Report of the Chair	
CB, Chair of the Governing Body gave a verbal update. She continued to engage with General Practice regarding ICS development and SW was leading the work and a Masterclass open to all CCG members was due to take place on 23 June 2021. PCN Clinical Directors had been engaged. CB co-chaired the elective recovery and reform board and the focus was on 'waiting well' with the first tackling inequalities group taking place on 15 June 2021 in order to support the waiting population and minimise inequalities. CB continued to meet weekly with Greater Manchester Clinical Chairs which ensured links to progress to developing locality structures and clinical leadership. CB added that PW, Vice Chair would cover as Chair during upcoming annual leave. **RESOLVED:** **That Governing Body noted the verbal update provided.**	
7. Report of the Chief Accountable Officer	
AG presented her report which included information regarding the stepping up of the Covid-19 response to address the delta variant, service restoration and current demand; urgent and emergency care; primary care; elective care; cancer and mental health along with an update on ICS Development and information regarding inclusion conversations with staff. AG highlighted the COVID 19 7-day rate was at 233/100,000 as at 10 June 2021. On 15 June 2021 there were 22 patients in hospital with 2 in critical care. AG outlined the excellent work undertaken on the vaccine response confirming that 57% of the Stockport adult population had received their 2nd dose which was in line with the 78% first dose target for 19 July 2021. JC added that the rate of increase had slowed in the last few days. She confirmed that there were no particular hotspots across the borough and that the highest rate rises had been in 10-19 year olds and 20-29 year olds. Public health continued to focus on messaging, reminding the public of hands, face, space and fresh air, promoting lateral flow testing in schools and encouraging close contacts of those with symptoms to take a test. Regular pop-up vaccine clinics continued along with the 5 regular vaccine offers in Stockport. CB expressed her thanks for all the work colleagues had put into the vaccine clinics and confirmed that General Practice were continuing to administer second doses to cohorts 1-9.	

AG asked the Governing Body to note that there remained significant challenges in recovering waiting times to pre-covid levels. This was the result of a combination of factors relating to best practice infection prevention controls leading to reduced throughput; the scale of the backlog; and availability of clinical staff who were still recovering themselves.

AG updated the Governing Body with regards to ICS development; further clarity had been received from GM regarding what localities would look like, further national guidance and the ICS framework was expected. She confirmed that the HR framework had not yet been received and would be unlikely before the second reading of the Bill.

Linked to the staff engagement plan, Inclusion conversations had started with staff along with an inclusion survey. The first inclusion conversation took place on Monday 14 June 2021 with the topic of anti-racism and this work would continue over the next 6-9 months.

RESOLVED:
That Governing Body noted the report for assurance.

8. Impacts of COVID-19 on health and wellbeing in Stockport

JC, Director of Public Health introduced the report which had been presented at the Health and Well Being Board on 14 April 2021, she highlighted that it outlined the position to end of March 2021.

Over a year since the start of the pandemic further evidence about the impacts of COVID -19 on the health and wellbeing of the population in Stockport were emerging. In particular there was learning about how impacts had not been experienced equally and were being felt more in particular settings and communities.

This JSNA report was envisaged as the second in a series of analysis of the impact of the COVID -19 pandemic for Stockport, following an initial report last summer.

JC took the Governing Body through a presentation outlining the key points to note:

- Over 20,000 people had been diagnosed with COVID-19 in Stockport, and more than 1,900 people had been admitted to hospital as a result.
- There had been around 700 deaths due to COVID-19 so far, and around 14% more deaths (all causes) in 2020 than would have been expected (excess mortality), this was similar to the national average.
- 23% of COVID-19 deaths occurred in care homes, and mortality levels in care homes in 2020 were 55% higher than average, again this is similar to the national average.
- COVID-19 is exacerbating existing inequalities in health and is particularly affecting: older people, males, black asian and minority ethnic groups and those living in deprived areas.
- National life expectancy modelling showed a loss in life expectancy of 0.9 years for females and 1.3 years for males between 2019 and 2020. 54.7% of the 18+ population in Stockport have had their first dose of the COVID-19 vaccine.

JC added that this was the first time in many years there had been a decline in life expectancy.

JC highlighted to the Governing body that there was still more to understand about the longer

term impacts of Covid-19 and the duration of these effects and the full extent of the level of increased need due to long Covid in Stockport.

Office for National Statistics modelling suggested that there would be both positive and negative effects on health from the pandemic and the control measures, such as improvements in health due to lower air pollution but deterioration due to mental wellbeing and economic consequences. It was possible that any future recession due to the impact of restrictions may have as a big of an impact on health as the direct impact of the disease. The long-term consequences for education, employment, the economy and communities were likely to be significant but as yet the level of impact is still not clear.

AJ asked how the fact that deaths reported within 28 days of a positive Covid test but not actually due to Covid would affect the reported deaths. JC reminded the Governing Body that the measure of importance was 'excess mortality' and in 2020 3,252 deaths from all causes were registered for Stockport. The 5-year average 2015-2019 number of deaths registered for the same period was 2,854; meaning there have been around 398 excess deaths (13.9%).

CB asked JC what could be done to understand the impact on communities and mitigate it. JC responded that the intelligence in the JSNA would be used to plan the service response and it had been recognised that there was a requirement to promote the offers around mental wellbeing and Covid safety. There had been a big community response to the pandemic and the Borough Plan and ONE Stockport had built on that. Community champions work had been established and there was a focus on vaccine inclusion work to address inequalities.

RESOLVED:

i. **That the work should continue and identify areas of focus for further and future JSNA analysis be agreed.**
ii. **That this draft first report which is being released for public consultation via the Stockport CCG Have Your Say hub and shared with members of the public, partners and VCSE community organisations for their input be promoted**
iii. **That plans for recovery and planning for future waves should focus on mitigating the inequalities identified in this report.**

9. ONE Stockport Borough Plan

JC shared some slides on the ONE Stockport Borough Plan, a 10 year plan for the borough which had been developed jointly with partners, communities, business and groups across Stockport.
The borough plan was underpinned by the ONE Stockport Values: we are inclusive, we are ambitious and we are collaborative; and the ONE Stockport Priorities of one heart, one home and one future.

ONE Stockport conversations had taken place over the last year to capture the experiences, insight and aspirations of Stockport's communities, businesses and different partnership perspectives with over 3,800 people having been engaged. The data and intelligence had been analysed to understand opportunities and challenges. The engagement was undertaken via online surveys, video booths, workshops, partnership forums and was underpinned by ongoing conversations.

The outcome of the engagement was that people were passionate about their local area, equality, equity and unity were important for our communities, our communities care for the environment, inclusive employment opportunities which enabled local people and businesses to flourish were important and that people and communities have, and continue to be, impacted by Covid-19.

JC shared the video https://youtu.be/kXKE_bBetJo .

The data gathered indicated Stockport's population was changing, with an increasingly culturally diverse community and an ageing population. Stockport had a strong economy and was responding well to new emerging industries, however, as with other areas it faced a challenge of unemployment. Stockport was a polarised borough, with a number of residents living in some of the most affluent and least affluent areas in England. Stockport's children generally achieved above average outcomes, however the most vulnerable children did not perform as well as their peers across England. Stockport tended to have good health outcomes and life expectancy that had been improving year on year, ageing population will result in health & care challenges in future.

The Governing Body was advised that feedback on the draft plan had been incorporated into the final designed version and work was progressing towards a launch with a focus on developing a supporting outcomes framework and clear delivery plans with a review built in for Summer 2022 to capture the Census and further Covid learning.

JC outlined the key next steps which fitted into the 3 priorities.

JC highlighted to the Governing Body the importance of focussing on outcomes and reminded them of the current consultation on the health and care plan and requested that they encouraged friends, neighbours and groups to get involved.

CB asked if the video which was shared could be communicate to General Practice.

ACTION: Video to be shared with General Practice via Comms and Engagement.

CB asked how Stockport would respond to the population need within the shopping centre areas (in particular Mersey Square) and is rebuild and included in the plan. JC responded that there was lots of work regarding Town Centre development, and as the Local Plan was developed housing and infrastructure would be considered. JC highlighted there had been work done as part of the town centre development, led by public health around social inclusion and social isolation in order to develop a new community and to integrate that community.

JJ asked if there were plans to make digital inclusion a priority. MC advised that within the Local Authority this was being prioritised, digital exclusion could manifest itself in multiple ways having multiple impacts on individuals in terms of health, economic and financial impacts. There was lots of work being done particularly around access to devices.

DP asked how the outcomes framework would be arrived at. JC responded that the process would be to identify what was there, what was being measured and establishing what the borough plan was trying to achieve and then what could be measured and if new indicators were required. In order to establish what was there, 'The Big Stockport Picture' had been established https://bigstockportpicture.co.uk/. AG added that there was very transparent evidence available to all on the ONE Stockport website in order for tracking against the outcome and improvements to be visible.

SC fed back that Healthwatch had heard that residents wanted to know what it meant for them and their neighbourhood. JC agreed that a key part of engagement had been with councillors and would continue, she highlighted the importance of community work. MC agreed that engagement must reach residents and that the Borough plan included working towards neighbourhood model of delivery where residents would see an impact.

RESOLVED:
That the One Stockport Borough Plan be approved.

10. Operational Planning	
LM, Performance and Delivery, presented the report to Governing Body to provide assurance on the CCG plan for the first half of 2021/22, following the receipt on 25 March 2021 of the National planning guidance for April to September 2021. The CCG submitted plans in relation to activity and finance including a full year Mental Health plan and a primary care workforce plan. All other plans required, including the GM system narrative, were co-ordinated by Greater Manchester system groups or by providers. Key identified risks included workforce resilience and capacity. The Greater Manchester Elective Recovery and Reform Programme had established working groups for the most challenged specialities to look at areas of mutual aid and use of available independent sector provision. Finance, activity, mental health, and workforce templates were completed locally and submitted to Greater Manchester for inclusion in the Greater Manchester system submission. Final plans were submitted on time to Greater Manchester in preparation for the system submission on the national returns date, 3 June 2021. The plan reflected realistic capacity based on current staffing levels and the impacts of infection prevention measures on capacity. The expected benefit of Independent Sector activity was also contained within the plan and was particularly focused on supporting the reduction in waiting lists and reducing waiting times for those patients who were less urgent and in clinical priority groups 3 & 4. The numerical plan was supported by a system narrative developed by GM which covered all aspects of the planning guidance. The CCG had begun to adapt this narrative with system partners at a local level to incorporate relevant elements of the delivery plans and to also align with the One Stockport Health & Care Plan. National planning guidance assumed that referrals would return to pre-COVID levels, but activity will only restore to a minimum of 85%. A local view was being developed with public health on any 'shortfall' in referrals related to patients not accessing healthcare since the start of the covid-19 pandemic. Although increases in referrals due to this work would increase the waiting list size there was concern to ensure that patients do access the care they need to prevent their conditions and/or their outcomes worsening as a consequence. Alongside the clinical prioritisation guidance on waiting lists which was implemented during the early phase of the pandemic there was a new national requirement to review and prioritise diagnostic waiting lists into equivalent categories. In local terms this would focus on endoscopy in particular. Greater Manchester had released information in relation to system wide approaches to paediatric surgical provision where dentistry was a specific area of focus supported by a system wide Paediatric Clinical Reference Group looking at the whole pathway; a 'long waiters' capacity initiative which was reviewing the development of high volume green sites (COVID free); supporting patients to travel further to access these; protecting this capacity during winter and further COVID waves; and focusing on speed and ease of implementation, impact on waiting lists and cost. Work in relation to the implementation of community diagnostic hubs was now being carried out with establishment of early adopter sites within Greater Manchester. Stockport NHS Foundation Trust had submitted an improvement plan regarding Maternity services, supported by £80m of additional System Development Funding to support	

implementation of the immediate and essential actions set out in the in the Ockenden review to improve safety and quality in maternity services.

MC confirmed that the report had been presented to the Planning and Comissioning Committee and the Finance, Development and Performance Committee prior to its presentation at Governing Body. He added that the financial regime implemented in the second half of 2020/21 had been rolled forward for the first six months of 2021/22. Greater Manchester had an overall system budget of £2.928bn for the first half of 2021/22 and all systems were required to break-even, the budget included £407m of system funding intended to support the cost of COVID related activity, growth funding and provider top-up funding. Distribution of system funding will be reviewed at month 3 and month 5 with an opportunity to move money between organisations if required.

NHS Stockport had been given an H1 (first half year of 2021/22) allocation of £266.838m a £16.680m increase in funding when compared to the second half of last year. While this was a significant increase, £13.297m would be matched by expenditure increases, in addition recurrent commitments and inflationary pressures would require £2,067m of efficiencies relating to H1 with further efficiencies required for H2.

In 2020/21 NHS Stockport CCG spent £46.820m on Mental Health Investment Standard (MHIS). With a 4.11% uplift in allocation, the CCG would be required to spend a minimum of £48.746m to meet the MHIS in 2021/22. The CCG's plan was above this minimum commitment, with a plan to increase mental health spending to £50.505m. In addition, the CCG was also committed to expenditure of £11.268m in Learning Disabilities and Dementia, £0.427m of Service Development Fund (SDF) on CYP community & crisis and £1.433m non-recurrent Spending Review (SR) funds (share of the £500m), which was not included in the MHIS:

AJ reflected that the GP workforce was underestimated and was not increasing despite population growth and asked what the CCG could be doing to encourage recruitment to support Primary Care. AG responded that PCN development had paused due to the pandemic, however the investment was there and available for PCNs to grow their workforce. AR added that there was now a GP workforce lead in post and he had an initial meeting with PCNs and was engaged with the wider GM workforce planning.

RESOLVED:
That the report be noted for assurance.

11. Finance Report

MC presented the report which covered the period to 31 May 2021

He expressed his confidence in the CCG meeting its statutory performance targets.

The CCG was reporting a breakeven for both the year-to-date (YTD) and forecast outturn positions. Efficiencies delivered in month 2 YTD were £0.689m in line with plan. It was forecast that planned efficiencies of £2.067m for the first half of the financial year will be delivered.

MC advised that the current contract for Wet AMD with Optegra had an annual value of approximately £3.6m. The existing contract ended on 2nd August 2021 and the Governing Body was asked to endorse the Finance, Performance and Delivery Committee recommendation to enact the 12 month contract extension clause.

