Agenda Item No. 2.1

Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

Manchester Health and Care Commissioning Board Meeting

Agenda Item	2.1	**Date**	27 January 2021
Report Title	Final minutes of meeting held on 25 November 2020		
Report Author	Catherine Regan, Senior Executive Assistant		
Summary	Documented discussion of MHCC Public Board meeting held on 25 November 2020		
Strategic Objectives considered in this report	Improve the health and wellbeing of people in Manchester Strengthen the social determinants of health and promote healthy lifestyles Ensure services are safe, equitable and of a high standard with less variation Enable people and communities to be active partners in their health and wellbeing Achieve a sustainable system		
Risks considered in this report	748 MHCC workforce capacity and capability 749 Local Care Organisation 750 Single Hospital Service 752 Service capacity 753 Care Pathways 754 Inequity 755 Community resources 756 Finance 757 Provider Service Delivery 758 Strategic Partnerships		
Confirmation that equality analysis has been fully considered in the preparation and design of the reported policy, plan or strategy.	N/A		
Financial Implications	N/A		
Public Engagement	N/A		
Recommendations	The Board is recommended to: 1. Approve the minutes as a true and accurate record		

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Notes of MHCC Public Board Meeting
held 25 November 2020
Virtual via Tele/Video Conference

Present

Ruth Bromley (RB)	Clinical Chair
Atiha Chaudry (AC)	Lay Member, PPI
Bev Craig (BC)	Cabinet Member, MCC, Adults Health and Wellbeing
Denis Colligan (DC)	GP Member, North Locality
Ed Dyson (ED)	Executive Director, Strategy & Deputy CAO
Nick Gomm (NG)	Director of Corporate Affairs
Chris Jeffries (CJ)	Lay Member, Finance
Michelle Irvine (MI)	Executive Director, Performance, Quality & Improvement
Sharmila Kar (SK)	Director of HR / OD
Manisha Kumar (MK)	Medical Director
Grenville Page (GP)	Lay Member, Governance
Chris Pearson (CP)	Nurse Board Member
Murugesan Raja (MR)	GP Member, Central Locality
Claire Yarwood (CY)	Chief Financial Officer
David Regan (DR)	Executive Director, Population Health, Nursing & Safeguarding
Geeta Wadhwar (GW)	GP Board Member, South Locality
Peter Williams (PW)	Secondary Care Doctor
Ian Williamson (IW)	Chief Accountable Officer

Apologies:

Cllr Garry Bridges	Executive Member, Childrens and Schools
Joanne Roney	Chief Executive, Manchester City Council

In attendance

Catherine Regan (CR)	Senior Executive Assistant, MHCC
Val Bayliss Brideaux (VBB)	Senior Engagement Manager, MHCC
Tom	Poverty Truth Commission
Sinead O'Connor	Poverty Truth Commission
Jessica McCormack	Health Tech Organisation

Item	Note	Lead
80/20	**Public/Patient Story – Poverty Truth Commission**	
	SOC explained that the Poverty Truth Commission had undergone a process over the last year using lived, personal experiences has a starting point of conversation which was relationship based. The Commission had been meeting and sharing experiences of poverty and the associated impact.	

	Commissioners had agreed 3 main priorities and established task groups around child and family poverty; welfare benefit system and exploitation. She advised that people had experienced child abuse, grooming, sex industry/exploitation, substance misuse, criminal justice, care system as children, mental health and disabled and modern slavery. These were the areas of focus of the Commission. Criminal exploitation was an umbrella of various experiences and a key focus was to understand who the people were that was experiencing this now. SOC explained the aim of the Commission was to understand what systems were in place to promote people safety and what systems exposed people to vulnerability. It was essential to ensure people were safer in these types of situations and the systems that were making people exposed to risk. There was also an opportunity to look at the experiences during covid also. In terms of influence, the representatives on the group were significant. Tom outlined his personal experience and highlighted the wok that had been discussed within the task group focusing on the universal credit system. He said there was an opportunity within the Commission to air views and advise on experience to enable the Commission to progress change. SOC stated that the energy of the Commission came from people who lived the experience, consequently the insight obtained was valuable. GP felt there should be more collaboration with community based organisations, such as voluntary sector groups and housing associations to work within a framework and framework of resources to ensure co-ordination. SOC advised that MACC and LGBT Foundation were commissioners on the Poverty Truth Commission and there were links with health, local authority and local strategies. She acknowledged that links with the voluntary sector were critical as they played a significant part in recognising and notice when people were struggling. GP referred to anchor institutions, such as housing which had a real potential role with more imaginative commissioning and collaborative working. He felt further thought should be given to anchor institutions and how to work collaboratively to join up the system with a clear focus on the individual's needs. BC explained that the Poverty Truth Commission would not necessarily provide speedy answers, but would ask questions in a different way in order to strategically tackle and eradicate poverty in the city. The process would need patience and reflection as it was more exploratory and working through people experience to shaping policies. It would be an iterative process. She advised that Poverty Truth Commission recommendations would be aligned to the City's Anti-Poverty Strategy. BC acknowledged that the key role of anchor institutes and the challenge would be to MHCC Board as to what actions it would take in order to make changes within the health and care sector. Responding to a question on what would be the greatest challenge post covid that MHCC should be taken into account, Tom was of the view this would be food poverty (especially the elderly population) and the impact on mental health. He emphasised the need to liaise and raise awareness within communities of the support that was available. Effective communication was vital. SOC felt that in terms of post-covid one of biggest challenges would be repaying the cost of covid and economic impact. It would be necessary to	

