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COMMISSIONING PARTNERSHIP BOARD
Agenda

Date Thursday 29 April 2021

Time 1.00 pm

Venue Virtual meeting - https://www.oldham.gov.uk/info/200608/meetings/1940/live_council_meetings_online

Notes

1. DECLARATIONS OF INTEREST- If a Member requires advice on any item involving a possible declaration of interest which could affect his/her ability to speak and/or vote he/she is advised to contact Paul Entwistle or Constitutional Services at least 24 hours in advance of the meeting.

2. CONTACT OFFICER for this agenda is Mark Hardman, email constitutional.services@oldham.gov.uk

3. PUBLIC QUESTIONS - Any Member of the public wishing to ask a question at the above meeting can do so only if a written copy of the question is submitted to the contact officer by 12 noon on Monday, 26 April 2021

4. FILMING - The meeting will be recorded for live and/or subsequent broadcast on the Council's website. The whole of the meeting will be recorded, except where there are confidential or exempt items and the footage will be on the Council's website. This activity promotes democratic engagement in accordance with Section 100A(9) of the Local Government Act 1972.

Recording and reporting the Council's meetings is subject to the law including the law of defamation, the Human Rights Act, the Data Protection Act and the law on public order offences.

MEMBERSHIP OF THE COMMISSIONING PARTNERSHIP BOARD
Councillors Chauhan, Fielding, Moores and Shah
CCG Ben Galbraith, Majid Hussain, Dr Ian Milnes, Dr John Patterson.

Item No

1 Election of Chair

The Panel is asked to elect a Chair for the duration of the meeting.

2 Apologies For Absence

3	Urgent Business Urgent business, if any, introduced by the Chair
4	Declarations of Interest To Receive Declarations of Interest in any Contract or matter to be discussed at the meeting.
5	Minutes of Previous Meeting The Minutes of the meeting of the Commissioning Partnership Board held on 25th March 2021 to follow.
6	Public Question Time To receive Questions from the Public, in accordance with the Council's Constitution.
7	Contract Extension - provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists (Pages 1 - 8)
8	White Paper Briefing (Pages 9 - 16)
9	NHS Operational Planning Process (Pages 17 - 22)
10	Exclusion of Press and Public That, in accordance with Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business on the grounds that it contains exempt information under paragraph 3 of Part 1 of Schedule 12A of the Act, and it would not, on balance, be in the public interest to disclose the reports.
11	Contract Extension - provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists (Pages 23 - 30)
12	Oldham Health and Care System Governance and Development (Pages 31 - 42)
13	Oldham CCG Draft Financial Plan 2021/22 The Director of Finance, Oldham CCG, to report.

Oldham cares
Health and Social Care for Oldham

Decision Maker	**Commissioning Partnership Board**
Date of Decision:	**29th April 2021**
Subject:	**Contract extension request, provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities.**
Report Author:	**Lynda Megram, Commissioning Manager, Oldham Cares**

Reason for the decision:	To seek approval to extend a contract for the provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists. The initial term of the contract ends on 31st May 2021: this report requests approval to extend the contract by a further year, from 1st June 2021 to 31st May 2022.
Summary:	The Commissioning Partnership Board agreed that the Council award, on behalf of Oldham Cares, a contract for 'provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities', on 28th March 2019, to commence on or after 1st June 2019 for two years with an option to extend by an additional two years on one-year increments. The contract is held by four suppliers who each hold one of four Lots. The provision is funded from the Disabled Facilities Grant (DFG) Capital allocation within the Better Care Fund. The legislative framework governing DFGs places a statutory duty on Local Authorities to approve an 'eligible application': the provision must therefore be available. Oldham council led on the procurement for the Council and for Tameside Council, who confirm their support for the requested extension.
What are the alternative option(s) to be considered? Please give the reason(s) for recommendation(s):	a) Not to approve the contract extension and allow the service to cease. This option is not recommended, as the legislative

framework governing DFGs places a statutory duty on Local Authorities to provide DFGs to those who qualify: the provision must therefore be available.

b) Not to extend the current contract and retender the provision for Oldham. This is not the preferred option, as the current joint arrangements with Tameside provide better value than tendering for one borough alone.

c) To extend the contract for provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities, by a further year, from 1st June 2021 to 31st May 2022.
This is the preferred option, as this enables continuity of provision which enables Local Authorities to meet their statutory duty to provide DFGs to those who qualify. Tameside have confirmed that they support the preferred option.