RESOLVED:
(i) **That a breakeven position is being reported year-to-date and for the forecast period 1 April 2021 to 30 September 2021 be noted.**

(ii) **That the 12 month extension to the current Optegra contract in the sum of c£3.6m to 2 August 2022 be endorsed.**	
12. Integrated Performance	
LM presented the performance data for March 2021. There had been a sustained increase in attendances to Urgent Care, including an increase in complex mental health presentations, this had continued into April 2021. Diagnostic services had seen a slight improvement for patients waiting less than 6 weeks from 56.7% to 61.1% achievement – the target was 99% patients waiting less than 6 weeks. Endoscopy remained challenged in terms of volume and access points. Patients were being offered the opportunity to take up appointments at Fairfield Hospital, however this was not sufficient enough to reduce waiting times. There was new guidance to clinically prioritise those patients waiting for diagnostic procedures into 4 categories, linking urgency to priority group A. This process must be completed by the end of July and maintained thereafter. In terms of planned care, 12% of the overall waiting list had waited more than 52 weeks. This was in line with national figures and across Greater Manchester. Waiting list management included increasing priority for patients waiting longer than 50 weeks however, there remained some patients who were reluctant to proceed with their treatment and preferred to continue to wait. For Cancer waiting times, the two-week waiting time standard from GP referral was met during March for the first time in 2020/21. Additionally, there was a significant improvement for patients with breast symptoms where cancer was not originally suspected, with 83.8% being seen within the standard. The overall standard of 96% of patients starting first definitive treatment within 31 days of diagnosis had been narrowly missed although the 31-day standard continued to be met where subsequent treatment was delivered. None of the 62 day cancer targets were met in March. There had been a significant improvement since quarter 1 in the proportion of people on the General Practice Learning Disability Register receiving an Annual Health Check. The standard for Children and Young People with Eating Disorders waiting 4 weeks or less from referral to treatment was again not met. Primary care continued to face increasing pressures as patients started to access healthcare while provision and support for patients with suspected COVID still remained. CB reflected that patients waiting more than 52 weeks impacted on the whole system for example increasing GP activity and added that it was encouraging that GM wide discussions were underway. DP asked what would assist patients to 'wait well'. LM responded that GM were producing some materials to be used for communications with patients and look at tailored messages, it was important for patients to know the next steps and be able to re-access support and care. AR added that there were health promotion messages regarding 'wait well' such as eat well, keep active to be ready when you are called for your procedure. JC would encourage the use of Healthy Stockport https://www.healthystockport.co.uk/	

RESOLVED: **That the report be noted.**	
13. SEND Written Statement of Action	
GM, Associate Director of Commissioning presented the report and advised that it was presented for assurance relating to the provision of services for children with Special Educational Needs (SEND). The report provided a review of progress on the Stockport SEND Written Statement of Action (WSOA) and the system wide SEND improvement programme. It outlined the overview of the CCG's areas of responsibility (Joint Commissioning) and the presentation of the SEND improvement programme given to the Health & Wellbeing Board in April 2021. GM advised the Governing Body that the SEND Board was jointly chaired by AG and Chris McLaughlin, Stockport Council's Director of Children's Services, and reported into the Health and Wellbeing Board. The Governance structure was a joint comissioning board chaired by Greater Manchester and the Local authority to give clear accountability. An outcomes framework had been co-produced with 7 key outcomes. Access to Services remained the highest risk for the CCG. Specifically long waiting lists for Autism Spectrum Disorder (ASD) and Cognitive Behavioural Therapy (CBT) within the HYMS/CAMHS service Governing Body noted that reinspection was imminent. SC reflected that the pandemic had produced innovative ways of working with families and that should be recognised. PR asked if the impact on young people was measured and if any feedback had been taken from them and their carers. GM confirmed they were represented on all the boards and feedback was presented via case studies and direct contact and was tracked closely. Families had given positive feedback on the work and recognised that services had to be realigned due to Covid. Webinars have been run and helpful feedback received. The service remained challenged in terms of recovery and meeting the needs. **RESOLVED:** **That the update and risks to delivery be noted.**	
14. Staff survey	
JN, Interim Head of HR attended in order to present the results from the Staff Survey 2020 and the high-level engagement plan for agreement by Members and assurance. A period of engagement had taken place since the staff survey findings were presented to the Executive Board in January 2021. There had been a working session with the CCG Executive on 11th March 2021 and 3 focus groups attended by staff. The wider management team were engaged and an all colleague session took place on 24 March 2021 with staff side being consulted on 30 March 2021. JN outlined the key themes and advised that the most agreed with statements were that the CCG corporate communications are frequent enough, staff liked the people in their team and staff were willing to give extra effort to help the CCG succeed, staff had sufficient communication with their team, their line manager treated them fairly. People also valued flexible working, their colleagues and good communication. The areas for improvement were discussed and action agreed with Members.	

PW felt that this work was crucial at this time, considering remote working and it gave people a voice considering the pending structural change Following approval of the staff engagement plan, progress would be monitored and reported through to the Governing Body . **RESOLVED** **That the report be noted and the action plan be endorsed.**	
15. Report from Committees	
a. Audit Committee report for the period to June 2021	
PW highlighted the great work undertaken from the finance teams resulting in delivery which met the standards of both internal and external auditors. PLG added that the Annual Reports and Accounts had been approved by the Audit Committee under delegation from the Governing Body, signed by the Chief Accountable Officer and submitted **RESOLVED:** **That the report be noted for assurance.**	
b. Primary Care Commissioning Committee report for the period to June 2021	
The report was accepted as read. **RESOLVED:** **That the report be noted for assurance.**	
c. Finance, Performance and Delivery Committee report for the period to June 2021	
The report was accepted as read. **RESOLVED:** **That the report be noted for assurance.**	
d. Planning & Commissioning Committee report for the period to June 2021	
The report was accepted as read. **RESOLVED:** **That the report be noted for assurance.**	
e. Quality and Governance Committee report for the period to June 2021	
The report was accepted as read. **RESOLVED:** **That the report be noted for assurance.**	
Questions were presented to the Governing Body from Deborah Hind a member of the informal NHS Stockport watch. Deborah did not attend the meeting and the questions and responses below will be sent to her in writing.	

Q1.	**What happened to Stockport Together and more importantly, what happened to the £19 million?**
A	The £19m was invested in community services as described in the transformation programme Stockport Together.
Q2.	**Why are the Stockport public being consulted again on changes to health and care with similar aims as previously?**
A	The previous engagement for Stockport Together was in 2017 this captured priorities at this time and contributed to the CCG's current Strategic Plan published in 2019. The existing plans, learning from the pandemic and latest JSNA are being bought into the development of the ONE Stockport Health and Care Plan, part of the overall ONE Stockport Borough Plan.
Q3.	**Where will the money come from this time and who will oversee the health part of the plan if Stockport CCG disappears as a result of the creation of a Greater Manchester Integrated Care System?**
A	From April 2022 the Greater Manchester Integrated Care System will receive funding direct from NHSE as CCGs and NHS Provider's do now, mechanisms will be in place to allocate funding to each of the 10 localities including Stockport. It is anticipated that the "Locality Board" as set out in the paper in my CAO report, will have oversight of the health element of the One Stockport Health and Care Plan with some funding going direct to healthcare providers as it has under the pandemic.

19. Date and time of the next meeting

The next meeting of the CCG's Governing body would be held on: Wednesday 11 August 2021.

MASTER COMMITTEES ACTION LOG

NHS Stockport Clinical Commissioning Group

Master Ref.	Committee	Meeting Date	Agenda Item	Current Status	Action Description (Provide a concise description of the action here)	Action Lead	Target Date	Comments Additional comments should be prefixed with UPDATE[dd/mm/yy]
MA190	Governing Body (public)	16/06/2021	9	COMPLETE	ONE stockport video to be shared with practices	Comms & Engagement	11/08/2021	Complete: circulated via GP newsletter

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Report of the Chief Accountable Officer

Report To (Meeting):		Governing Body			
Report From (Executive Lead)		Andrea Green, Chief Accountable Officer			
Date:		August 2021	**Agenda Item No:**	7	
Previously Considered by:		N/A			
Decision		**Assurance**	✓	**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	None relating to this report
Purpose of the report:	
The report is presented to advise Members of the Governing Body of activities and issues since the last Governing Body meeting.	
Key points (Executive Summary):	
1. Covid-19 Response 2. Service restoration and current demand; urgent and emergency care; primary care. elective care; cancer and mental health. 3. The NHS 73rd Birthday and staff updates. 4. ICS Development update.	
Recommendation:	
The Governing Body is asked to: ○ **NOTE** the report and seek any further assurance	
Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	The report potentially cuts across all of the CCG's aims and objectives.
Risk and Assurance:	
List all strategic and high level risks relevant to this paper	The report potentially cuts across all of the CCG's Strategic Risks
Consultation and Engagement:	
Patient and Public	None relevant directly to this report

Involvement:	
Clinical Engagement:	None relevant directly to this report

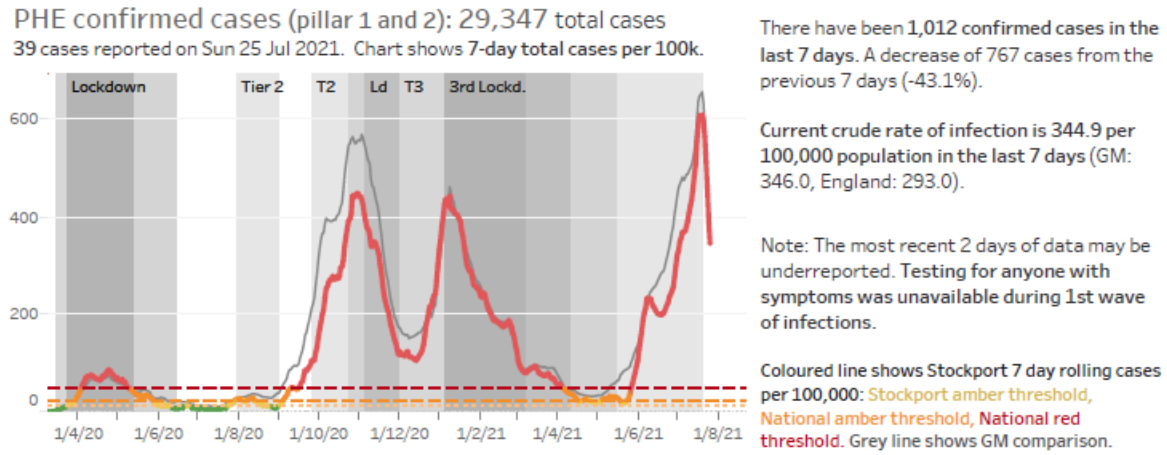
1. Covid-19 response

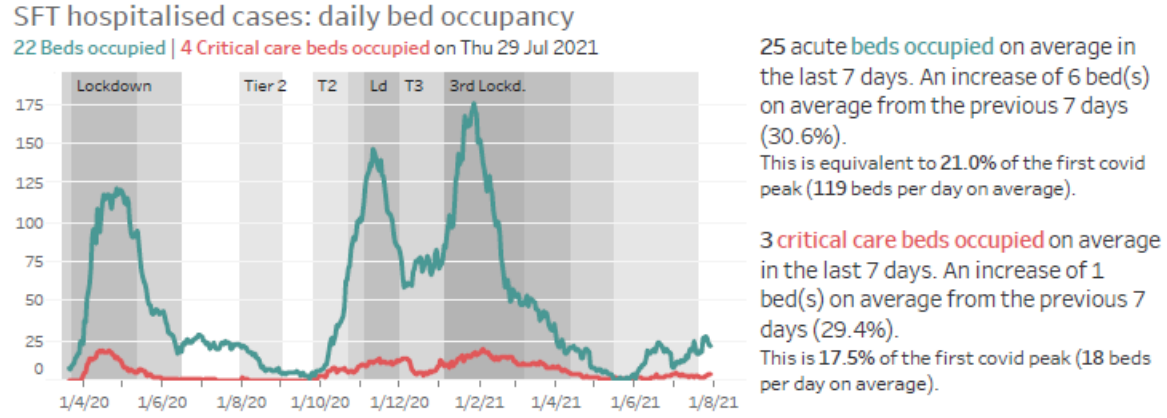
1.1. The CCG has sustained our Category 2 tactical co-ordination work reporting in to the Stockport Strategic Command Group since my last report.

1.2. The number of confirmed cases of infection seen in late July appears to be on a steep decline over recent days after a spike early-mid July. Public Health England and local Directors of Public Health are working together to understand the certainty, and drivers resulting in the steep decline which is a common phenomena across England. Detailed analysis is underway to gather evidence about the change as it is atypical for an infection and more likely a combination of behavioural, environmental and measurement factors. Chart 1 below shows rates peak at >600 then reduce with the latest rate of 345 per 100K as of 25th July.

1.3. The demand from people with Covid on health care has grown slightly and Stepping Hill hospital has seen a small increase in demand from people with Covid as shown in Chart 2 below. The North West reports that we are seeing people 35 and younger more likely to be in hospital than the 75's and over.

Chart 1: Cases confirmed by Public Health England; Chart 2 People in hospital.





1.4. The vaccination programme continues to go very well in Stockport with the vaccine now available to those 18 and over and younger population who are vulnerable. Across the

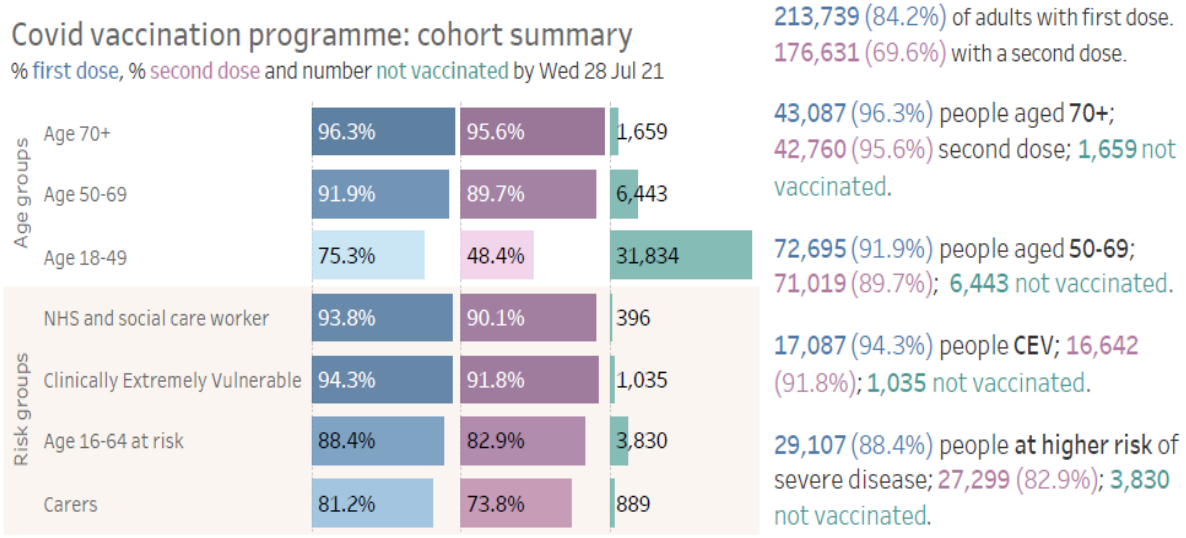
North West region as of 27th July, 86% of those eligible had received the first dose and 71% the second dose, we remain very slightly below this.

1.5. Regional colleagues have reported that national evidence is now available that shows that the vaccination programme has prevented 35,200 deaths and >11 million infections.

1.6. Legislation has been passed which mandates that by November 2021, all Care Home staff must be fully vaccinated. Directors of Adult Social Care are working with Home providers to mitigate any risks, and we understand that anybody providing services to a home or visiting will be asked to provide evidence of their vaccination status.