	ensure communities were resilient as there would be difficult decisions to be made which would re-emphasise the need for collaboration within the city. DR referred to Tom's experience, particularly in relation to the complex benefits system. He welcomed a further discussion, in order to have a greater impact and reassure people on what they can claim/support available when they are being encouraged to attend for covid testing. AC felt that some of the critical issues were beyond the influence at a local level as they were national programmes. She questioned how the leadership in the city could take action and how it would feed into the GM commission. AC reported there had been an increase in poverty, impact of covid, food poverty and unfortunately there would be further distress in the city. **ACTION: MHCC Board thanked Poverty Truth Commission colleagues for the work being undertaken in the city and for attending MHCC Board to share personal experiences.**	
81/20	**Minutes of meeting / Matters Arising**	
	Action: MHCC Board approved the notes of the meeting held on 28 October 2020 as a true and accurate record.	
82/20	**Chief Officer Update**	
	IW introduced the Chief Accountable Officer update. He mentioned that the paper included a record of the decisions made by the Executive Team and provided an explanation around the preparation for exiting the European Union. Section 4.4 detailed the areas of risk to be managed, predominantly it related to the NHS but there were similar risks that applied to MCC and other partners. IW outlined the complexity of work currently being undertaken and described an illustrative example of the work within the Manchester and Trafford Community Cell DR outlined the current position with regard to Covid-19 and covid indicators both of which indicated a downward trend. He reported on the Manchester approach to mass testing which would include targeted testing at scale. MK updated on progress with regard to the mass vaccination programme which was one of the largest vaccination programmes in recent times and could only be managed effectively if there was joint system working across health and social care. She provided an update on Manchester mass vaccination programme. DR advised that governance arrangements were in place for both programmes to ensure clinical governance risks were governed appropriately. DR confirmed that an announcement would be made by the Prime Minister tomorrow with regard to the national tier system. RM referred to the increased hospital admissions and whether there was any data collected other than ages 60+. DR advised that a deep-dive analysis had been undertaken and data intelligence had been collated into over 50s up to 85s. He mentioned that the University of Manchester had supported MFT in terms of modelling work around admissions and critical care measures which has been recognised nationally and would be linked to community information. MHCC had also requested data on age profiles/ethnicity on hospital data to ensure that intelligence is combined. AC asked about potential concerns with regard to the content on the vaccine and whether assurance could be provided to increase take-up. MK explained	

	that information was limited until the vaccine had been licensed, however there had been early communication from the Islamic organisation that there was no issue with the vaccine as it was being portrayed. MK mentioned there had been a miscommunication that flu vaccinations were required prior to receiving the covid vaccination. The actual guidance was that it is not possible to have the vaccinations within 7 days of each other. MK emphasised the need to work with communities and encourage people to receive the vaccination. PW requested an update on the challenges for general practitioners, particularly in relation to resource and capabilities to deliver the vaccine at scale. MK explained the process for transportation of the Pfizer vaccine. In terms of delivery she advised there would be national training, however a significant amount of information was still awaited. GP acknowledged there would be a significant impact and additional pressure on primary care. He asked what plans had been developed to mitigate the risks. MK confirmed that support and funding was available to support primary care capacity. Primary care was supportive of the challenge and there had been incredible offers of people volunteering. IW commented that the workload should not be underestimated. He reminded members that in wave 1, services had stopped to manage the covid epidemic, however this was not the case during the second wave, the NHS was currently dealing with the aftermath of wave 1, the second wave of covid, preparation for winter and the two vaccine programmes. There was also increasing signals and communication around the likelihood direction of organisational change, intense pressure on council budgets and operation. He mentioned that although the NHS continued to receive additional resources, this was not the case for Manchester City Council, adding to the complexity and challenges. In relation to BREXIT, RB emphasised the need to not lose sight of the potential impact in moving forwards. AC requested MHCC Board receive assurance that this issue was being addressed at Executive /Strategy level and reported back to Board. NG confirmed that a strategic risk would be created and discussed at the Governance meeting. The Board would be kept informed and a further update would be provided at the December board meeting. **ACTION: MHCC Board noted the Chief Accountable Officer update.**	
83/20	**One Report**	
	MI presented the performance update, reporting that some of the challenges had worsened throughout the covid pandemic. She informed members that urgent care activity levels had returned to pre-pandemic levels with no reduction in A&E attendances. There had been a slight deterioration in A&E 4 hour standard target, the main reason being due to patient flows within hospitals. Each hospital site was in excess of 98% bed occupancy which created a significant challenge. The team was currently focusing on out of area medically optimised patients, although these were low levels, there were challenges with Bury and Stockport patients, consequently escalation calls had been established to facilitate discharges. MI reminded board members that due to the escalating level of admissions within hospitals, a decision had been made to pause elective activity. The focus of work was mainly theatre activity for pathway 1/pathway 2 patients, life threatening and cancer. She mentioned	