Recommendation(s):

To approve option c, i.e.
To extend the contract for provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities, by a further year, from 1st June 2021 to 31st May 2022.

Implications:

*What are the **financial** implications?*

The commissioning team are seeking approval to extend the contract for stairlifts, ceiling track hoists, step lifts and gantry hoists for 1 year until May 2022.

The contract is costed to the Disabled Facilities Grant (DFG) capital fund, which is part of the Better Care Fund, a pooled budget with the CCG.

The costs of the contract which includes the 4 suppliers shown at paragraph 2.2 are summarised in table 1 below. The table also shows the total DFG spend per year with the month 10 monitor forecasting an outturn of £2.1m spend this year. Projected spend is within

budget and whilst the service is somewhat demand-led, expenditure is consistent with previous years activity. The 2021/22 DFG allocation has yet to be notified but it is anticipated that it will be similar to that for 2020/21 and a budget for 2021/22 is £2m assumed. Access to an additional £1.006m carried forward from 2020/21 is also available if required which is currently phased in to the 2021/22 budget.

There are no adverse effects to the overall budget expected in 2020/21 or 2021/22.

Table 1:

	2019/20 £000	**2020/21 (up until 31/01/21) £000**	**2020/21 Forecast Outturn £000**
Cost of Contract	652	409	543
Total DFG Spend	1,953	1,531	2,113

What are the ***procurement*** implications?

Provision exists in the original procurement exercise to extend this contract in line with the recommendations in this report. Commercial Procurement therefore supports the recommendations in this report. The commercial procurement also recommends the following future actions:

a. A clear KPI's must be agreed with the provider and the commissioning team manages and monitors KPI's.

b. A contract variation document must be agreed and includes full financial information such as rates we pay i.e. per hourly or daily; not just the financial envelope.

c. Set up a working group involving Procurement team at early stage ensuring no further requests will be made to extend these contracts in the future.

d. Ensure appropriate consultation is undertaken at pre-procurement stage with the provider market that will entail us targeting local suppliers.

(Interim Sourcing, Mohammad Sharif 10.02.2021)

*What are the **legal** implications?*

There is provision in Rule 17.1 (a) of the

	Council's Contract Procedure Rules for the Council to modify a contract in circumstances where the originally tendered contract includes clauses which list the scope and nature of the possible modifications and when they can be used and the modifications would not alter the overall nature of the contract. The circumstances outlined in the body of the report would support the proposed modification under Rule 17.1.(a). (Elizabeth Cunningham Doyle)
*What are the **Human Resources** implications?*	N/A
***Equality and Diversity Impact Assessment** attached or not required because (please give reason)*	No: an EIA has not been completed as the proposals enable continuity of statutory provision of adaptations to improve the independence, health and wellbeing of people with disabilities, and to enable them to remain living for as long as possible in their own homes. The provision is available to disabled children and adults with an assessed / eligible need.
*What are the **property** implications?*	None: the provision is installed in recipients own domestic properties.
Risks:	There are no risks identified from pursuing the preferred option.