1.7. In Stockport we have continued the core offer and additional targeted walk-in services to try to extend the reach to those who potentially will not book via other methods, or who don't find the core offers convenient due to other commitments. These walk-in offers are publicised and now also able to be booked from the national booking site.

Chart 3 – Covid vaccination progress summary as of 28th July



2. Service restoration issues

2.1. Staffing constraints due to self isolation continue to be experienced by all services. Across Greater Manchester, in hospital and out of hospital care providers are developing a common compassionate approach to support fully vaccinated staff who test negative, to safely return to work with additional regular testing so as to sustain vital services.

2.2. The urgent and emergency care demand is now above pre-pandemic levels across all care systems in Greater Manchester with NWAS 999 and 111 and CAS services under considerable strain. Additional national funding has been allocated to regions to help to address the activity growth and capacity constraints, and bids for Accelerator Funding to support the unexplained demands in primary care, mental health, ambulance and hospital services are being developed against this funding.

2.3. We do not yet have the results of the qualitative review of those presenting to A&E. The Urgent and Emergency Care Board have oversight of delivery of the transformation in same day emergency care; primary and community urgent care alternative offers; 111 utilisation and GP connect; discharge flow.

2.4. The elective care recovery work is progressing however a small number of elective cases have been disrupted by the exceptional urgent and emergency demands on hospital care.

2.5. Mental health demand remains high, in respect of home based treatment, community mental health teams and early intervention teams. Levels of delayed transfers and out of area placements have increased, and the GM Mental Health Executive are leading some intensive work.

2.6. In respect of Cancer services, significant progress has been made, but further work remains to secure improvements in some pathways. We are still embedding the improvements of the 2 week waits breast pathway. The GM Cancer Board met on the 19 July and received a progress report on actions to address the longest waiters. They also received a report on the prehab and rehab support for Cancer patients, which showed some excellent evidence of faster recovery after surgery after accessing the services we have commissioned.

2.7. Members are asked to note that there remain significant challenges in recovering service waiting times to pre-covid levels, this is a combination of factors such as best practice infection prevention controls leading to reduced throughput, the scale of the backlog, staff needing to take their leave, and staff needing to self-isolate.

3. The NHS 73rd Birthday and staff updates

3.1. The NHS celebrated the 73rd birthday on 5th July, we celebrated with a key thank you to staff and a celebratory cake and coffee at lunchtime on the 5th.

3.2. Emma Ince is to leave the CCG on the 13th August, we have agreed that Mrs Mel McGuiness will join the CCG as a secondment from Bolton CCG from 16th August. Mel is a very experienced commissioner, has expertise across the whole portfolio of commissioning and contracting and has also previously worked in NHS providers. Mel leads several workstreams at the Greater Manchester level, and has significant experience working collaboratively with local authority colleagues. Mel is already well known to many Stockport senior leaders which will aid a smooth induction.

3.3. The GM People and Culture Group have collated a set of slides to update staff on how the programme of managing the transition to the ICS and some clear frequently asked questions that can be used. I led the staff through these slides at the weekly floor brief on 13 July, we have also ow an established staff website for any ICS documents, reports and a running FAQ area.

4. ICS Development

The New Health and Care Bill was taken through the Commons during the week of 12th July. It will progress to Committees after the summer recess and then expected to be final by the end of the year. The recruitment for the Chair of the future GM NHS Integrated Board has commenced with an expectation of appointments by September. The recruitment of the CEO is expected to commence in another 3 or 4 weeks.

The GM Health and Social Care Partnership Board received a paper on the emerging governance proposals for the future ICS at their meeting on Friday 30 July. A copy of the paper is attached for Members reference. The document describes the basic design principles and our ethos that the new governance must enable us to achieve our ambitions of improving health;

reducing inequalities; achieving constitutional standards; innovation at scale and pace and creating a comprehensive sustainable system.

The whole approach has been developed through the engaged design events that I described in my last report, and the approach is described as building from where we are after our five years of operating as a GM system, and embed a truly collaborative governance model. The Health and Care Partnership Board agreed to the proposed new governance model acknowledging this as a practice way forward to operate in shadow form from 1 October 2021, with review and adjustments before final adoption ready for 1 April 2022. Please find the report attached as an appendix.

GM has established an ICS Transition Board to bring all the aspects of implementing the new ICS infrastructure together so that Execs can have oversight of the developments and address any issues and risks as we go. We are establishing a similar structure in Stockport. We currently have Execs and Deputies working together on the programme however some of the workstreams are system-wide and not just CCG activities so we have agreed to broaden the approach.

In Stockport we have now invited Partners to join a task and finish group to shape the locality provider or delivery alliance, colleagues are nominating participants for a first facilitated meeting in August. The aim is to understand the scale of common purpose for an alliance, the potential benefits, readiness and willingness of provider partners to work in this way, further work together is planned for September.

Myself and key partners met with Healthwatch Stockport Strategic Monitoring Group to address some key questions they had and to hear leaders views about how the locality system will need to work ensuring the patient and public voice is not lost, and accountability is sustained.

The engagement on the One Stockport Health and Care Plan closed as planned at the end of July. The Plan will be finalised after fully considering these, and a final report will be bought back to the Governing Body.

Members are asked to note this report, and or seek any further assurances.

POTENTIAL IMPLICATIONS

Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure	None directly relating to this Report					
	Recurrent Expenditure	None directly relating to this Report					
	Expenditure included within CCG Financial Plan	Yes	✓	No		N/A	
Performance Impact:	None directly relating to this Report						
Quality and Safety Impact:	None directly relating to this Report						
Compliance and/or Legal Impact:	Requirement under the Constitution to report the use of the Urgent and Emergency Powers under the Constitution to the Governing Body.						
Equality and Diversity:	General Statement: There are no direct considerations relating to this report						

	Has an equality impact assessment been completed?	Yes		No	✓	N/A	
	If Not Applicable please explain why	Not Applicable					

GMICS Emerging Governance Proposals

July 2021

Purpose

The purpose of this paper is to set out the emerging proposals for the governance model and architecture of the new GM health and care system. These proposals have been developed by the governance task and finish group and informed by a paper produced by Sir Richard Leese that was submitted to the Partnership Executive Board in June.

Design Principles and Requirements

The proposed approach is designed to enable GM to meet its strategic objectives (tackling inequality, guaranteeing constitutional healthcare standards, innovation at pace and scale and creating a comprehensive sustainable system). In doing so, it also meets five essential requirements -

1) GM health and care system proposed governance **must offer the continuity of purpose, ethos and culture that have underpinned the GMS devolution deal** in the previous five years of its ten year journey

2) GM health and care system is required **to meet the national policy requirements and priorities** of the forthcoming legislation on integrated care; and **the principles of good governance**

3) GM health and care system governance must be designed to **enable the oversight and delivery of the aims and intentions of the new GM operating model** (recognising its architecture and its incentives)

4) the proposed governance arrangements should further develop the commitment in the operating model ***to a shared approach to its key functions**** by establishing **the crucial principle of shared governance.** This will serve to create the necessary commitment of constituent organisations to taking responsibility for delivery of the system's aims and avoid the GM ICS (Boards and Executive functions) being seen and felt as a separate entity (there is a strong desire to avoid an 'us and them' culture)

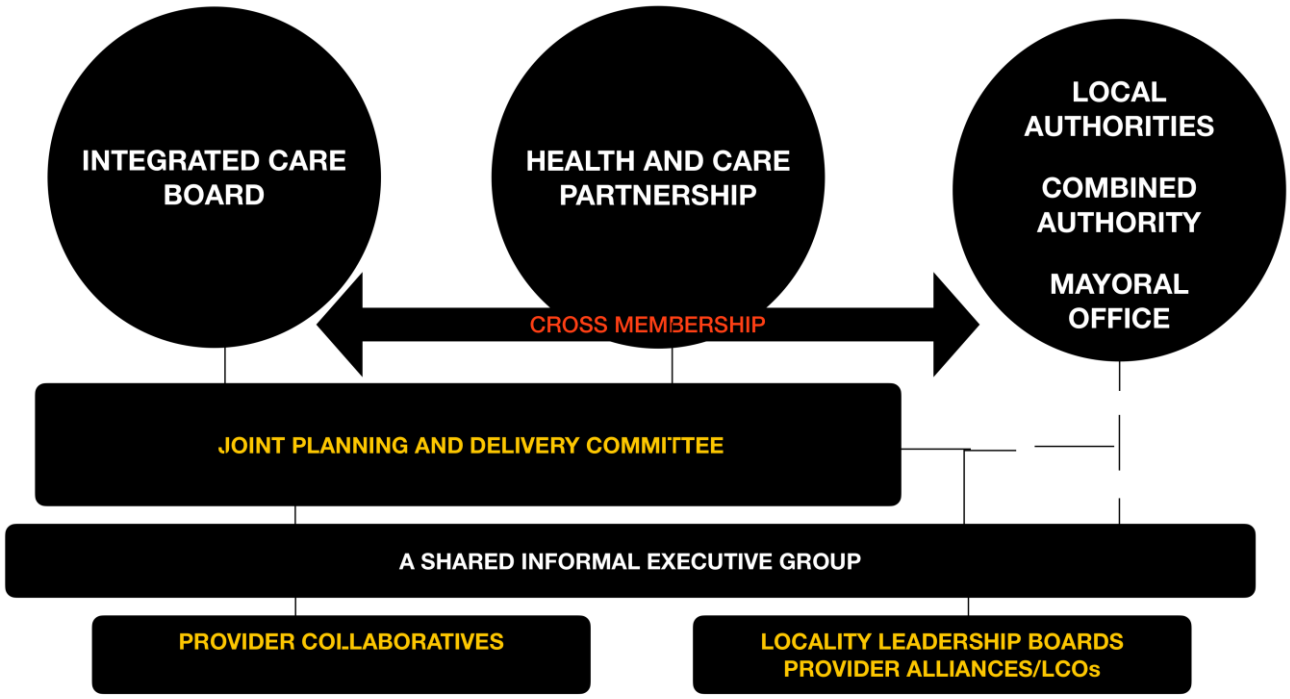
5) the proposed arrangements are built to respond to the challenge issued at the design workshops of **keeping it simple and reducing bureaucracy**. Hence meetings are dovetailed and designed to be coherent in terms of inter-connectedness and will operate with delegated powers and clarity of roles and functions. (See the meeting schedule section later)

As these principles are informing a new set of arrangements it is proposed to keep them under review as the new system beds in, with a more formal review set up to take stock prior to the ICS becoming a legal statutory entity on April 1st 2022 (subject to legislation).

Proposals

The new arrangements are designed to meet the principles above by

- Creating **a new Health and Care Partnership (HCP) which is central** to setting priorities and preserving the culture and ambitions of GM devolution. This replaces the current Partnership Board
- Establishing **an Integrated Care Board (ICB) to deliver the legal national requirements and functions** including allocation of, and accounting for NHS resource; and fulfilling primary care and specialised commissioning functions
- Creating **a Joint Planning and Delivery Committee (JPDC) that replaces PEB and JCB** and ensures/oversees joined up service planning and delivery between the GM enabling programmes, locality programmes (LA and health), Collaborative programmes and adjacent programmes (eg Mayoral office, Health Innovation Manchester, Marmot City Region etc)
- Establishing **a shared executive group (SEG) that meets weekly to coordinate executive delivery** on an ongoing basis and support the work of the three structures above
- Building on **the key delivery vehicles of Locality Boards/Alliances working through their constituent neighbourhoods** and **Provider Collaboratives** taking responsibility for programmes requiring a wider GM footprint to achieve their objectives
- Being **consistently underpinned by expert clinical and care professional advice** through lead professionals, advisory groups and forums, and adoption of a clinically and professionally empowering culture to enable service transformation and population health improvement. These mechanisms are not listed here but will be present in practice to support all the governance arrangements



Detailed Governance Functions

The GM governance model encompasses these **key collaborative governance mechanisms** with the stated intention of them operating coherently to oversee the planning and delivery of services and programmes.

The structures are part of a governance system organised in such a manner not to duplicate but to undertake the collective roles and functions of priority setting, pooling and alignment of budgets, stewardship of budgets, delivery of services and the accountability for achieving objectives.

The proposal would be **to establish the following in shadow form as of October 2021 with a review** and any adjustments made prior to formal adoption from April 2022.

1) Integrated Care Board

Function

- Fulfil all the NHS statutory functions for the ICB as set out in the 2021 Health and Care Bill including setting strategy to achieve national priorities (as set out by DHSC/NHSE in Planning and Priorities Guidance) and GM priorities (as proposed by the GM HCP and built on Locality and Provider Collaborative priorities) , allocation of NHS resources to support this strategy, oversee the commissioning or primary and specialised care, ensuring the component programmes and organisations fulfil their collective and individual responsibilities for delivering their contribution to the GM aims as agreed in the planning process.

Membership (12 members)

- 1 x Independent Chair
- 2 x Independent NEDs
- 1 x Chief Accountable Officer
- 1 x Medical Director
- 1 x Nursing Director
- 1 x Chief Finance Officer
- 3 x Partner Directors as specified (1 x LA; 1 x Primary Care; 1 x NHS Provider)
- 1 x VCSE Representative
- 1 x Chair of HCP (ex-officio)

Board of 12 Directors with ability to have observers in attendance (eg GMCA CEO)

Ability to delegate any, or all, functions
- priority setting to HCP
- planning and delivery to Joint PDC

Ability to establish joint committees (eg with Localities and Provider Collaboratives)

Ability to establish functional committees (eg Audit, Remuneration, Finance etc)

Meets 8 times per year (see meeting schedule in section below)

2) **Health and Care Partnership**

Function

- fulfil all, if any, statutory functions for the HCP as set out in the Health and Care Bill 2021; takes responsibility for setting priorities, informing and being informed by national and local priorities; provides a forum for wide engagement

- liaises, where appropriate, with Local Health and Well Being Boards on understanding locality needs, priorities and strategies

- has the power to establish wider working parties or engagement mechanisms (eg BAME forum, Inequality assembly, Younger People's Forum etc)

- With the ICB, replaces HSC Partnership Board

Membership (numbers tbd)

- Chaired by GMCA Health and Care Portfolio Holder
- Representatives from all constituent parties (eg Trusts, LAs, VCSE, local Primary Care forums/boards, academics, private sector, etc)

- Mixture of elected members, NED, lay members with executive directors, officers and lead clinical and care professionals
- Healthwatch and patient groups

- Meets 4 times per year, aligned with business planning and priority setting process (see meeting schedule in section below)

3) Joint Planning and Delivery Committee

Function

- operates with delegated responsibility to oversee the detailed **joint planning and delivery** process which will ensure that Locality programmes, Provider Collaborative programmes and GM enabling programmes work coherently. The process will coordinate the spatial levels for delivery of the programmes and the consequent financial flows set out in the GM operating model
- **strong focus on delivery of national and locally determined standards and outcomes**
- considers, determines and resolves operational issues associated with the delivery of the GM strategy
- has informal routes through Chair to political leadership
- advises ICB and HCP on potential priorities
- reports into ICB for formal decisions that have not otherwise been delegated
- liaises directly with LAs, GMCA, and Mayoral Office to align operational planning and delivery across the £7bn health & care spend with £15bn non health and care spend
- aligns the direct commissioning functions transferred from the CCG or NHSE/I (eg spec com, primary care etc) to ensure alignment of these budgets/programmes with other key programmes
- **replaces PEB and JCB**

Membership (23 members)

- 1 x Chair is GMCA health and care portfolio holder
- 1 x ICB Chair
- 3 x Provider CEOs (PFB Chair, MH Lead CEO, LCO Lead CEO)
- 1 x PCB Chair
- 10 x Locality Representatives (individuals to be determined by each locality but could potentially be the Chair of the Locality Boards as a default option)
- 4 x ICS officers (CAO, CFO, MD, ND)
- 1 x CEO GMCA
- 1 x VCSE Representative
- 1 x CEO Health Innovation Manchester

In attendance - specific attendees with distinct backgrounds, if not covered through locality representatives; and clinicians by invitation for key items

4) Shared Executive Group

Function

Brings together the key executive leaders on a weekly basis under the chairing of the ICS CAO. **Not a formal decision making group, but one that can fulfil the key role of ensuring coherence in the implementation of strategy**. The group will help steer the implementation process and serve to fix elements or programmes that are under performing. Sets agenda for Board, Partnership and Committee meetings and commissions papers.

