TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

31 October 2017

Commenced: 2.00 pm **Terminated: 4.00 pm**

Present: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Steven Pleasant – Tameside Council Chief Executive & Accountable Officer for NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Dr Alison Lea – NHS Tameside and Glossop CCG
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance
Stephanie Butterworth – Director of Adult Services
Gill Gibson – Director of Quality and Safeguarding
Jessica Williams – Interim Director of Commissioning
Tom Wilkinson – Assistant Director of Finance
Sarah Dobson – Assistant Director, Policy, Performance & Communications
Ali Rehman – Head of Business Intelligence and Performance
Debbie Watson – Interim Assistant Director of Population Health

Apologies: Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC

56. DECLARATIONS OF INTEREST

Members	Subject Matter	Type of Interest	Nature of Interest
Christina Greenhough	Item 6(a) – Tameside and Glossop Proposal for Effective Urgent Care: Case for Change	Prejudicial	Director of Go-to-Doc

57. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 26 September 2017 were approved as a correct record.

58. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a jointly prepared report of the Director of Finance, Tameside and Glossop CCG / Tameside MBC and the Director of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust providing a 2017/18 financial year update on the month 5 financial positon, at 31 August 2017, and the projected outturn at 31 March 2018.

It was highlighted that Tameside and Glossop Integrated Care Foundation Trust had still to agree a financial control total with its regulator, NHSI Improvement and the Trust. However, as reported a previous meetings of the Single Commissioning Board, this was affecting the Trust's eligibility to access the targeted element of Sustainability and Transformation funding as providers must have accepted an agreed control total. The Chief Executive and Accountable Officer added that Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership, had written to the Department of Health expressing the Partnership's concern on this matter.

RESOLVED

(i) That the 2017/18 financial year update on the month 5 financial position at 31 August 2017 and the projected outturn at 31 March 2018 be noted.

(ii) That the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budged be acknowledged.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.

59. PERFORMANCE REPORT

Consideration was given to a report of the Assistant Director (Policy, Performance and Communications) providing an update on quality and performance data. Assurance was provided for the NHS Constitutional Indicators. In addition, Clinical Commissioning Group information on a range of other indicators were included to capture the local health economy positon. This was based on the latest published data at the end of July 2017. The following which were highlighted as exceptions:

- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Diagnostic standard failed;
- Ambulance response times were not met at a local or at North West level;
- 111 Performance against Key Performance Indicators.

In response to a previous request from members of the Single Commissioning Board, the Assistant Director outlined examples and suggestions of Children's Social Care performance. This was not intended to be exhaustive but rather a starting point for inclusion in future performance reports.

It was also reported that the North West Ambulance Service had recently introduced new standards to enable the service to identify patients' needs better and send the most appropriate response. Under the new standards there were four response categories:

- Category one – for calls about people with life-threatening injuries and illnesses;
- Category two – for emergency calls;
- Category three – for urgent calls; and
- Category four – for less urgent calls.

The Single Commissioning Board noted that these changes followed the largest study of an ambulance system and the bar would be set at 90% of calls to be reached in the target times rather than 75% under the old system. The North West Ambulance Service would be providing data on performance against the new standards from November 2017 and these would be integrated into future performance reports to the Single Commissioning Board.

The Director of Quality and Safeguarding made reference to the Quality and Safeguarding monthly exception report, discussions at the Quality and Performance Assurance Group and her intentions for future reporting arrangements.

RESOLVED

That the quality and performance update report be noted.

60. TAMESIDE AND GLOSSOP PROPOSAL FOR EFFECTIVE URGENT CARE: CASE FOR CHANGE

(Dr Greenhough declared her prejudicial interest as a Director of Go-to-Doc but as this was a consultation and not an award of contract she was advised there was no need for her to leave as there was no prejudicial conflict of interest.)

The Interim Director of Commissioning presented a report describing the vision for an enhanced offer of urgent care, i.e. support for conditions that needed prompt medical help to avoid a person deteriorating but were not life threatening. It set out the case for change summarising the national, Greater Manchester and local context, reflected the insights gained through previous pre-consultation engagement exercises and outlined the potential scenarios for the enhanced urgent care offer.