	there had been no reduction in cancer activity. MI briefly updated MHCC Board on the progress made by MFT in relation to the elective care outpatient reform programme. MI updated on the 2 main cancer performance indicators, advising that all hospitals across MFT were delivering the GP referral 2 week wait apart from breast and dermatology services. She explained there had been a backlog, as result of activity stopping early in the year, which had not yet been cleared, however detailed service plans had been developed to manage the situation. Members were informed there had been an improvement in relation to 62 day cancer treatments. Over the last 3 months provision had significantly increased and backlogs had been reduced. Mental Health – there had been a significant decrease in referrals to IAPT, however there has been an increase over the last 3 months. The 2 week standard for first episode of psychosis was not being achieved, however assurance has been received that every patient had been risk assessed and contact made within the 2 weeks, although this did not comply with the standard of face to face assessment. There had been risk stratification of patients. MI mentioned that operational conversations to offer support to care home providers continued 3 times per week. Members were advised that MFT were currently investigating a never event at St Mary's Hospital, information around the circumstances would be presented at a future meeting. PW updated on the discussions at the Performance, Quality and Improvement Committee. Members had felt the situation was concerning with regard to the cancer targets, however acknowledged that assurance had been received to improve the situation and there would be a need to monitor the 62 days cancer target, recognising the issue was diagnostic delays. PW highlighted there had been an increase in out of area placements. He referred to the issue around "hidden children during covid", children referrals had dropped to community services, however there had been an increase in police attending domestic incidents. RM stated that it was essential to monitor any service requiring diagnostics as the situation had deteriorated since covid. It was crucial not to lose focus on non-covid conditions as morbidity was occurring of non-covid conditions. AC made reference to two particular issues: patients being admitted with non-covid conditions, but becoming covid positive as a result of delays in discharge; and BAME frontline NHS workers being asked to return to work when recovering from covid and feeling unwell. MI stressed there was rigorous monitoring of patients and there was reporting 3 times a week on in-hospital infections. Infections were not necessarily due to delays in discharge, although there was infection levels across hospitals. She assured board members that MFT was working with national teams to look at systems, process and practices to offer additional guidance. The Trust had set itself challenging targets to eradicate hospital based infections. With regard to staff being asked to return to work, MI advised that MFT reported on all measures and there had been no evidence at strategic level of incidences of this nature. Staff welfare discussions had been positive at MFT strategic group.	

	ACTION: MHCC Board noted the update and supported the actions being undertaken to improve the quality and performance of commissioned services for the population of Manchester. The PQI Committee update was noted.	
84/20	**MHCC Finance Report**	
	CY explained that the paper did not report on the pooled budget as arrangements for health were complex. She advised that for months 1-6 an allocation had been received each month to break even, however the actual allocation for month 6 would not be received until early December. Until that was finalised and secured, months 1-6 would remain separate. For months 7-12, a plan had been developed for the final 6 months of the year based on planning guidance which centred on recovery. CY advised that following a resubmission of plans, there was a deficit of £5m for Manchester, £109m for Greater Manchester and £347m deficit for the North West. Due to there being a national deficit plans had not yet been signed off. Members noted that work was underway to submit MHCC forecast expenditure. CY reported that the financial plan for adult social care budget was a deficit of £6.8m of which £9.9m was expenditure on covid and an underspend of £3.1m on ASC budgets. She advised that health at month 7 was forecasting a deficit in relation to £5.8m plan submitted. Details had been received of a primary care allocation, consequently it would be necessary to look at potential duplication of that allocation with the expenditure being planned and whether this allocation would improve the financial position overall. Members were updated on the work being undertaken at GM level to ensure all localities were forecasting similar positions on areas such as prescribing. CY mentioned that Manchester had maintained its forecast based on full year assumptions. A review of expenditure in relation to primary care standards would need to take place, particularly in light of the significant amount of work required around the vaccination programme. CY advised that additional resources were expected to support the vaccination programme in relation to the DES, however there would be additional costs over and above this. Work was ongoing to forecast the vaccination programme. CY highlighted the financial risks which included: CHC assessments regime for hospital discharge programme which would impact on health but could also impact on the ASC position (if not eligible); BREXIT risk relating to prescribing. She informed that advice had been received not to include BREXIT prescribing financial risk in forecasts at this stage. **ACTION: MHCC Board noted the update and risks and expressed their gratitude for the work undertaken.**	
85/20	**Committee Reports**	
	Finance Committee – CJ updated the report and stated it should have said the overall overspend for ASC was £6.8m, which related to £9.9m additional expenditure on COVID with an underspend against ASC budget of £3.1m. This was clearly understood at Finance Committee. **ACTION: MHCC Board noted the Committee update.**	
	Strategy Committee – **ACTION: MHCC Board noted the Committee update.**	
	Health Care Professional Committee – **ACTION: MHCC Board noted the Committee update.**	