Produces an action note rather than formal minute.

Membership

- to be determined by ICS AO, but not a formal membership list, much more about a fluid group depending on the nature of the work in hand.

5) Locality Leadership Boards

Function

- Responsible for setting local priorities, pooling and aligning NHS and social care spending, allocating budgets to local providers or local provider alliances, ensuring delivery of key programmes set out in the GM Operating Mode, liaison with GM enabling programmes and Provider Collaboratives.
- working closely with local HWBs on priorities and strategy
- subject to local scrutiny
- supporting, developing and embracing neighbourhood working as a key element of their strategy and integrated programme delivery
- aligning non health and care spend to deliver a health and care dividend
- can operate as a joint committee with ICS to allow for pooled budget

Membership

- to be determined locally but may be helpful to mirror the model options set out in the GM operating model
- will need an appointed ICS place based lead

6) **Provider Collaboratives**

Function

- take responsibility for leading (predominantly urgent care and elective care programmes) and partnering in the delivery of key programmes on behalf of the GM

ICS. In particular, to help GM achieve progress towards the national constitutional standards and priorities (including in cancer, mental health and physical health care)

- signals appropriate resource allocation to each Trust to deliver their collective clinical strategy
- liaison with locality boards and GM enabling programmes
- undertake programmes to standardise care, optimise workforce and sites; deliver technical efficiency and productivity improvement for existing quantum of resources spent
- has the ability to convene wider provider groupings where relevant to the GM aims (eg health and criminal justice issues etc)

Membership

- PCB - As now but may be reviewed as the system and responsibilities develop
- PFB - Executive Group - membership and structure as per recent agreements
- PFB - Chairs Group - meets quarterly
- PFB - All decisions made and accountable via individual Trust Boards steered by PFB Executive Group and Chairs to ensure visibility, and public/partner scrutiny

Schedule of Meetings

	Jan	Feb	Marc	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
ICB	X	Devel	X	X	X	Devel	X		X	Devel	X	X
HCP		X			X				X			X
JPDC	X	X	X	X	X	X	X	X	X	X	X	X
SEG	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx	xxxx	xxxx	xxxxx

Notes

ICB (Integrated Care Board)

- Meets 8 time per year formally at the beginning of each month
- Has 3 Optional Development Sessions a year (strategic session with no expected papers for decision) - can invite wider attendance
- Meets nationally prescribed membership (with GM additional membership, as set out above)
- REPLACES the GM Partnership Board

HCP (Health and Care Partnership)

- Meets 4 times formally per year, at the beginning of the month in question, and dovetailed with the NHS ICS Board
- Has larger membership drawn from the full range of stakeholders

JPDC (Joint Planning and Delivery Committee)

- Meets monthly in the middle of each month dovetailed with ICS Board and HCP
- Takes direction, informs and statutorily reports into NHS ICB
- Minutes also go to CA
- Has a standing membership drawn from ICSB, HCPB, LA and Mayoral Office
- REPLACES Partnership Executive Board and JCB

SEG (Shared Executive Group)

- Meets weekly
- Is an informal meeting but with action notes taken
- Has a small core membership but with ability to bring in additional input on a fluid basis

RECOMMENDATION - Taken together these proposals are recommended for adoption by the GM Health and Care Partnership Board

NHS
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Greater Manchester Public Services – Race Commitment for Change 2021

Report To (Meeting):		Governing Body			
Report From (Executive Lead)		Andrea Green, Chief Accountable Officer			
Date:		11 August 2021	**Agenda Item No:**	8	
Previously Considered by:		Greater Manchester Combined Authority - Greater Manchester Race Equality Panel			
Decision	✓	**Assurance**	✓	**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	None relating to this report

Purpose of the report:

To seek support from Members of the Governing Body to sign up to the Greater Manchester Public Services – Race Commitment for Change 2021 by adopting the pledges appended to this report.

Key points (Executive Summary):

All public sector organisations aim to deliver fair, consistent and high-quality services irrespective of a person's race and cultural diversity, however that last year has very clearly exposed evidence of greater inequality for some of our people and communities.

Across Greater Manchester leaders are working together to eradicate this and have come together to agree a suite of commitments to help us to purposefully improve the lives and opportunities of those from radically diverse communities who use the services we plan and commission and for our staff.

The Commitment attached sets how what we will do to drive this change.

Recommendation:	
The Governing Body is asked to agree and adopt the Public Sector - Race Commitment for Change 2021 pledges within the appended document.	
Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	Addressing inequality cuts across all the CCG's aims
Risk and Assurance:	
List all strategic and high level risks relevant to this paper	The report potentially cuts across the CCG's Strategic Risks related to safe and equitable services.
Consultation and Engagement:	
Patient and Public Involvement:	Through the Greater Manchester Race Equality Panel
Clinical Engagement:	Through the Greater Manchester Race Equality Panel and the Leadership for Inclusion Group development

POTENTIAL IMPLICATIONS

Potential Implications:								
Financial Impact:	Non-Recurrent Expenditure	None directly relating to this Report						
	Recurrent Expenditure	None directly relating to this Report						
	Expenditure included within CCG Financial Plan	Yes		No	√	N/A		
Performance Impact:	Reduction in race inequality							
Quality and Safety Impact:	Reduction in race inequality of access							
Compliance and/or Legal Impact:	This commitment should help the CCG with action to improve Equality, Diversity and Inclusion activity both for staff and our population to support the CCG's Public Sector Equality Duty.							
Equality and Diversity:	General Statement: The ambition is the pledges will help to drive down race inequalities for staff and local people for whom we commission							
	Has an equality impact assessment been completed?	Yes		No	✓	N/A		
	If Not Applicable please explain why	Not Applicable						

Greater Manchester Public Services – Race Commitment for Change 2021

As public service organisations we aim to deliver fair, consistent and high-quality services to the richly diverse communities of Greater Manchester. 2020, through COVID and the death of George Floyd, highlighted the depth of individual and institutional racism which still affects our racially diverse communities and workforce on a daily basis.

We can see this affects the services we deliver and the people who access them – and we are committed to change this. We accept that we have not made the progress that we should have on issues related to race. The statistics speak for themselves. And, we recognise that change will not happen without purposeful commitments and actions.

As public service organisations we have reach and influence and we should lead by example. We impact on every individual across Greater Manchester through the services we deliver, and we have the collective power to make a real difference to the life opportunities of racially diverse groups through these services, and through good employment.

These pledges describe the actions we intend to take as individuals, organisations and as a collective system to deliver real change for our communities of Greater Manchester.

Our pledges acknowledge that we can, and must, do better.

We pledge to seek out the lived experience of the workforce and people, and to combine this with data to identify priorities for improvement, to ensure:

- The people working in our organisations are representative of our communities at all pay grades
- That people of colour are just as likely to get a job from shortlisting to recruitment as their white counterparts.
- That people of colour are no more likely to be subject to formal disciplinary processes and dismissal as their white counterparts.

As the public service leaders of Greater Manchester, we pledge to:

» **Keep learning**, to intentionally seek out the experience of staff and service users and to use it to inform our personal and our organisation's decision making

» **Be bold**, and accept that we will make mistakes on this journey

» **Be positive and vocal advocates** for diverse groups – speaking up and speaking out

» **Use our influence** to challenge and drive change in our organisations

» **Take action to make a difference** for our workforces and the people who use our services.

As Greater Manchesters' public sector we pledge to:

» Actively create or support **our internal staff networks** with funding, development and executive sponsorship to deliver what they see as important

» **Set ambitious plans** and targets to improve the experience of the workplace; improve life opportunities; and address the inequalities across our communities.

» Make sure **our workplaces are diverse at all levels**, and are places where everyone feels they are safe and belong

» **Develop our leaders and workforces** to be anti-racist and passionate advocates for inclusion and diversity in the way we work together and deliver our services

» Work in **collaboration at a place level**, using our combined resources to make positive improvements in the way the work place and our services are experienced

As a Greater Manchester system we pledge to:

» Give **voice to lived experience** of racially diverse groups across GM

» **Connect people and organisations** at place and GM level with shared objectives to drive improvements in representation, workforce and service user experience.

» **Share data** that shows the diversity and experience of our workforce across Greater Manchester – and take actions to change that data for the better.

» **Provide expertise, capacity and capability** through system level interventions, which support places and organisations to take the actions needed to change the representation and experience of diverse groups across our workforces and communities

» **Design and deliver programmes** which support racially diverse groups across Greater Manchester to enter into work, or progress within our public services

» Proactively **celebrate the racial diversity** of our communities

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CHC Service Specification

Report To (Meeting):	Governing Body		
Report From (Executive Lead)	Anita Rolfe, Executive Nurse		
Report From (Author):	Sue Brett, Associate Director of Continuing and Complex Healthcare		
Date:	11 August 2021	**Agenda Item No:**	9
Previously Considered by:	GM CHC Forum , Quality and Governance Committee		

Decision		**Assurance**	**x**	**Information**	**x**

Conflicts of Interests	
Potential Conflicts of Interest:	N/A

Purpose of the report:
To update on the refreshed CHC service spec that has been approved by GM CHC leads
Key points (Executive Summary):
Updated service specification
Recommendation:
Governing Body are asked to 1. Note the refreshed service specification 2. Note that the document has been agreed as a standardised GM document

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	***Statutory duties***
Which corporate objective(s) is / are supported by this report:	***Statutory duties***

Risk and Assurance:	
List all strategic and high level risks relevant to this paper	Standardised process that reflects GM approach reduces risk

Consultation and Engagement:	
Patient and Public Involvement:	*None*
Clinical Engagement:	*None currently*

POTENTIAL IMPLICATIONS

Potential Implications:								
Financial Impact:	Non-Recurrent Expenditure	None						
	Recurrent Expenditure	None						
	Expenditure included within CCG Financial Plan	Yes		No		N/A		
Performance Impact:	***Performance in line with expectations***							
Quality and Safety Impact:	***Performance in line with expectations***							
Compliance and/or Legal Impact:	Compliance with CHC guidance							
Equality and Diversity:	General Statement:							
	Has an equality impact assessment been completed?	Yes		No	X	N/A		
	If Not Applicable please explain why							

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Governing Body Assurance Framework – Quarter 1 Review 2021/22

Report To (Meeting):	Governing Body		
Report From (Executive Lead)	Andrea Green, Chief Accountable Officer		
Report From (Author):	Paul Lewis-Grundy, Deputy Director of Corporate Affairs		
Date:	11 August 2021	**Agenda Item No:**	10
Previously Considered by:	Executive Board – 21 July 2021 Finance, Performance and Delivery Committee – 28 July 2021 Planning and Commissioning Committee – 28 July 2021 Quality and Governance Committee – 28 July 2021		

Decision		**Assurance**	**x**	**Information**	

Conflicts of Interests	
Potential Conflicts of Interest:	None identified

Purpose of the report:
To present an update to the CCG's Governing Body Assurance Framework at the end of quarter 1 2021/22
Key points (Executive Summary):
The Risk Management Strategy approved by the Governing Body in October 2019 sets out the requirement for the CCG's Governing Body and its Committees to regularly review its strategic risks. The strategic risks form the Governing Body Assurance Framework. Through a facilitated review of the Governing Body Assurance Framework in Quarter three 2020/21, ten strategic risks were agreed by the Governing Body. This report sets out the controls in place to mitigate each of the strategic risks under the Governing Body Assurance Framework. Specific actions to address gaps in control or assurance have been identified. The review at Quarter 1 has been completed with the relevant Executive Leads and Executive

Board before being considered at the Committee meetings on 28 July 2021. There was consensus of the effectiveness of the management of the strategic risks on the GBAF, a recommendation to open a new revised risk reflecting the CCG's financial position and the reduction in the score of the risk defined about the restoration and maintaining access to services to avoid significant reduction in, and impact on, patient referrals and attendances, all of which are incorporated in this report.
Recommendations:
1. To review and discuss for assurance the Governing Body Assurance Framework report. 2. To agree the opening and description of a revised Strategic Risk 1 for the GBAF in 2021/22. 3. To agree the reduction in the score of Strategic Risk 3 from 4 x 2 (8) to 4 x 2 (1).

Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	This report relates to the CCG's Corporate Aims to Live Well and to Lead Well and to the objectives to restore, prepare, transform and maintain business as usual.
Which corporate objective(s) is / are supported by this report:	

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	This report covers all the CCG's strategic risks in the Governing Body Assurance Framework.

Consultation and Engagement:	
Patient and Public Involvement:	Not Applicable
Clinical Engagement:	Not Applicable

1. INTRODUCTION

1.1 The Governing Body Assurance Framework (GBAF) sets out how NHS Stockport CCG will manage the principal risks to delivering its objectives. The GBAF enables the Governing Body to corporately assure itself on the level of risk of achieving each objective. The framework aligns risks, key controls and assurances alongside each objective.

1.2 Where gaps are identified, or key controls and assurances are insufficient to reduce the risk of non-delivery, action needs to be taken. Planned actions will be identified to enable the Governing Body to monitor progress in addressing gaps or weaknesses and to ensure that resources are allocated appropriately.

1.3 Each of the strategic risks identified within the GBAF have been assigned to a Committee to ensure relevant oversight and assurance is provided on the risks.