Has the relevant Legal Officer confirmed that the recommendations within this report are lawful and comply with the Council's Constitution/CCG's Standing Orders?	Yes
Has the relevant Finance Officer confirmed that any expenditure referred to within this report is consistent with the S.75 budget?	Yes
Are any of the recommendations within this report contrary to the Policy Framework of the Council/CCG?	No

Reason(s) for exemption from publication:	3. Information relating to the financial or business affairs of any particular person including the Council

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Reason why this Is a Key Decision	(1)	to result in the local authority incurring expenditure or the making of savings

which are, significant (over £250k) having regard to the local authority's budget for the service or function to which the decision relates; and

(2) to be significant in terms of its effects on communities living or working in an area comprising two or more Wards or electoral divisions in the area of the local authority.

The Key Decision made as a result of this report will be published within **48 hours** and cannot be actioned until **five working days** have elapsed from the publication date of the decision, i.e. **before 12th May 2021,** unless exempt from call-in.

This item has been included on the Forward Plan under reference: **CPB - 01 - 21**

There are no background papers for this report

Report Author Sign-off:	
Date: LV Megram	**Date:** 18.02.21

Please list any appendices: -

Appendix number or letter	**Description**
N/A	N/A

1. Background:

1.1 This report seeks approval to extend a contract for provision of stairlifts, ceiling track hoists, vertical and step lifts and gantry hoists in domestic properties where residents have disabilities. The Commissioning Partnership Board awarded the contract on 28th March 2019, to commence on or after 1st June 2019 for two years with an option to extend by an additional two years on one-year increments. The initial term of the contract ends on 31st May 2021: this report requests approval to extend the contract by a further year, from 1st June 2021 to 31st May 2022. The contract is held by four suppliers who each hold one of four Lots.

1.2 The provision is funded from the Disabled Facilities Grant (DFG) Capital allocation within the Better Care Fund operating under section 75 NHS Act 2006 pooled budget arrangements between Clinical Commissioning Groups and Councils. This provides funding to adapt a disabled person's home - where an assessed need has been identified - to enable the occupant to continue to live as independently as possible in their own homes. The legislative framework governing DFGs remains,

and places a statutory duty on Local Authorities to provide DFGs to those who qualify: i.e. where the council considers the adaptation to be 'necessary and appropriate to meet the disabled applicant's needs' and 'reasonable and practicable in relation to the age and condition of the property'. The provision must therefore be available.

1.3 Oldham Council led on the procurement exercise for Oldham and Tameside boroughs and hold the contract: however, there is no pooling of budgets between the two authorities, with each area paying for its own activity. Oldham has a history of collaboration with Tameside Council on contracts relating to DFG provision, as we have similar local arrangements, demands and requirements. It is considered by both local authorities that the advantages gained through economy of scale in letting larger contracts across both areas has resulted in better value for money, and more robust and well-run contracts, to the benefit of both Authorities. Tameside have confirmed that they also want to extend the contract.

2 Current position:

2.1 The contract was awarded to four suppliers who each hold one of four Lots:

- Lot 1 - Stairlifts: Platinum Stairlifts Ltd
- Lot 2 - Ceiling track hoists: Handicare Accessibility Ltd
- Lot 3 - Vertical and step lifts: Wessex Lifts Ltd
- Lot 4 - Temporary free standing and pressure fit Gantry hoists: Prism UK Medical Ltd

Each Lot of the contract includes the supply and installation of the provision, all with *'life of client'* warranty: this places responsibility for the maintenance/replacement of installed equipment on the contractor for as long as the recipient needs the provision, thus securing long term revenue savings for each local authority, who would otherwise have to fund this aspect from revenue.

2.2 The provision is primarily demand-led so levels of activity/spend can vary, however they are in line with expectations apart from this financial year, where Covid-19 and lockdown impacted on delivery of all types of installations/adaptations. Prior to these contractual arrangements, spend in 2018/19 on this provision was £384,868 for Oldham and £382,433 for Tameside.

2.3 The suppliers have provided added value in the form of holding 'training days' on their products for occupational therapists and technical officers from Oldham and Tameside. They have also taken part in career days and mock interviews for students across both boroughs, however it has proven difficult to employ local people given that the suppliers are mainly specialist, nationally based organisations. Both boroughs consider that the current contract is working very well in terms of efficiency, quality of the provision and customer after care.