It was explained that key to the proposal was the simplification of access to urgent care whilst improving the level of service available. Multiple access points would be replaced by telephone access through a patient's own GP practices to book appointments as well as a single location for urgent walk-in services. This would reduce the need for people to 'self-triage' and maximise the opportunities for people to receive the right care in the right place at the first appointment. In addition, neighbourhood support would be strengthened through increased evening and weekend appointments alongside advice and treatment available through local opticians and pharmacists.

Reference was made to the proposed consultation, the aim of which was to inform the public about two options for the delivery of the new urgent care service. Both options created an urgent treatment centre, open 12 hours a day, seven days a week from 9.00 am to 9.00 pm. This would offer bookable, same day / urgent and routine general practice appointments, Walk-in access for urgent care and be able to provide direct access to urgent diagnostics along with safe transfer to more specialist services when necessary. In both options this would replace the existing Walk-in services at Ashton Primary Care Centre which would relocate to the hospital site and be developed to deliver the Urgent Treatment Centre. The two options varied in the number of Neighbourhood Care hubs where bookable appointments could be made in addition to the Urgent Treatment Centre when those hubs would be open. In summary, the options detailed in the report were as follows:

Option 1		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	9.00am to 1.00pm
South	6.30pm to 9.00pm	9.00am to 1.00pm
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm
Option 2		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	None*
South	6.30pm to 9.00pm	None*
West	6.30pm to 9.00pm	None*
East	6.30pm to 9.00pm	None*
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm

* Able to book appointments at the Urgent Treatment Centre in Ashton or at Glossop Neighbourhood Care Hub.

The Single Commissioning Board heard that both options provided:

- Additional bookable appointments at the Urgent Treatment Centre;
- The ability for practices to arrange appointments directly at the Urgent Treatment Centre for patients likely to need diagnostics or additional hospital based care ;
- A single location for urgent walk in access that removes the need for the person attending to 'self-triage';
- Improved patient safety as people with emergency/serious conditions currently attending the Walk In Centre and then are transferred to A&E will already be in the correct place;
- Access to urgent diagnostics.

Reference was made to the detailed impact of the proposed options analysed through the Equality Impact Assessment in Appendix 1 and the quality implications set out in the Quality Impact Assessment in Appendix 2 to the report.

It was further reported that pre-consultation discussions, detailed in Appendix 3 to the report, had highlighted the fact that members of the public wanted a simple trusted arrangement that was well communicated to avoid confusion when an urgent need arose.

In responding to questions raised by members of the Single Commissioning Board, the Interim Director of Commissioning advised that initial financial analysis of both options showed that they were affordable within the current funding envelope. It was expected that efficiencies could be made through the bringing together of these services and therefore value for money increased.

RESOLVED

(i) That approval be given to consult on two options for the Tameside and Glossop urgent care offer as above and explained in detail in the report.

(ii) That the Equality Impact Assessment and Quality Impact Assessment in Appendices 1 and 2 to the report be noted.

61. IMPROVING DEMENTIA SERVICES IN THE NEIGHBOURHOODS

The Director of Adults Services submitted a report explaining that there were an estimated 2,691 people in Tameside and Glossop with dementia. As part of the Care Together development, Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care. In 2016 in Tameside, the rate of emergency admissions, aged 65+ with dementia was 4,839 per 100,000 population compared to the rate for England of 3,046 per 100,000 population.

It was further explained that 10 days in a hospital bed (acute or community) led to the equivalent of 10 years ageing in the muscles of people over 80. Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

The overall vision for Tameside and Glossop was linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their well-being and independence for as long as possible.

It was reported that the business case presented had three main objectives:

(i) Establish a pilot with Alzheimer's Society for Dementia Support Workers in each Neighbourhood in Tameside.
(ii) Establish Dementia Practitioners in each neighbourhood team by investing in three new roles to add to existing Pennine Care Foundation Trust Community Mental Health Team nurses, Willow Wood Dementia Nurse and Integrated Care Foundation Trust Admiral Nurse capacity.
(iii) Appoint an Executive Lead for dementia. This individual would have delegated responsibility from the locally partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.