Dashboard Summary at Quarter 1

10 Strategic Risks on the GBAF		1 Proposed New (Revised) Risk SR1	
Risk Increase / Decrease Recommendation			
GBAF Risk No	Descriptor	Increase / Decrease in Score	Rational
SR3	If the CCG fails to restore and maintain access to services to avoid significant reduction in, and impact on, patient referrals and attendances across many specialties (including cancer, cardiology, stroke/TIA), this may result in increased inequalities.	Decrease in Risk Score Proposed From 4 x 2 (8) High To 4 x 1 (4) Medium	Establishment of an inequalities group overseeing workstreams in urgent care (paediatrics); cancer care referral gap identification; community diagnostic hub planning; waiting well for treatment

Overview at Q1

GBAF No	Risk Descriptor	Lead	Q1	Q2	Q3	Q4	Target
SR1	If the CCG does not deliver a balanced budget in 2021/22, gain a reduction in the underlying expenditure, and secure a system-wide financial recovery strategy for 2021 onwards, this may result in the failure of meeting statutory financial duties, and adversely affect viability of a future Greater Manchester Integrated Care System (ICS).	MC	4x3 (12)				4x2 (8)
SR2	If the CCG is unable to maintain staffing levels due to sickness, absence or self-isolation as a result of living with COVID-19 or organisational change related to formation of an ICS, then there may be an adverse impact on the CCG's ability to deliver its functions, staff morale and wellbeing.	AG	3x2 (6)				3x1 (3)
SR3	If the CCG fails to restore and maintain access to services to avoid significant reduction in, and impact on, patient referrals and attendances across many specialties (including cancer, cardiology, stroke/TIA), this may result in increased inequalities.	LM	4x1 (4)				4x1 (2)
SR4	If the CCG fails to find acceptable alternative provision and support providers to appropriately engage with patients and the public to build confidence in using services and provide effective communications, there is a risk that the public will not access services leading to a potential negative impact on health outcomes and greater inequality.	AG	4x3 (12)				4x2 (8)
SR5	If the CCG fails to establish adequate systems for the oversight and improvement of care provided to patients from commissioned services, then it may not identify deteriorations in quality of care leading to patient harm or poor experience.	AR	4x3 (12)				4x2 (8)
SR6	If the CCG fails to encourage, influence and commission the right system improvements to reduce avoidable demand and increase flow out of Stockport NHS Foundation Trust identified in the CQC report and SIB, then the quality and safety of care at the Trust, may not be recovered and sustained as planned.	EI / AR	4x3 (12)				4x2 (8)
SR7	If the CCG do not agree a system-wide Winter Plan, support achievement of uptake of Flu vaccine at rates previously achieved, lead the TCG for Stockport linking in with GM-wide LRF, and manage impacts of the end of the EU exit transition - services could be stretched leading to stopping essential non Covid services, and poorer outcomes from ED and other services.	EI / AR	3x3 (9)				3x2 (6)
SR8	If the CCG fails to actively lead, collaborate, sustain and develop positive relationships and a "Just Culture" at a system level, this may impact on the CCG's ability to influence, lead and deliver the future development of effective Place based Partnership as part of GM wide ICS.	AG	3x2 (6)				3x2 (6)
SR9	If the CCG fails to ensure effective development and maturity of "Primary Care at scale" (for example OOHs, PCNs, GM GP cell) in line with the national Primary Care Plan, performance may fall and there may be a potential adverse impact upon other services (care homes / acute services /mental health services), as well as primary care resilience, responsiveness and quality of care.	EI	3x3 (9)				3x2 (6)
SR10	If the CCG's safeguarding systems for children and vulnerable adults are not fully embedded and fully operational there is a risk of serious incidents due to heightened vulnerabilities as a result of the pandemic.	AR	4x2 (8)				4x1 (4)

Heat Map at Quarter 1

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major	SR3	SR10	SR1 SR4 SR5 SR6		
3 Moderate		SR2 SR8	SR7 SR9		
2 Minor					
1 Negligible					

At the end of quarter 1, seven of the Strategic Risks (SR1, SR4, SR5, SR6, SR7, SR9 and SR10) have a high level of risk, three (SR2, SR3 and SR8) have a moderate level of risk. Two of the risks SR3 and SR8 are at their target score.

Target Strategic Risk Profile

Consequence	Likelihood				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic					
4 Major	SR3 SR10	SR1 SR4 SR5 SR6			
3 Moderate	SR2	SR7 SR8 SR9			
2 Minor					
1 Negligible					

Risk Grading

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Significant risk

2. DETAIL

2.1 The Governing Body is responsible for ensuring that an Assurance Framework is in place, which sets out the strategic risks that threaten the achievement of the objectives, and which includes the following information, so that it can assure itself that its agreed objectives will be met:

- The design of key controls intended to manage these principal risks.
- The arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk.
- The assurance across all areas of principal risk.
- positive assurances and areas where there are gaps in controls and / or assurances

- Plans to take corrective action where gaps have been identified in relation to principal risks.
- Risk management arrangements including a well-founded risk register.

2.2 The review of the GBAF in the autumn of 2020 reflected the emergence of a number of objectives over the following year, including restoration, transformation, preparation and maintaining Business As Usual. The review was conducted in two parts - a facilitated session with the CCG Executive Team in October 2020, followed by a further facilitated session with the Governing Body in November 2020, the GBAF was updated using the outputs from these sessions through a series of discussions with the relevant Directors and was presented back to the Governing Body in January 2021.

2.3 The GBAF has been updated at the end of quarter 1 2021/22 in discussion with the respective Executive leads and is presented to the Governing Body for discussion and assurance, following review and scrutiny at the Executive Board and Committees in July 2021.

2.4 Committee Review

2.4.1 At the meeting of the Finance, Performance and Delivery Committee, members agreed to recommend to Governing Body a broader definition of the Strategic Risk to the CCG's financial position reflecting the full year rather than just the first half of the year (H1), which is reflected through this report.

2.4.2 The Planning and Commissioning Committee supported the proposed reduction in the risk score for Strategic Risk 3 (If the CCG fails to restore and maintain access to services to avoid significant reduction in, and impact on, patient referrals and attendances across many specialties (including cancer, cardiology, stroke/TIA), this may result in increased inequalities.)

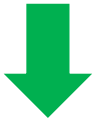
2.4.3 All the Committees were assured of the ongoing effective management of the strategic risks at the end of quarter 1.

2.5 The table below gives a summary of each of the strategic risks making up the current Governing Body Assurance Framework and a commentary at the end of Quarter 1 2021/22. The full Assurance Framework is provided in the supporting documents pack for the meeting. The initial, mitigated and target risk scores have been calculated using the matrix in the CCG's Risk Management Strategy.

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR1	If the CCG does not deliver a balanced budget in 2021/22, gain a reduction in the underlying expenditure, and secure a system-wide financial recovery strategy for 2021 onwards, this may result in the failure of meeting statutory financial duties,	4 x 5 (20)	4 x 3 (12)	4 x 2 (8)	NEW

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
	and adversely affect viability of a future Greater Manchester Integrated Care System (ICS).				
Commentary at Quarter 1 Following the agreed closure of risk SR1 at the end of 2020/21, this is the proposed newly defined risk reflecting the CCG's financial position and challenge during 2021/22.					

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR2	If the CCG is unable to maintain staffing levels due to sickness, absence or self-isolation as a result of living with COVID-19 or organisational change related to formation of an ICS, then there may be an adverse impact on the CCG's ability to deliver its functions, staff morale and wellbeing.	3 x 3 (9)	3 x 2 (6)	3 x 1 (3)	
Commentary at Quarter 1 The staff engagement plan incorporating the outputs from the staff survey, time to talk conversations and the AQUA Resilience Workshops has been co-produced with staff and following approval has been added as a control to mitigate this risk. The gap in assurance reporting on the implementation of the plan is a matter of timing and will be resolved during the next quarter through progress reporting. The Workforce Dashboard reported to the Executive Board and the Quality and Governance Committee in quarter one had been added as a source of assurance across the organisation. An internal audit review of the CCG's Workforce Strategy and Resilience is being scoped and planned for the second quarter, which will provide the Governing Body with additional external assurance on the controls mitigating this risk. It is proposed that the risk score remains the same at the end of Quarter 1.				

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR03	If the CCG fails to restore and maintain access to services to avoid significant reduction in, and impact on, patient referrals and attendances across many specialties (including cancer, cardiology, stroke/TIA), this may result in increased inequalities.	4 x 3 (12)	4 x 2 (8) Proposed 4 x 1 (4)	4 x 1 (4)	

Commentary at Quarter 1

An inequalities group has now been established overseeing workstreams in urgent care (paediatrics); cancer care referral gap identification; community diagnostic hub planning; waiting well for treatment.

Whilst the lack of complete data on which to base timely reports is a gap in assurance, the additional control, reduces the likelihood of this risk materialising and therefore increases the level of assurance that can be derived from the management of this risk and is now being managed at its target score.

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR04	If the CCG fails to find acceptable alternative provision and support providers to appropriately engage with patients and the public to build confidence in using services and provide effective communications, there is a risk that the public will not access services leading to a potential negative impact on health outcomes and greater inequality.	4 x 4 (16)	4 x 3 (12)	4 x 2 (8)	

Commentary at Quarter 1

During the first quarter the CCG has approved the One Stockport Borough Plan and received detail of the updated Covid-19 JSNA, both of which provide additional controls to facilitate engagement with patients and the public.

The Health and Care Plan is currently subject to further engagement before it is considered for approval and which is recognised in the update to this risk at the end of quarter 1.
It is proposed that the risk score remains the same at the end of Quarter 1.

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR5	If the CCG fails to establish adequate systems for the oversight and improvement of care provided to patients from commissioned services, then it may not identify deteriorations in quality of care leading to patient harm or poor experience.	4 x 4 (16)	4 x 3 (12)	4 x 2 (8)	
Commentary at Quarter 1 Stockport NHS Foundation Trust's actions to address its CQC report have now been incorporated into its business as usual governance arrangements an additional action has been included against this risk that the Patient Safety Group will continue to monitor these improvements and additional assurance will be received through reporting to the System Improvement Board and the CCG's Quality and Governance Committee. There is a gap in external assurance through a follow up visit by the CQC to confirm reported progress. It is proposed that the risk score remains the same at the end of Quarter 1.					

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR6	If the CCG fails to encourage, influence and commission the right system improvements to reduce avoidable demand and increase flow out of Stockport NHS Foundation Trust identified in the CQC report and SIB, then the quality and safety of care at the Trust, may not be recovered and sustained as planned.	4 x 4 (16)	4 x 3 (12)	4 x 2 (8)	
Commentary at Quarter 1 Clarification has been added to the controls, as the commentary under SR5 that the actions following the CQC report at Stockport NHS FT (SFT) have been embed as business as usual and that the winter planning incorporates SFT's winter resilience planning. There have been improvements, however evidence is still needed of a standardised approach maintaining the cohort of patients who are 'no criteria to reside' and for a consistent commissioned D2A offer from primary care to support discharges into the care					

home sector.

It is proposed that the risk score remains the same at the end of Quarter 1.

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR7	If the CCG do not agree a system-wide Winter Plan, support achievement of uptake of Flu vaccine at rates previously achieved, lead the TCG for Stockport linking in with GM-wide LRF, and manage impacts of the end of the EU exit transition - services could be stretched leading to stopping essential non Covid services, and poorer outcomes from ED and other services.	3 x 4 (12)	3 x 3 (9)	3 x 2 (6)	
Commentary at Quarter 1 Completion of the evaluation of performance over last winter has been completed whilst the current planning for winter 2021/22 which hasn't yet concluded has been included as a gap in the mitigating controls again this risk and an additional action. It is not therefore proposed to alter the risk score at the end of quarter 1.					

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR8	If the CCG fails to actively lead, collaborate, sustain and develop positive relationships and a "Just Culture" at a system level, this may impact on the CCG's ability to influence, lead and deliver the future development of effective Place based Partnership as part of GM wide ICS.	3 x 3 (9)	3 x 2 (6)	3 x 2 (6)	
Commentary at Quarter 1 The Stockport Local Transition Implementation Plan and PCN Assessment Framework have been added as controls to mitigate this risk during quarter 1, as has the planned adoption of learning from the work commissioning to review the impact of Stockport Together and related transformation programme. The report which will be shared with partners has been added as a form of external assurance along with the annual assessment process for the CCG by NHSE/I. The establishment of the Project Group for the evolution of place in the					

GM ICS is a further form of organisation wide assurance that the Controls are working effectively.

The completion of the two identified actions, recognising that they are on plan for completion have been revised and therefore it is not proposed to alter the risk score at the end of Quarter 1.

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR9	If the CCG fails to ensure effective development and maturity of "Primary Care at scale" (for example OOHs, PCNs, GM GP cell) in line with the national Primary Care Plan, performance may fall and there may be a potential adverse impact upon other services (care homes / acute services /mental health services), as well as primary care resilience, responsiveness and quality of care.	3 x 4 (12)	3 x 3 (9)	3 x 2 (6)	
Commentary at Quarter 1 The Locally commissioned Service Contract has been added as an additional control to mitigate against this risk, however there is a lack of assurance on the implementation of the PCN Direct Enhanced Service through capacity which has been affected by the pandemic. The completion dates for the previous agreed actions have also been revised. it is not therefore proposed to alter the risk score at the end of Quarter 1.					

Risk reference	Principal Risk Identified	Initial Score	Current Score	Target Score	Change in current score since last report
SR10	If the CCG's safeguarding systems for children and vulnerable adults are not fully embedded and fully operational there is a risk of serious incidents due to heightened vulnerabilities as a result of the pandemic.	4 x 4 (12)	4 x 2 (8)	4 x 1 (4)	
Commentary at Quarter 1 The Annual Safeguard Report is due to be prepared and presented during Quarter 2, at which point it is expected that with this additional assurance the risk would move during Quarter 2 to its target risk score.					

3. NEXT STEPS

3.1 The Strategic risks will continue to be actively monitored through the second quarter.

4. POTENTIAL IMPLICATIONS

<table>
<tr><td colspan="8">Potential Implications:</td></tr>
<tr><td rowspan="3">Financial Impact:</td><td colspan="2">Non-Recurrent Expenditure</td><td colspan="5">None directly from this report.</td></tr>
<tr><td colspan="2">Recurrent Expenditure</td><td colspan="5">None directly from this report.</td></tr>
<tr><td colspan="2">Expenditure included within CCG Financial Plan</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>x</td></tr>
<tr><td>Performance Impact:</td><td colspan="7">The Governing Body Assurance Framework includes the Strategic Risks to the delivery of the CCG’s Corporate Objectives</td></tr>
<tr><td>Quality and Safety Impact:</td><td colspan="7">None directly from this report</td></tr>
<tr><td>Compliance and/or Legal Impact:</td><td colspan="7">The CCG should ensure that it has an adequate risk management strategy and process in place, including a Governing Body Assurance Framework which details all the strategic risks to the CCG achieving its agreed objectives and that this is regularly reviewed.</td></tr>
<tr><td rowspan="3">Equality and Diversity:</td><td colspan="7">General Statement: There is no direct Equality and Diversity Impact of this report</td></tr>
<tr><td>Has an equality impact assessment been completed?</td><td>Yes</td><td></td><td>No</td><td>x</td><td>N/A</td><td></td></tr>
<tr><td>If Not Applicable please explain why</td><td colspan="6">Not Applicable</td></tr>
</table>

NHS
Stockport
Clinical Commissioning Group

Finance Report for the Period Ending 30 June 2021

Report To (Meeting):	Governing Body		
Report From (Executive Lead)	Michael Cullen		
Report From (Author):	David Dolman		
Date:	11 August 2021	**Agenda Item No:**	11
Previously Considered by:	This is the first time the report has been presented. Elements of the report have been considered by the CCG Executive Board on the 22 July 2021 and Finance, Performance and Delivery Committee on the 28 July 2021.		