3 Conclusions and recommendations:

3.1 The Commissioning Partnership Board is asked to approve the contract extension, as this enables:

- cost avoidance in the wider health and social care system - by ensuring continuity of provision that supports people with disabilities to better manage their conditions and remain living as independently as possible in their own

homes, helping to avoid the need for increased care packages or residential care

- the current joint arrangements with Tameside to continue, which provides continued economies of scale from a contract across a larger footprint

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Report to COMMISSIONING PARTNERSHIP BOARD

White Paper Briefing

Portfolio Holder:
Councillor Z Chauhan, Cabinet Member for Health & Social Care

Officer Contact: Mike Barker, Strategic Director of Health & Resources

Report Author: Mike Barker, Strategic Director of Health & Resources

April 2021

Reason for Decision

This report has been produced to provide a briefing for members of the Health & Wellbeing Board on the recently published NHS White Paper entitled Integration and Innovation: Working Together to Improve Health & Social Care for All.

Recommendations

The Board is asked to note the briefing

NHS White Paper Briefing: *Integration and Innovation: Working Together to Improve Health & Social Care for All*

Introduction

1 The origins of the white paper were in 2019, when the Secretary of State for Health and Social Care Matt Hancock asked NHS England to identify and consult on what legislative changes were needed to fulfil the ambitions of the ten-year NHS long term plan. So, the white paper was expected at some stage.

2 The white paper does not cover broader social care reform – it gives a commitment that proposals for reform will be published this year – but it does give some direction of travel for adult social care and also for changes in public health.

3 The proposals in the white paper are considered in the following themes:

i. Working together to integrate care – statutory Integrated Care Systems (ICSs) with "dual structure" governance arrangements (the main focus of this policy briefing).

ii. Reducing bureaucracy – removing requirements on competition and procurement in the NHS.

iii. Improving accountability and enhancing public confidence – the formal merger of NHS England and NHS Improvement and new powers for the Secretary of State (SoS).

4 Additional proposals – many related to public health and adult social care. Proposals will be set out in a Health and Care Bill, with legislation in place for implementation in 2022.

Working together to integrate care

5 The white paper proposes that the forthcoming Health and Care Bill will support two forms of integration.

i. ***Removing barriers within the NHS and making "working together an organising principle".*** NHS bodies (NHSE, ICSs and providers) will have a "triple-aim" duty of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. The intention is to help align NHS bodies around a common set of objectives with strong engagement with local communities.

ii. ***Greater collaboration between the NHS and local government*** as well as wider delivery partners to improve health and wellbeing outcomes for local people. There will be a broad "duty to collaborate" across the healthcare, public health and social care system applied to NHS organisations (ICSs and

providers) and local authorities. This aims to rebalance duties which focus on the role of individual organisations and their interests. Local authorities and NHS bodies will be expected to work together in the ICS under one system umbrella. The Secretary of State will have powers to issue guidance on how the duty may work in practice.

6 ICSs will be put on a statutory footing to allow stronger and streamlined decision making and accountability. ICSs will have "dual structure" arrangements which reflect the two forms of integration – an ICS NHS body (board) and an ICS Health and Care Partnership.

7 **The ICS NHS body** will be responsible for the daily running of the ICS. Responsibilities will include developing a plan to meet health needs of the population, setting out the strategic direction for the system, "explaining" the plans for capital and revenue spending of NHS providers in the system, securing the provision of health services to meet the needs of the system population, and achieving system financial balance. The ICS NHS body will take over the functions and funding of CCGs (Clinical Commissioning Groups) and will be able to delegate funding "significantly" to place level and to provider collaboratives. It will take over CCGs' responsibilities in relation to overview and scrutiny committees.

8 NHS trusts and foundation trusts will remain separate statutory bodies and the ICS NHS body will not have the power to direct providers. But there will be a new duty to have regard to the system financial objectives so both providers and ICS NHS bodies will have a mutual interest in financial control at the system level.