It was proposed that Dementia expertise was embedded within the integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. Dementia support was increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding.

The business case detailed in the report, supported the Single Commission's Quality Innovation, Productivity and Prevention agenda. It was anticipated that as the cost savings from reduced unscheduled admissions would ultimately allow movement of money within the system that ensured the implementation was sustainable in the first instance, and cost saving in the medium and long term.

RESOLVED

(i) That the current position regarding unscheduled admissions related to dementia and the need for additional resources and actions to enable progression towards reducing a figure that was an outlier at a national level be recognised.

(ii) That the development of a rich post-diagnostic community offer supported by the clinical delivery of Dementia Practitioners and the co-ordinating role of the Dementia Support Workers would be a significant step in improving dementia care in Tameside be agreed.

(iii) That the investment of non-recurrent Adult Social Care Transformation budget to establish a pilot with the Alzheimer's Society to embed Dementia Support Workers in the Tameside Neighbourhood Teams to support people living with dementia from diagnosis to end-of-life care be agreed.

(iv) That compliance with procurement standing orders be waived to enable this pilot to be established from the Alzheimer's Society, a specialist provider.

62. PERSONAL HEALTH BUDGETS

Consideration was given to a report of the Director of Quality and Safeguarding explaining that a personal health budget was an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budges was to enable people who were frequent users of healthcare services to have greater choice, flexibility and control.

The expectation of Clinical Commissioning Groups to expand personal health budgets was outlined in the 'Forward View to Action: Planning for 2015/16' and the NHS England mandate was that by 2020 0.1-0.2% of the population would hold a personal health budget. In order to deliver the national mandate local trajectories had been set seeking to establish personal health budgets for 99 patients by March 2018 rising to 153 by April 2019.

It was reported that Greater Manchester was establishing a Personalisation Programme in which the locality would be actively engaged. It was hoped that this would expand from a health focus to encompass the national drive towards Integrated Personal Commissioning, a nationally led, locally delivered programme supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector. The programme aimed to ensure that services were tailored to people's individual needs, building on learning from personal budgets in social care and progress with personal health budgets. Through Integrated Personal Commissioning, people carers and families with a range of long-term conditions and disabilities were supported to take a more active role in their health and wellbeing, with better information and access to support in their local community, and greater choice and control over their care.

The Single Commissioning Board was advised that despite having focused approaches to marketing personal health budgets with frontline staff, there had been very little take-up and currently only 13 personal health budgets awarded, the lowest rate in Greater Manchester. An analysis of the locality's personal health budget approach and process had raised a series of actions that were now being taken forward.

It was recognised that if numbers were to be increased towards achieving the national target recurrent investment would be required, as well as the commitment to extract funding from block contracts to provide a viable budget to continue to expand personal health budget numbers in the

future. Due to the financial position, it was recommended that the economy worked within existing resources rather than increase investment at this time.

After assessing the risks, it was felt it would be better to delay the achievement of local trajectories and that a phased implementation plan for personal health budgets be agreed. This would align with the implementation of transformation plans including the move towards a more sophisticated contracting model and accountable care system.

RESOLVED

(i) That a phased implementation plan for personal health budgets be agreed.

(ii) That the associated impact on the ability of the Clinical Commissioning Group to meet the personal health budget target in 2017/18 and therefore the Improvement and Assessment Framework Standards, potentially resulting in reputational damage, be noted.

(iii) That the risks associated with the delay in achieving personal health budget target be escalated to the Tameside and Glossop NHS Clinical Commissioning Group Governing Body.

(iv) That the focus in 2017/18 would be to expand the offer of personal health budgets to patients already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care as this would be within existing resources.

(v) That the Clinical Commissioning Group lead would continue to work with Greater Manchester on the personalisation agenda.

63. URGENT ITEMS

The Chair reported that there were no urgent items had been received for consideration at this meeting.

64. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 14 November 2017 commencing at 2.00 pm at Dukinfield Town Hall.

CHAIR