Decision	✓	**Assurance**	✓	**Information**	✓

Conflicts of Interests	
Potential Conflicts of Interest:	Potential conflicts of interests exist for any member who has an association with Beechwood Cancer Care or St Ann's Hospice.

Purpose of the report:

The purpose of this report is to provide an overview of the CCG's performance in context of the financial regime that NHSE/I has put in place during the period 1 April 2021 to 30 September 2021 (H1) in response to COVID-19.

This report provides an update on:-

- The financial position as at 30 June 2021
- The forecast outturn position for the period 1 April 2021 to 30 September 2021

- Key messages from the National CFO/DoF Briefing
- The development and implementation of the CCG efficiency plan.
- Procurement

Key points (Executive Summary):

All statutory financial duties and performance targets are forecast to be achieved.

The H1 efficiency target of £2.067m will be delivered with schemes totaling £1.744m identified to be delivered in H2.

Greater Manchester Health & Social Care Partnership (GMH&SCP) reviewing CCG and NHS Provider financial positions at month 3 to assess if system resources need to be reallocated to enable all organisations to breakeven. It is not anticipated that the review will result in an adjustment to Stockport CCGs revenue allocation.

Elective Recovery Fund (ERF) threshold to increase to 95% of 19/20 activity levels from 1 July 2021. The CCG's H1 plan does not assume any ERF therefore there is no financial risk to the CCG but a GM system financial risk.

The H1 2021/22 financial regime will be rolled forward into H2 2021/22 with an increased efficiency requirement. The current planning assumption is that the we will be required to deliver efficiencies totalling £5.0m - £6.0m in H2.

Preparatory work for 2022/23 to be completed by November 2021 to inform discussions with government prior to the December spending review.

It is proposed to permitted the 2-year contract extension of both the Beechwood Cancer Care and St Ann's Hospice contracts as recommended by the Finance, Performance and Delivery committee.

Recommendation:

(i) **Note** that a breakeven position is being reported year-to-date and for the forecast period 1 April 2021 to 30 September 2021.

(ii) **Note** the H1 financial regime will be rolled forward into H2 and the expected requirement for systems to deliver an increased efficiency target in H2.

(iii) **Note** the progress made delivering the H1 efficiency target and identifying efficiencies to be delivered in H2

(iv) **Approve** the permitted 2-year contract extension of both the Beechwood Cancer Care and St Ann's Hospice contracts as recommended by the Finance, Performance and Delivery committee.

Aims and Objectives:

Which Corporate aim(s) is / are supported by this report:	Lead Well - We will reform the health and care system in Stockport to build a sustainable system for future generations
Which corporate objective(s) is / are supported by this report:	Ensure financial balance across the system

Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	Failure to manage costs within notified allocations may result in the CCG failing to deliver its financial statutory duties and performance targets and consequently impact the CCG annual assessment.

Consultation and Engagement:	
Patient and Public Involvement:	Not Applicable
Clinical Engagement:	Not Applicable

1. INTRODUCTION

1.1 This report provides an overview of the CCG's performance in context of the financial regime that NHSE/I has put in place during the period 1 April 2021 to 30 September 2021 in response to COVID-19. The CCG performance is measured against its Statutory Financial Duties and Financial Performance Targets highlighting both the year to date and forecast outturn positions for the 6 month period 1 April 2021 to 30 September 2021.

1.2 This report provides an update on:-

- The financial position as at 30 June 2021
- The forecast outturn position for the period 1 April 2021 to 30 September 2021
- Key messages from the National CFO/DoF Briefing
- The development and implementation of the CCG efficiency plan.
- Procurements

2. STATUTORY FINANCIAL DUTIES AND PERFORMANCE TARGETS

2.1 As a CCG we are required to deliver statutory duties and financial performance targets. Table 1 below RAG rates our financial performance on both a 'Year to Date' (YTD) and forecast outturn basis for the 6-month period 1 April 2021 to 30 September 2021.

Table 1: Statutory Duty and Performance Targets

Area	Statutory Duty / Performance Target	Performance YTD	Performance Forecast 1 April 21 – 30 Sept 21
Revenue	Not to exceed revenue resource allocation		
Running Costs	Not to exceed running cost allocation		
Capital – *(Note: The CCG has not received a capital allocation in 2021/22)*	Not to exceed capital resource allocation	N/A	N/A
Cash	Operate within the maximum drawdown limit		
Business Conduct	Comply with Better Payment Practices Code 95% of all valid invoices are paid within 30 days of invoice date		
Efficiencies	Achieve efficiency target of £2.067m		

Mental Health Financial Performance Target	Growth in Mental Health spend is at least equal to programme allocation growth of 4.11%		
Net Risk	All risk to be fully mitigated (NIL Net Risk)		

3.0 FINANCIAL POSITION AS AT 30 JUNE 2021 (Month 3)

3.1 The financial position as at month 3 is summarised in Table 2 and 3 below.

Table 2: Summary of YTD Financial Position as at 30 June 2021

Financial Position as at 30 June 2021	YTD budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Memo Covid Expenditure	
				M3 Covid Expenditure £m	Total YTD Covid Expenditure £m
Revenue Resource Limit (RRL)					
Confirmed Allocations	(£132.205)	(£132.205)	£0.000		
Retrospective Allocation Received	£0.000	£0.000	£0.000		
Total RRL	**(£132.205)**	**(£132.205)**	**£0.000**		
Net Expenditure					
Acute	£69.773	£69.773	£0.000	£0.000	£0.000
Community Health	£9.933	£9.933	£0.000	£0.000	£0.000
Continuing Care	£6.500	£7.949	£1.449	£0.464	£1.447
Corporate	£1.416	£1.416	£0.000	£0.000	£0.000
Mental Health	£12.350	£12.350	£0.000	£0.000	£0.000
Other	£3.082	£3.340	£0.258	£0.307	£0.506
Prescribing	£13.178	£13.179	£0.001	£0.000	£0.000
Primary Care	£15.973	£16.298	£0.325	£0.404	£0.509
Total Net Expenditure	**£132.205**	**£134.238**	**£2.033**	**£1.175**	**£2.462**
(Surplus) / Deficit before anticipated retrospective allocation	**£0.000**	**£2.033**	**£2.033**		
HDP Allocation Anticipated	£0.000	(£2.033)	(£2.033)		
Elective Recovery Fund (ERF)	£0.000	£0.000	£0.000		
Total Anticipated Allocations	**£0.000**	**(£2.033)**	**(£2.033)**		
(Surplus) / Deficit after anticipated retrospective allocation	**£0.000**	**£0.000**	**£0.000**		

3.2 CCG's will be funded separately for Hospital Discharge Programme (HDP) and Elective Recovery Fund (ERF) expenditure. As at month 3 the CCG is anticipating a retrospective non-recurrent allocation totalling £2.033m for HDP expenditure which has now been received and is therefore able to report a breakeven position.

3.4 The YTD M3 position includes COVID-19 expenditure totalling £2.462m of which, £2.033m relates to the HDP.

3.5 Efficiencies of £1.034m have been delivered in line with YTD plan.

Significant YTD variances are:

3.6 **Continuing Health Care** adverse variance of £1.449m mainly reflects Hospital Discharge Programme expenditure incurred directly by the CCG (includes Bramhall Manor £0.425m per month).

3.7 **"Other"** programme expenditure adverse variance of £0.258m reflects Hospital Discharge Programme expenditure of £0.506m recharged by the local authority and non-recurrent benefits totalling £0.248m.

3.8 **Primary Care** adverse variance of £0.325m reflects an adverse variance against the Primary Care Delegated Budgets with expenditure £0.248m above the notified delegated allocation. The adverse variance also includes £0.077m related to Bramhall Manor GP medical cover which will be funded from the Hospital Discharge Programme.

3.9 **Table 3: Summary of Forecast for the Period 1 April 2021 to 30 September 2021**

Forecast Outturn H1 21/22	Annual Budget (£m)	Forecast Outturn (£m)	Forecast Variance (£m)	Memo Forecast Covid Expenditure £m
Revenue Resource Limit (RRL)				
Confirmed Allocations	(£267.464)	(£267.464)	£0.000	
Retrospective Allocation Received	£0.000	£0.000	£0.000	
Total RRL	**(£267.464)**	**(£267.464)**	**£0.000**	
Net Expenditure				
Acute	£140.737	£140.737	£0.000	£0.000
Community Health	£19.865	£19.865	£0.000	£0.000
Continuing Care	£13.000	£15.705	£2.705	£2.704
Corporate	£2.832	£2.832	£0.000	£0.000
Mental Health	£25.673	£25.673	£0.000	£0.000
Other	£6.263	£6.753	£0.490	£0.986
Prescribing	£26.356	£26.356	£0.000	£0.000
Primary Care	£32.738	£33.375	£0.637	£0.825
Total Net Expenditure	**£267.464**	**£271.296**	**£3.832**	**£4.516**
(Surplus) / Deficit before anticipated retrospective allocation	**£0.000**	**£3.832**	**£3.832**	
HDP Allocation Anticipated	£0.000	(£3.832)	(£3.832)	
Elective Recovery Fund (ERF)	£0.000	£0.000	£0.000	
Total Anticipated Allocations	**£0.000**	**(£3.832)**	**(£3.832)**	
(Surplus) / Deficit after anticipated retrospective allocation	**£0.000**	**£0.000**	**£0.000**	

3.10 A breakeven position is forecast to be delivered in H1 21/22. The forecast breakeven position assumes anticipated allocations totalling £3.832m consisting of:

- Hospital Discharge Programme (HDP) £3.832m
- Elective Recovery Fund (ERF) £NIL – Independent Sector (IS) expenditure is forecast to be within plan. As per the ERF distribution policy approved by the Greater Manchester Financial Advisory Committee (FAC), CCG's will only receive ERF if Independent Sector expenditure exceeds planned levels. Therefore, the CCG will not receive any ERF based on current forecasts.

3.11 The £2.067m H1 21/22 efficiency plan is forecast to be delivered in full.

3.12 It is forecast the CCG will incur COVID-19 expenditure totalling £4.516m consisting of:

- HDP expenditure £3.832m
- GP Covid expansion fund £0.609m
- Covid Hot Clinics £0.075m

Significant forecast outturn variances are:

3.13 **Continuing Health Care** adverse variance of £2.705m mainly reflects Hospital Discharge Programme costs incurred directly by the CCG (includes Bramhall Manor £2.550m for the 6 month period).

3.14 "**Other"** programme expenditure adverse variance of £0.490m reflects Hospital Discharge Programme expenditure of £0.986m recharged by the local authority and non-recurrent benefits totalling £0.496m.

3.15 **Primary Care** adverse variance of £0.637m reflects an adverse variance against the Primary Care Delegated Budgets with committed expenditure £0.496m above the notified allocation. The adverse variance also includes £0.141m related to Bramhall Manor GP medical cover which will be funded from the Hospital Discharge Programme.

4.0 NATIONAL FINANCE BREIFING UPDATE

4.1 The key messages from the July national finance briefing attended by CFO/DoF were:

4.2 <u>H2 Financial Arrangements</u>

- H1 2021/22 financial regime will be rolled forward into H2 2021/22 with an increased efficiency requirement. The current planning assumption is that the we will be required to deliver efficiencies totalling £5.0m - £6.0m in H2.
- Block payment arrangements will continue.
- System Covid allocations will continue to the extent that Covid requirements remain in place but subject to the overall reduction requirement.
- Intention that an activity-based elective recovery fund (ERF) will continue.

4.3 Elective Recovery Fund (ERF)

- Given progress to date and Q2 forecasts, the thresholds for earning ERF has been adjusted to 95% of 19/20 activity levels from 1 July 2021. This is to be kept under review.
- ERF to be paid at 100% of tariff above 95% of threshold and 120% above 100% of threshold.
- Quantitative gateway targets will not be set for long waiters and outpatient transformation in Q2 but will be a focus in H2. Systems are asked to deliver further reductions in the number of long waiters in Q2.

4.4 Hospital Discharge Programme (HDP)

- From 1 July 2021 up to 4 weeks (down from 6 weeks) of care and support can be funded from the HDP for people being discharge from hospital.
- Discussions are ongoing regarding H2 arrangements.

4.5 Planning Timelines

4.6 The table below details the timelines for H2 2021/22 and 2022/23 plans.

Key Event	Possible Dates
H2 2021/22 settlement confirmed	Sept 2021
H2 2021/22 planning	Sept – Nov 2021
2022/23 preparatory work: • Review NHS block payments and system top-up baselines	By Nov 2021
Spending review outcome	Dec 2021
2022/23 planning	Jan – Mar 2022

5.0 EFFICIENCY PLAN UPDATE

5.1 The H1 efficiency target will be delivered in full through non-recurrent benefits and improvements against planning assumptions.

5.2 The focus is now to identify and implement efficiency schemes in anticipation of an increased efficiency target of £5.0m - £6.0m in H2 and to reduce the CCG recurrent deficit.

5.3 To date efficiencies of £1.744m as detailed in Appendix 1 have been identified to be delivered in H2.

6.0 PROCUREMENT

6.1 In preparation of the future GM ICS a set of principles have been developed to be used by each of the 10 Greater Manchester localities to ensure consistent approach when making procurement and contracting decisions supporting the transition to the GM ICS as well as providing a level of assurance to sectors of the health and care system such as the VCSE sector who may be worried about the future commissioning landscape.

6.2 All current and future procurement recommendations will be aligned to these GM principles.

6.3 The Finance, Performance and Delivery Committee recommend the following permitted 2-year contract extensions to the Governing Body for endorsement. In each case the current contract expires on 31 March 2022.

6.4 <u>Beechwood Cancer Care</u>

6.4.1 Stockport CCG is the sole commissioner of the Beechwood Cancer Care contract based in Adswood, Stockport. The contract value is £254,016 per annum.

6.4.2 Beechwood is a VCSE organisation providing mild to complex (levels 1-3) counselling, psychological support and complementary therapies for adults with cancer and life-limiting illnesses, including those:

- newly diagnosed
- awaiting diagnosis
- ongoing diagnosis
- in recovery
- their carers
- bereaved (of the diagnosed)

6.4.3 The delivery of bereavement support by Beechwood is an integral part of the Stockport end of life model and is aligned with the Stockport Foundation Trust palliative care provision.

6.4.4 The organisation is innovative and works well with other stakeholders in the end of life, social prescribing and mental health pathways. In Stockport they remain the main provider of psychological and practical support for the ongoing needs of clients finishing treatment. These elements form part of an overall support and self-management package for people affected by cancer, managing consequences of treatment, and information, financial and work support needs.