9 Each ICS NHS body will have a unitary board accountable for NHS spend and performance within the system. It will, as a minimum, have a chair and a CEO and will include representatives from NHS trusts, general practice, local authorities and others determined locally, such as mental health trusts, plus non-executive directors.

10 NHSE will publish guidance on how boards should be constituted. There will be a more clearly defined role for social care in the structure of ICS NHS boards to give adult social care a greater voice in NHS planning and allocation.

11 **The ICS Health and Care Partnership** will bring together the NHS, local government and wider partners, such as the voluntary and community sector and Healthwatch, to "develop a plan to address the system's health, public health and social care needs" and to promote partnership arrangements. The ICS NHS body and local authorities will have to have regard to that plan when making decisions.

12 The Health and Care Partnership cannot impose arrangements that are binding on local government and the NHS "given this would cut across existing local authority and NHS accountabilities". Membership and functions will be determined locally.

13 The white paper suggests that the Partnership could be used as a forum for agreeing on priorities, coordinated action and aligned funding on key issues, which may be particularly useful in the early stages of ICS formation. Guidance will be published to support ICS partnerships to align operating practices and culture to "deliver for the adult social care sector".

14 The white paper stresses that within the dual structure there will be local flexibility over how ICSs are arranged, and partners are encouraged to develop mature joint arrangements that deepen integration and improve outcomes.

15 There will be new legislation to make it easier for organisations to work closely together through setting up joint committees which could either be between ICSs and NHS providers or between NHS providers. Both types of joint committee could include representation from other bodies such as primary care networks, GP practices, community health providers, local authorities and the voluntary sector.

16 The white paper makes many references to the "primacy of place". ICSs must "support place based joint working", with place-based arrangements "at the core of integration". Place-level commissioning will "frequently" align geographically to a local authority boundary, and the Better Care Fund (BCF) will be a tool for agreeing on priorities. ICSs will work closely with health and wellbeing boards (HWBs) as they have "the experience as place-based planners". The ICS NHS body will be required to have regard to joint strategic needs assessments and joint health and wellbeing strategies produced at HWB level (and "vice versa", presumably this means HWBs will need to have regard to the ICS partnership plan). ICSs will need to consider how they can align allocation and functions with places, such as using joint committees, but models will be for local determination. NHSE and other bodies will provide support and guidance based on insights from early wave ICSs.

17 The Department for Health Social Care (DHSC) will explore how to enhance the role of the Care Quality Commission (CQC) in reviewing system working. It wants to strengthen the patient voice at place and system levels to create "genuine coproduction".

18 Other legislative proposals include:

i. A reserve power to set a capital spending limit on foundation trusts, if needed, to support the third aim of the Triple Aim duty in relation to the sustainable use of NHS resources.

ii. Collaborative commissioning – for instance, NHSE delegating commissioning to more than one ICS board, ICSs collaborating on delegated commissioning, groups of ICSs using joint and lead commissioner arrangements to make decisions and pool funds across all their functions, and a greater range of delegated options for NHS England public health responsibilities, such as national immunisation programmes.

iii. A specific power to issue guidance on joint appointments between NHS bodies, NHS bodies and local authorities, and NHS bodies and combined authorities.

iv. More effective data sharing to support integration and digital transformation of care pathways – to be set out in the forthcoming data strategy for health and care.

v. NHS decision-making bodies will be required to protect promote and facilitate patient choice with respect to services or treatment.

Reducing bureaucracy

19 The requirement for competition applied to the NHS through the Health and Social Care Act 2012 will be removed. The NHS will no longer be subject to the Competition and Markets Authority. Where there is no value in running a competitive procurement process, these can be arranged with the most appropriate provider.

20 NHSE will consult on a “bespoke health services provider selection regime” which will enable collaboration and collective decision making. The division between funding-decisions and provision of care will be maintained. The NHS will have greater discretion over procurement.