6.4.5 Performance against the quality and performance indicators in 2020/21 has been excellent and met throughout the year. This includes targets to increase the number of males seeking counselling support and increasing the number of patients receiving treatment from the most deprived areas of Stockport. There have been no formal quality or safety concerns raised during the course of the current contract.

6.5 St Ann's Hospice

6.5.1 Stockport CCG is the coordinating commissioner of the St Ann's Hospice contract. Co-commissioners to the contract are Trafford, Manchester and Salford CCGs. St Ann's has two sites: Heald Green, Stockport and Little Hulton, Salford.

6.5.2 The Stockport CCG contract value in 2020/21 was £1,137,651. The total contract value including Manchester, Salford and Trafford CCGs is c£4,3m, which is approximately a third of the income that St Ann's require to run the hospice each year. Due to COVID St Ann's was prevented from fundraising for most of 2020/21.

6.5.3 St Ann's delivers specialist palliative care for those with progressive life-limiting illness which includes:

- the inpatient units at Heald Green and Little Hulton,
- medical and supportive outpatient services,
- day care,
- lymphoedema management service
- 24-hour advice and guidance helpline for health professionals.

6.5.4 Whilst the provision of specialist palliative care is for a small cohort of patients, it is delivered by a dedicated set of professionals who have specific expertise in caring for people with complex needs. St Ann's use a multi-disciplinary team approach to care which is in line with the NICE supportive and palliative care guidance. This includes medical, nursing, spiritual and emotional, rehabilitation, pharmacy and complementary therapies professionals to deliver a valued service to patients. Commissioning this type of service is a core and integral part of end of life and palliative care services.

6.5.5 During the pandemic, St Ann's has supported the health and social care system in Stockport by adapting their services to keep patients and staff safe and took a proactive approach, liaising with commissioners and providers regularly to update on inpatient bed capacity and offer support wherever possible. They had to reduce bed capacity at Heald Green to comply with social distancing rules but despite this they accepted more admissions overall into their inpatient units in 20/21 than in 19/20.

6.5.6 Performance against the quality and performance indicators in 20/21 has been very good and performance overall has been more consistent and higher than in the previous year despite the many challenges that COVID presented to the hospice. This includes outcomes such as patients dying in their preferred place, advanced personalised care planning and timely access to the service.

7.0 NEXT STEPS

7.1 The CCG will implement national guidance for the second half of the financial year when it is published.

7.2 Continue to develop and implement an efficiency programme to deliver the anticipated increase in the efficiency target in the second half of the year.

8.0 POTENTIAL IMPLICATIONS

<table>
<tr><td colspan="8">Potential Implications:</td></tr>
<tr><td rowspan="3">Financial Impact:</td><td colspan="2">Non-Recurrent Expenditure</td><td colspan="5">N/A</td></tr>
<tr><td colspan="2">Recurrent Expenditure</td><td colspan="5">N/A</td></tr>
<tr><td colspan="2">Expenditure included within CCG Financial Plan</td><td>Yes</td><td>✓</td><td>No</td><td></td><td>N/A</td><td></td></tr>
<tr><td colspan="3">Performance Impact:</td><td colspan="5">Reporting a YTD and forecast a break-even positions in accordance with national guidance.</td></tr>
<tr><td colspan="3">Quality and Safety Impact:</td><td colspan="5">Not Applicable</td></tr>
<tr><td colspan="3">Compliance and/or Legal Impact:</td><td colspan="5">Reporting is in compliance with national guidance in response to COVID-19 pandemic.</td></tr>
<tr><td rowspan="3">Equality and Diversity:</td><td colspan="7">General Statement:</td></tr>
<tr><td colspan="2">Has an equality impact assessment been completed?</td><td>Yes</td><td></td><td>No</td><td></td><td>N/A</td><td>✓</td></tr>
<tr><td colspan="2">If Not Applicable please explain why</td><td colspan="5"></td></tr>
</table>

Appendix 1 – Efficiency Plan H2 2021/22

SRO/Lead	Ref	Scheme	Tracked	System Recurrent Savings	H2 2021/22 Efficiency Forecast	Update
Anita Rolfe/ Jacqueline Coleman	E04	Stoma Care	Y	£192,000	£96,000	Trial of COBWEB service due to start in Tame Valley PCN in August 2021. This is delayed from original start date of July 2021 due to governance processes within SFT.
Anita Rolfe/ Faduma Abukar	E07	Medicines Optimisation	Y	£1,100,000	£961,042	A programme of QIPP schemes has been developed to be signed off by PCN Clinical Directors and Viaduct at the end of July. Implementation is planned ffrom August with savings expected from September.
Gillian Miller/ Kim Roberts	PCC02	Primary Care Contracts Review	Y	£1,000,000	£500,000	New LCS and Viaduct contract to be agreed by the end of September 2021. Full savings to be quantified once the contracts are scoped fully and agreed.
Gillian Miller/ Gale Edwards	PCC06	Spinal Assessment Treatment Service Procurement	Y	£280,000	£187,000	New contract in place from mid-July with savings from August onwards.
Emma Ince/ Karen Moran	PC02	Elective Recovery	Y	TBC	TBC	This scheme will restore elective activity and improve pathway efficiency through waiting list validation, advice and guidance and PIFU initiatives. Due to block contracting arrangements no cash savings are possile for the CCG.
Emma Ince/ Karen Moran	PC04	Orthopaedic Pathway	Y	£522,000	TBC	Prior to block contracting arrangements a saving of £522k was expected by reducing the number of patients referred to the outpatient clinic by 30%. This will now become a system saving with no cash release for the CCG.
Liz McLean/ David Dolman	E06	CHC Pricing Policy	Y	£520,000	£0	Implemention of a CCG CHC pricing policy together with the GM CHC Choice Policy the average weekly cost of a placement is expected to reduce. It is anticipated that the policies will be implemented from 1 October 2021
TOTAL				£3,614,000	£1,744,042	

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Integrated Performance Report Month 2 data – May 2021

Report To (Meeting):	Governing Body		
Report From (Executive Lead)	Liz McLean		
Report From (Authors):	Aaron Atkinson, Claire Pickup,		
Date:	11 August 2021	**Agenda Item No:**	12
Previously Considered by:	Finance, Performance and Delivery Committee – 28 July Executive Board – 21 July		

Decision		**Assurance**	**x**	**Information**	**x**
Conflicts of Interests					
Potential Conflicts of Interest:	No known conflicts of interest				
Purpose of the report:					
To provide the 2021/22 M2 data on performance, service and quality updates with added information on restoration and delivery against the final first half year (H1) plan.					
Key points (Executive Summary):					

The main report identifies the performance related to the end of May 2021. Further detail is appended to the report.

Matters of concern and key risks to escalate:

- Waiting lists and wait times for diagnostic and planned care procedures remain significantly challenged.
- Routine Endoscopy waiting times continue to impact General Surgery and Gastroenterology pathways;
- 62 day cancer waits remain challenged
- Cancer 2 week wait performance deteriorated again in May due to pressures in Dermatology and Breast services.
- Waiting times for Children and Young People mental health services key concern
- General increasing pressure across primary and urgent care remains with further particular increases in mental health related needs across all urgent care services and significant increases in paediatric attendances.

Actions and work underway to mitigate risk:

- Continued support with hospital delivery across specialities to ensure that long waiting times are minimised where possible
- Clinical validation and prioritisation work on diagnostic waiting lists has commenced in line with recent NHS guidance
- SFT have recruited additional gastroenterology consultants; mutual aid has also been sought and additional capacity used at partner providers (Fairfield) though uptake is mixed
- Additional CT capacity was utilised at SFT in May to expedite the reduction of 6+ week waits for diagnostics
- Use of the Greater Manchester Cancer hub and mutual aid remains in place
- Additional elective theatre capacity at SFT opened in May
- Use of Independent Capacity Framework providers remains in place across Greater Manchester with uptake being closely monitored.

Positive assurance:

- Vaccination programme remains on track
- Significant progress continued in May in discharging longer length of stay patients, particular those with more complex needs and with greater focus on flow outside hospital.
- New diagnosing dementia clinics were established on Saturdays during May to support efforts to reduce the backlog of assessments caused by the pandemic.

New guidance on access to the elective recovery fund was received which increases the delivery requirements to 95% of the 2019/20 baseline position with immediate effect, impacting on the H1 plan which was set to deliver the original 85% target from 1 July.

Early indications on the expectations of second half year (H2) planning have been released in relation to outpatients and delivery of significant reductions in the number of patients waiting over 52 weeks. This will need careful working through if the demand expectations related to winter planning are experienced and consequentially impact significantly on the delivery of planned care.

Recommendation:	
The Governing Body is asked to **Note** the report and **Discuss** areas of concern.	
Aims and Objectives:	
Which Corporate aim(s) is / are supported by this report:	• Lead well
Which corporate objective(s) is / are supported by this report:	The following objectives are: - • Continuously improve the quality and safety of care • Ensure people can access safe, high quality care when necessary
Risk and Assurance:	
List all strategic and high-level risks relevant to this paper	The following risks may be considered: • Cancer clinical prioritisation and treatment timescales • Recovery of planned care and ensuring patients are 'waiting well' • Mental health wait times and access

	• CYP mental health wait times and access						
Consultation and Engagement:							
Patient and Public Involvement:	Patient and public engagement is took place as part of the COVID recovery planning.						
Clinical Engagement:							
Potential Implications:							
Financial Impact:	Non-Recurrent Expenditure						
	Recurrent Expenditure						
	Expenditure included within CCG Financial Plan	Yes		No		N/A	X
Performance Impact:	Deterioration in the waiting list position due to capacity constraints and some impact of patients wishing to avoid attending hospitals for appointments. Capacity is severely restricted for elective care and delivery remained focused on the national priorities of cancer and diagnostics though restarting elective activity for other patients has now resumed.						
Quality and Safety Impact:	Not completed						
Compliance and/or Legal Impact:	None						
Equality and Diversity:	General Statement:						
	Has an equality impact assessment been completed?	Yes		No	x	N/A	
	If N/A please explain why						

Month 2 - Integrated Performance Report
Governing Body

11 August 2021

1. Introduction

1.1. This report provides an overview of the CCG's performance against key national standards for month 2 (May 2021) as well as delivery of CCG actions against delivery plans in 2021/22. The data used in this report largely relates to validated data for month 2 (May 2021), where it does not relate to April this is identified within the report. At the time of writing some national data is not currently available.

1.2. May 2021 was a period of relatively light covid impact with covid activity in the hospitals and in the care homes bed bases reduced significantly in comparison to March 2021. Elective care capacity increased with additional capacity within staff groups and re-opening of additional theatres.

2. Primary and community care

2.1. Primary and community response restoration shows a return to 102% activity for GP appointments in General Practice as compared to the previous 24 months.

2.2. During May concentration on delivering the vaccination programme remained a major focus.

3. Urgent Care

3.1. During May, 77.9% of patients were seen, admitted, or discharged within 4 hours in A&E which maintained the position in April despite the significant sustained pressure seen nationally and across all parts of the local system.

3.2. One patient waited over 12 hours for admission resulting from complex mental health needs and a positive decision to keep the patient in A&E as the best place at the time.

3.3. Delivery against the first half year (H1) plan shows performance rose to around 107% for type 1&2 attendances but fell to around 88% for types 3&4, with just over 100% in relation to the number of NEL admissions.

3.4. Indications for June and July suggest a rise in the number of paediatric attendances across the whole system, not just in A&E and rising numbers of COVID presentations as relaxation of rules takes effect with pressure in NWAS services in category 1 and 2 presentations.

4. Diagnostics

4.1. Diagnostic service delivery within six weeks began to show a slight improvement this month to 63% though this still falls far short of the 99% target. SFT benefitted from additional CT capacity during this period in support of this reduction.

4.2. As a CCG, in May 2021 4,247 patients were waiting more than six weeks for a routine diagnostic procedure compared to 4,740 at the end of April. The programme for prioritising diagnostic waiting list patients should be complete by the end of July to ensure that patients are seen in clinical priority order rather than just in order of length of wait.

4.3. Endoscopy capacity remains a matter of significant local concern, also reflecting a much wider national issue. Access to the Fairfield Hospital for additional endoscopy capacity remains in place.

4.4. Other areas of issue are shortfalls in MR reporting (particularly for prostate patients) where three additional radiologists have been recruited and DEXA where an additional radiographer is now in post.

4.5. The H1 delivery plan shows overall above plan performance of +4.7%, though shortfalls at a test level relate particularly flexi-sigmoidoscopy and also to non-obstetric ultrasound (NOUS). There was a slight shortfall in echocardiography against the May delivery plan. Colonoscopy achieved better than plan, improving performance compared to April.

5. Planned care

5.1. At the end of May there were 38,910 Stockport patients on waiting lists - a rise of 1,244 from April.

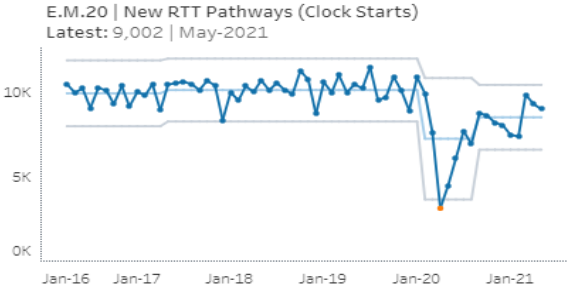
5.2. With waiting times remaining beyond 18 weeks for 15,502 patients at the end of May (39.8% of the total waiting list), 3,683 patients were waiting in excess of 52 weeks (9.5% of the total waiting list). This represents a slight improvement in the CCG position since April.

5.3. The table below shows the further breakdown of the CCG's position at the end of May with 2.0% of 52+ week waiting patients waiting more than 18 months and 0.1% over 2 years. The focus of SFT is to reduce the number of patients waiting beyond 52 weeks and targeting specifically those whose waits are approaching 2 years.

Providers	Over 52 weeks		Of which, over 18 months		Of which, over 2 years	
Stockport NHS Foundation Trust	2576	10.4%	491	2.0%	13	0.1%
Manchester University NHS Foundation Trust	881	10.6%	271	3.3%	13	0.2%
Salford Royal NHS Foundation Trust	73	2.0%	8	0.2%	0	0.0%
Others	61	5.1%	15	1.2%	1	0.1%
BMI The Alexandra	92	9.1%	4	0.4%	0	0.0%
CCG Total for May 2021	**3683**	**9.5%**	**789**	**2.0%**	**27**	**0.1%**

5.4. It should also be noted that although the number of patients waiting more than 52 weeks reduced during April and May 2021, this is likely to be partly an artefact of the first COVID wave when referrals were significantly suppressed on usual levels. As we are now one year on from that point, this automatically affects the number rising to exceed this waiting time and this is expected to impact on the improvement in the 52+ week wait volume over time.

5.5. The chart below shows demand slowly restoring to pre-COVID levels and therefore an expectation that the 52 week wait 'reduction' will slow or even reverse over the coming months depending on capacity going forward.



5.6. Access to independent sector capacity further improved in May in support of the delivery of treatments for longer waiting patients in priority 3. Plans for Q2 are being collated but assumes a steady run rate for the period.

5.7. Work has started on how best to support patients locally who are waiting, particularly for those with elongated waiting times, under the banner of waiting well and in consideration of the focus on inequalities with Stockport being a pilot site for GM on this approach.

5.8. H1 plan delivery is +2.8% for total outpatient appointments with better performance in restoration of face to face consultations (above plan by 11%) but a reduction in telephone/virtual appointments and a reduction in follow up appointments.

5.9. In a recent letter the H1 target for access to the Elective Recovery Fund has been increased to 95% of 2019/20 activity levels from 1 July compared with the planning requirement of 85%. For future reports covering July this figure will now be used.

5.10. This immediate change followed the national review of the success of the Q1 delivery. The requirement for this target relates to the value of the activity rather than the activity volumes themselves. ERF will be paid to systems at 100% of tariff prices for activity value above 95% and at 120% for values above 100%. Use of the independent sector to achieve these targets is expected.

6. Cancer

6.1. Disappointingly the CCG failed again this month to meet the two week waiting time standard again principally due to dermatology and breast referral increases. Information suggests that referrals have increased significantly across GM and impacting on the current capacity available.

6.2. A new dermatology pathway is being implemented in Salford. The new pathway aims to improve the current referral process, reduce time from referral to diagnosis, increase capacity for routine appointments, and avoid unnecessary hospital admissions. If successful it will be rolled out to Stockport and Bury during the autumn after its evaluation.

6.3. The CCG just failed again this month the overall standard of 96% of patients starting first definitive treatment within 31 days of diagnosis with 93.8% of patients starting treatment within this timescale. Of the ten patients impacted by this six were at East Cheshire Trust.

6.4. The 31-day standard where subsequent treatment was surgery was also just failed in May at 93.1% impacting on 2 patients, though the other two standards were met (commencement of anti-cancer drugs or radiotherapy).

6.5. The CCG did not meet any of the three 62 day wait cancer targets in May with a total of 32 patients impacted across the three target areas. Twenty one of these patients were following GP referral with two patients waiting more than 104 days due to their complex pathways.

6.6. In relation to H1 delivery urgent GP referrals exceed the plan by +5% and first treatments were 100% against plan (reflected in the above performance indicators).

7. Mental Health

7.1. Most mental health data for May has not yet been published but actions have been updated in the report to reflect an up to date position.

7.2. In relation to Improving Access to Psychological Therapies (IAPT) access target commissioners across GM are working together with providers to draw up recovery plans given the ongoing failure to meet these standards.

7.3. In relation to the proportion of people on the Health Checks there is:

- additional work with Pennine Care to ensure they forward the health checks that they do so that they can be captured on the GP systems.

- in 2021/22, all six elements of the comprehensive annual physical health check for patients with schizophrenia, bipolar affective disorder and other psychoses as defined in the NHS Long Term Plan included within QOF.

7.4. The dementia diagnosis rate remained at 64.3% in May against the target of 67%. Services were suspended during the first wave of the pandemic.

7.5. The Memory Assessment Clinic action plans are being rolled out to address the backlog and it is hoped that the roll out of the vaccination programme to older age groups will provide confidence for patients attending face to face appointments in future months. The Spending Review/Mental Health Recovery identified additional investment to address the dementia diagnosis rate, and this will be led by provider organisations. Also Saturday morning clinics have been started with additional investment that has been provided. The investment has been provided through System Recovery (SR) allocated directly to Mental Health Trust providers.

7.6. In relation to Children and Young People (CYP) with Eating Disorders, Pennine Care have recently been allocated some national Covid monies via GM to address pressures in community services. Additionally, through System Recovery (SR) funding Pennine Care are working on an additional service offer to provide an intensive community offer for CYP presenting with eating disorders.

8. RECOMMENDATIONS

The Governing Body is asked to **Note** the report and **Discuss** areas of concern.

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Audit Committee Report for the period to August 2021

Achievements/Decisions Made/Items to Note

Since the last written report to the Governing Body, the Committee has met once: on 21 July 2021.

The Committee has a series of standing items on the agenda which are received and scrutinised by members:

Internal Audit
The Committee received an Internal Audit Progress report from MIAA in respect of the progress made against the Internal Audit Plan for 2021/22. Members heard that since the last update, two reviews had been completed (DSPT Readiness Review and Section 75 Review) and a further two were in progress (DSPT New Mandated Standards and HR Workforce Strategy and Resilience). The Internal Audit Plan was presented to the Committee for 2021/22, which set out the internal audit activity for the coming year. This was approved by members.

The Committee also received a final Head of Internal Audit Opinion for 2020/21 for assurance.

External Audit
The Committee received the External Auditors Annual Report for 2020/21 for assurance. The report provided members with a summary of the findings and key issues arising from the 2020/21 audit of the CCG. Members heard that an unqualified opinion of the CCG's accounts had been issued by the Auditors.

Finance Reports
The Committee was presented with the CCG's routine financial update. It was noted that for the period 1 April 2021 to 31 May 2021, there had been no losses and special payments; no occasions when the Detailed Financial Instructions relating to Tendering (DFP 6) were waived and no entries into the register of sealing. As at 31 May 2021 there was one debt greater than £5,000 outstanding for more than 30 days.

In addition to the standing items, the following items were covered by the Committee during the meeting:

Review of registers
Audit Committee Members were provided with a copy of the CCG's Procurement Register and Gifts and Hospitality Register for 2020/21. Members noted that during the previous financial year, no offers of gifts or hospitality were received by CCG employees and no declarations were made within year in relation to any of the procurement decisions undertaken by the CCG.

Governing Body Assurance Framework
Members of the Committee were presented with a report which provided an update on the development of the Governing Body Assurance Framework and a schedule of review of the strategic risks following the comprehensive review of the GBAF in the autumn of 2020.

Key Issues for the Governing Body

- That the Committee approved the internal audit plan for 2021/22
- Members noted external audit update
- Members noted the update relating to the Procurement Register and Gifts and Hospitality Register for 2020/21
- Members noted the Governing Body Assurance Framework update

Key Information:

Committee Chair: Phil Winrow, Lay Member
CCG Lead: Michael Cullen, Chief Finance Officer

Matters referred to the Governing Body for approval, debate or further consideration:

None

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Finance Performance and Delivery Committee Report for the period to August 2021

Achievements/Decisions Made/Items to Note

Since the last written report to the Governing Body, the Committee has met once: 28 July 2021.

The Committee has a series of standing items on the agenda which are received and scrutinised by members:

Finance Report
Members were provided an update on the financial position for the period ending 30 June 2021. The report provided the Committee with an overview of the CCG's performance in context of the NHSE/I financial regime put in place during the period 1 April 2021 to 30 September 2021 (H1) in response to COVID-19.

Members also received a report which outlined the reasons for the CCG's underlying deficit. The report highlighted the key structural, strategic and operational drivers which contributed to the CCG's recurrent deficit and set out plans to enable CCG management and system partners to develop a strategy to address the known issues and improve the financial position.

Review of Local Primary Medical Care
The Committee received a report which provided an overview of Stockport CCG's local Primary Medical Care investments and the recommended approach and framework for developing future investment plans, in light of the funding streams available both locally and under delegated commissioning.

Integrated Performance Report
The Committee received the Integrated Performance Report which summarised the CCG's performance up to May 2021. Data was provided to members on performance, service and quality updates, and additional information was supplied relating to the restoration and delivery against the final H1 plan.

Procurement Update
Members received a report which allowed the Committee to scrutinise progress against the CCG's procurement activities to provide assurance to the Governing Body regarding delivery against requirements and regulations.

In summary, the Committee:

- Endorsed the GM contract principles, considered the risks and noted the impact on the CCG contracts and procurement plan.
- Noted the continued preparations for the procurement programme on Care Homes, homecare support (Domiciliary Care) and transitional care (e.g. Intermediate Tier and D2A).
- Noted the commissioning arrangements and the proposal for the Community Gynaecology service for 5 years plus an option to extend for a period of up to a further 5 years
- Endorsed a Direct Award to Mastercall and variation to the Viaduct contract for a period of two months to the end of August 2021 for the continued provision of the COVID hot clinic.
- Endorsed a Direct Award of a 6-week contract to Routes Healthcare for domiciliary care to the end of July 2021
- Endorsed a Grant Award to British Red Cross for the continuation of the Stockport High Intensity User Project for a period of 6 months to 31 March 2022.
- Agreed and recommended to the Governing Body the proposals to enact the permissible two-year extensions to:
    - Beechwood Cancer Care
    - St Ann's Hospice

Governing Body Assurance Framework
Members were provided a report which presented an update on the CCG's Governing Body Assurance Framework at the end of quarter one 2021/22. The report provided specific details about the risk assigned to the Finance, Performance and Delivery Committee.

Corporate Risk Register
Members received an update on the CCG's Corporate Risk register, relating to the risks owned by the Committee as at the end of July 2021.

It was noted that are currently 13 risks which are monitored by the Committee, and three of those are classed as high level. This presented a revision to two of the risks on the register, which had been given a lower risk rating as a result of the controls and assurances in place which are helping to mitigate the risk. Members were assured that the Finance, Performance and Delivery risks were being managed effectively.

Key Issues for the Governing Body

- That the procurement updates were endorsed and noted as outlined above
- That the Committee agreed and recommended to the Governing Body the enactment of a contract extension as outlined above
- That the reports brought for assurance and information were scrutinised and noted by the Committee members

Key Information:

- **Committee Chair:** Peter Riley, Lay Member
- **CCG Lead:** Michael Cullen, Chief Finance Officer

Matters referred to the Governing Body for approval, debate or further consideration:

- Note the enactment of the permissible two-year extensions to:
    - Beechwood Cancer Care
    - St Ann's Hospice

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Planning & Commissioning Committee Report for the period to August 2021

Achievements/Decisions Made/Items to Note

Since the last written report to the Governing Body, the Committee has met once on 28 July 2021

The meeting covered:

Update on Integrated Care System (ICS) developments

The Committee was provided with a brief update on progress surrounding the latest ICS developments from the Transition Board, including some key dates of note in the process and the commitment which has been made to staff.

Public Health Update

Members of the Committee received an update on the Covid-19 vaccination programme from a public health-point of view and a forward plan for work to address the borough's inequalities.

Winter Planning 2021/22

Members were provided an update on the progress of the Stockport system's winter planning for 2021/22. Specific reference was given to a system-wide planning workshop which had taken place on May 2021. The Committee heard about the outputs that had been achieved following a series of pathway-specific task and finish groups for Mental Health, Children, Respiratory including Covid-19 and Frailty.

The Committee noted that a peer review was planned for late August 2021, which would further aid the development of the winter plan for 2021/22.

Review of Local Primary Medical Care 2021/22

The Committee received a report which provided members with an overview of Stockport CCG's current local Primary Medical Care investments and the recommended approach and framework for developing future investment plans taking into account the funding streams available both locally and under delegated commissioning.

GM Choice and Equity Policy (CHC)

The Committee approved a proposed Greater Manchester Choice and Equity Policy which had been jointly written by GM CCG CHC Leads. Members heard that the purpose of the policy was to support CHC commissioning decisions in respect of packages of care for individuals who have been assessed as eligible for fully funded NHS CHC. It set out how CCGs will commission care in a manner which reflects the choice and preferences of eligible individuals but balances the need for CCGs to commission care that is safe and effective and makes the best use of available resources.

Contracts and Procurement Report

Members received a report which outlined the NHS Healthcare contracts guidance 2021/22 and provided a forward look to potential procurement requirements on which decisions will be required in the next few months, including the GM contract and procurement approach and impact on Procurement planning process 2021/22 and the current procurement project updates.

Health and Care Bill

The Committee was provided a synopsis of the Health and Care Bill for information. It was noted that the Bill is currently at committee stage, during which amendments to the initial measures within the Bill may be proposed before it returns to the House for further readings and amendments.

The Committee was asked to note the potential areas in relation to future pricing approaches and to the repeal of legislation relating to procurements.

Corporate Risk Register

Members received an update on the CCG's Corporate Risk register, relating to the risks owned by the Committee as at the end of July 2021.

It was noted that are currently 8 risks in total, with the majority being rated either a 12 or a 10 which gives them an amber rating. There were no high level risks. Members were assured that the Planning and Commissioning risks were being managed effectively.

Governing Body Assurance Framework
Members were provided a report which presented an update on the CCG's Governing Body Assurance Framework at the end of quarter one 2021/22. The report provided specific details about the three risk assigned to the Planning and Commissioning Committee.

Key Issues for the Governing Body

- That the reports brought for assurance and information were scrutinised and noted by the Committee members
- That the Committee approved the proposed GM Choice and Equity Policy

Key Information:

- **Committee Chair:** Phil Winrow, Lay Member
- **CCG Lead:** Emma Ince, Director of Integrated Commissioning

Matters referred to the Governing Body for approval, debate or further consideration:

- None

NHS
Stockport
Clinical Commissioning Group

Quality and Governance Committee Report for the period to August 2021

Achievements/Decisions Made/Items to Note

Since the last written report to the Governing Body, the Committee has met once on 28 July 2021.

Members received updates for assurance on items outlined below. In addition to this, Committee members approved two policies:

- Procurement Policy for Healthcare and Goods & Services
- Dignity at Work Procedure

Governance Items

Members received an update on the CCG's Corporate Risk register, with specific focus given to the risks owned by the Committee as at the end of July 2021. It was noted that are currently 26 risks which are monitored by the Committee, and 11 of those are high level risks. Members heard that in the reporting period, 2 new risks had been added, 1 had been closed and 1 had achieved its target risk score. Members were assured that the Quality and Governance risks were being managed effectively.

Members were provided a report which presented an update on the CCG's Governing Body Assurance Framework at the end of quarter one 2021/22. The report provided specific details about the risk assigned to the Quality and Governance Committee.

Members also received a report containing the results from the Committee Effectiveness Review survey.

System Improvement Board update

The Committee received a Stockport Patient Safety Group update from the System Improvement Board which outlined the assurance that had been received and the areas that required continued focus following the group meetings which had taken place in June and July 2021.

Secondary Care Exception Report

Committee members were provided a report for assurance which summarised the information from the Trust's Integrated Performance Report and highlighted areas of concern. This included CQC Inspections and Action Plan, A&E 4 Hour Target, 52 week RTT, Cancer 62 Day RTT, Agency Spend/Staffing and Falls.

Flash Reports

A series of flash reports were circulated to members for information.

Key Issues for the Governing Body

- Note that the Committee approved the Procurement Policy for Healthcare and Goods and Services and the Dignity at Work Procedure
- That the reports brought for assurance and information were scrutinised and noted by the Committee members

Key Information:

- **Committee Chair:** John Jolly, Secondary Care Consultant
- **CCG Lead:** Anita Rolfe, Executive Nurse

Matters referred to the Governing Body for approval, debate or further consideration:

None