21 The SoS will have the power to create new trusts within an ICS where this would result in the best health outcomes. Subject to engagement and consultation, ICSs may apply to the SoS to set up a new trust.

Improving accountability and enhancing public confidence

22 The merger of NHS England and NHS Improvement will be put on a statutory footing, with the organisation called NHS England.

23 The government will have new powers over the NHS to support greater collaboration, information sharing, aligned responsibility, and future agility in responding to change. These include:

i. Reforms to make the government’s mandate to the NHS more flexible (the current mandate sets annual priorities and expectations for NHSE).

ii. Power to transfer functions between arm’s length bodies (no plans currently other than those already underway – the NHS England/Improvement merger and establishing the National Institute for Health Protection (NIHP) and related reforms to the public health system).

iii. Removal of time limits on special health authorities (such as NHS Blood and Transplant) which currently must be renewed every three years.

24 Also, since contested reconfigurations are often lengthy and ministers have to account for decisions in parliament without being meaningfully engaged in the process, the SoS will have the power to intervene at any point in the reconfiguration process. The SoS will have to seek appropriate advice to inform their decision and publish it transparently. Statutory guidance will be issued on the new process, including removing the current local authority referral process “to avoid creating any conflicts of interest”. The Independent Reconfiguration Panel is expected to be replaced by new arrangements which will be based on learning from the work of the IRP.

25 Additional measures

i. Additional proposals have emerged from work on the pandemic and will support health and care system recovery. They are designed to address specific problems or barriers rather than providing comprehensive reform.

Social care

26 The government recognises the significant pressures faced by the sector and will bring forward proposals for reform this year, aimed at ensuring everyone can access affordable, high quality, joined-up and sustainable adult social care.

27 A new improved level of accountability will be introduced within social care, with an "enhanced assurance framework" allowing greater oversight over local authority delivery of care to raise standards and reduce variation in quality. The framework will involve improved data collection to allow for better understanding of capacity and risk, for example, better data on services provided to self-funders. The Health and Care Bill will introduce a new duty for the CQC to assess local authorities' delivery of adult social care duties, and the SoS will have a new power to intervene if it is considered a local authority is failing to meet their duties. The DHSC will work with the sector on the assurance framework which will be introduced over time. There will be a new standalone legal basis for the better care fund (BCF) separating it from the NHS mandate setting process – a technical change with no impact on the BCF policy.

28 The current requirement to assess people before hospital discharge will be replaced by a Discharge to Assess model in which an individual can receive NHS continuing health care (CHC) and NHS funded nursing care (FNC) assessments and Care Act assessments after they have been discharged. This will allow assessments in a familiar environment, enabling a more person-centred evaluation of care needs. The new model will not change eligibility thresholds for CHC or the Care Act; the white paper says it will not increase financial burdens on local authorities. The system of discharge notices and financial penalties will no longer be required.

29 The SoS will have a new legal power to make payments directly to social care providers in exceptional circumstances, such as in maintaining the stability of the market (correcting a limitation in existing legislation).

Public health

30 The experience of the pandemic has underlined the importance of a population health approach and robust health protection. The government will publish proposals for the future of the public health system – the new NIHP and the remaining functions from the closure of Public Health England "in due course".

31 The proposals in the white paper will address targeted issues that need primary legislation. There will be a public health power of direction through which the SoS can require NHSE to discharge public health functions and direct how the delegated functions are exercised – effectively strengthening existing powers.

32 Legislative changes will support the rollout of the national obesity strategy; specifically, introducing further restrictions on the advertising of high-fat salt and sugar foods before 9 pm and a new power for ministers to alter certain food and alcohol labelling requirements to make healthy choices easier.

33 The white paper says that water fluoridation is clinically proven to improve oral health. Currently, ten per cent of the population of England receives fluoridated water. Councils have the power to propose and consult on new fluoridation schemes and the SoS has responsibility for approving these. In light of difficulties identified by local authorities, the white paper proposes that the DHSC would take responsibility for proposing new schemes and the associated costs; schemes would continue to be subject to public consultation.

34 Other additional proposals relate to safety and quality, such as changes to regulatory bodies including a statutory NHS Health Services Safety Investigations body and Medical Examiners System and standards for hospital food.

Some Discussion Points

35 There is a lot of detail in the white paper, and, while some of its proposals are controversial, such as powers of the SoS to intervene earlier in reconfigurations and changes to overview and scrutiny and the Independent Reconfiguration Panel, it provides a coherent set of proposals. The DHSC has listened to concerns from local government and CCGs on the central importance of place, and on making sure that ICSs reflect a broad range of stakeholders, including local government. There is much to welcome in the document on that basis.

36 With measures in the Health and Care Act 2012 under review, it would have been possible for health and wellbeing boards to have been abolished but their value has been recognised and all HWBs now need to up their game to the level of the best. The proposals give a mainstream role for local government in ICSs – boards and partnerships. This needs to be maintained in the subsequent legislation and guidance.

37 How the ICS body/board and the partnership work together will be crucial and there is much to do to get the system level working effectively everywhere, as well as the vital issue of establishing place-based arrangements. Statutory joint committees with real control over resources, bringing together providers, primary care networks, local government and voluntary and community sector representatives should be a positive way forward. These would work alongside health and wellbeing boards to establish the broad vision and priorities, promote collaboration and focus on the social determinants of health. CCGs became a valued part of the health and care landscape in many areas and their important contribution needs to be maintained.

38 The white paper describes the “shift away from an adversarial and transactional system centred on contracting and activity payments to one that is far more collaborative and dedicated to tackling shared problems”. It will probably take some time for some partners to adjust to a collaborative culture.

39 There are also some unclear areas – this is a rolling back of competition rather than a whole scale dismantling of the commissioner/provider split in the NHS. The white paper says that funding decisions will be separate from provision, but it is not clear how this will happen with providers as board members.

40 A new assessment framework for adult social care is advocated. Hopefully, a system involving both sector-led improvements with light-touch national oversight will evolve.

The ultimate aim must be for assessment of integration – the CQC local system reviews of 2019 proved very informative.

41 The document does not give many clues about the future of the remaining PHE functions and how NIHP will operate. On public health it says, “rather than containing health improvement expertise within a single organisation, driving change in future will mean we need many different organisations to have the capacity and responsibility for improving health and preventing ill health”. It would have been helpful to have more emphasis on the role of ICSs in prevention and, particularly, in tackling the social determinants of health.

Conclusions

42 The white paper has been influenced by the extensive collaboration and innovation that partners from all sectors have demonstrated in tackling the pandemic. It shows a good understanding of how health, social care and public health fit together, while stakeholders’ concerns, such as ICSs potentially undermining effective place-based arrangements, have been listened to.

43 Overall, this white paper is a positive development. The lack of information on social care reform remains a huge gap, and the proposals will need to be carefully worked on. It also doesn’t seem to address the huge issues around health inequalities. ICSs have changed a lot since they were set up as sustainability and transformation partnerships and it is doubtful that this will be the last word.

Report to Commissioning Partnership Board

NHS operational planning process

Portfolio Holder: Not applicable

Officer Contact: Mike Barker, Strategic Director of Health & Resources and CCG's Chief Operating Officer

Report Author: Erin Portsmouth, CCG's Director of Corporate Affairs

29th April 2021

Reason for Decision
No decision – briefing paper.

Executive Summary
All NHS organisations needs to participate in a mandatory operational planning process. This paper outlines the process for the 2021/22 financial and planning year, which NHS Oldham CCG is currently undertaking.

Recommendations
The Commissioning Partnership Board is asked to note the updates in relation to the NHS operational planning process.

NHS operational planning process

1 Introduction

1.1 All NHS organisations needs to participate in a mandatory operational planning process. This paper outlines the process for the 2021/22 financial and planning year, which NHS Oldham CCG is currently undertaking.

1.2 Whilst the returns are being submitted into the national NHS via the burgeoning Integrated Care Systems (GM Health and Social Care Partnership in our case), local systems are supporting with data returns, and also producing an operational plan 'narrative' for local prioritisation.

2 Operational plan priorities

2.1 The following section outlines the NHS's operational plan priorities for the 2021/22 year.

A. Supporting the health and wellbeing of staff and taking action on recruitment and retention:

    1. Looking after our people and helping them to recover
    2. Belonging in the NHS and addressing inequalities
    3. Embed new ways of working and delivering care
    4. Grow for the future

B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services

    1. Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services
    2. Restore full operation of all cancer services
    3. Expand and improve mental health services and services for people with a learning disability and/or autism
    4. Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review

D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities:

    1. Restoring and increasing access to primary care services
    2. Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments, improve timely admission to hospital for ED patients and reduce length of stay:

    1. Transforming community services and improve discharge

2. Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

F. Working collaboratively across systems to deliver on these priorities:

1. Effective collaboration and partnership working across systems
2. Develop local priorities that reflect local circumstances and health inequalities
3. Develop the underpinning digital and data capability to support population-based approaches
4. Develop ICSs as organisations to meet the expectations set out in Integrating Care
5. Implement ICS-level financial arrangements

3 Action planning

3.1 The CCG along with key partner organisations and teams is in the process of preparing mandatory local data returns in relation to finance, activity and workforce.

3.2 It is also compiling a narrative plan against the planning indicators, set out per financial year 'quarters'.

4 Submission timeline

4.1 NHS providers have already submitted their draft capital and cash plans to NHS England and NHS Improvement, and localities have submitted a first draft of their financial plans, with the remainder of the submission timelines below.

- ***Tuesday 4 May***
  - ***Localities (place) to send to GM draft activity, workforce (primary and secondary care) and mental health workforce numerical submission***

- Thursday 6 May
  - The ICS to send into the national 'centre' the system finance plan submission
  - The ICS to send into the national 'centre' the mental health finance submission
  - The ICS to send into the national 'centre' the draft activity, workforce (primary and secondary care) and mental health workforce numerical submission
  - The ICS to send into the national 'centre' the draft narrative plan submission

- W/c 24 May
  - NHS providers to send in non-mandated finance plan submissions

- ***Tuesday 1 June***
  - ***Localities (place) to send to GM final activity, workforce and mental health workforce numerical submission***

- Thursday 3 June
  - The ICS to send into the national 'centre' final activity, workforce and MH workforce numerical submission

- The ICS to send into the national 'centre' final narrative plan submission

5 Options/Alternatives

5.1 Not applicable.

6 Preferred Option

6.1 Not applicable.

7 Recommendation

7.1 The Commissioning Partnership Board is asked to note the updates in relation to the NHS operational planning process.

8 Consultation

8.1 Not applicable in relation to the process. Engagement is taking place through the planning work itself, which is on-going.

9 Financial Implications

9.1 Not applicable.

10 Legal Services Comments

10.1 Not applicable.

11 Co-operative Agenda

11.1 Not applicable.

12 Human Resources Comments

12.1 Not applicable.

13 Risk Assessments

13.1 Not applicable.

14 IT Implications

14.1 Not applicable.

15 Property Implications

15.1 Not applicable.

16 Procurement Implications

16.1 Not applicable.

17 Environmental and Health & Safety Implications

17.1 Not applicable.

18 Equality, community cohesion and crime implications

18.1 Not applicable.

19 Equality Impact Assessment Completed?

19.1 Not applicable.

20 Key Decision

20.1 Not applicable.

21 Key Decision Reference

21.1 Not applicable.

22 Background Papers

22.1 The guidance on the priorities, planning and implementation of the national NHS 'planning round', and also the finance and contracting arrangements, are held on the NHS website here: https://www.england.nhs.uk/operational-planning-and-contracting/

23 Appendices

23.1 None.

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