**TAMESIDE AND GLOSSOP**
**CARE TOGETHER SINGLE COMMISSIONING BOARD**

**6 September 2016**

**Commenced: 2.30 pm** **Terminated: 3.50 pm**

**PRESENT:** Alan Dow (Chair) – Tameside and Glossop CCG
Steven Pleasant – Chief Executive, Tameside MBC, and Interim Accountable Officer, Tameside and Glossop CCG
Richard Bircher – Tameside and Glossop CCG
Christina Greenhough – Tameside and Glossop CCG
Graham Curtis – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC

**IN ATTENDANCE:** Sandra Stewart – Director of Governance
Kathy Roe – Director of Finance
Angela Hardman – Director of Public Health and Performance
Clare Watson – Director of Commissioning
Ali Rehman - Public Health

**APOLOGIES:** Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC

## 61. WELCOME AND CHAIR'S OPENING REMARKS

In opening the meeting, the Chair made particular reference to the financial context and the financial position of the care together economy, especially the Clinical Commissioning Group position. The CCG Governing Body has convened a special single item meeting regarding this and its QUIPP/ Recovery plan on 7 September 2016 which was required by NHS England on 9 September 2016. He also noted that the decision of the Transformational Fund requested was awaited.

## 62. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by Members of the Board.

## 63. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 2 August 2016 were approved as a correct record.

## 64. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance, Single Commissioning Team, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 4 financial position at 31 July 2016 and the projected outturn at 31 March 2017.

It was explained that the report included components of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2016/17 financial year. The total ICF was £447.5m in value, detailed in **Appendix C** to the report, but this value was subject to change throughout the year as new Inter Authority Transfers were actioned and allocations amended.

The 2016/17 financial year was particularly challenging due to the significant financial gap and the risk of CCG QIPP schemes not being sufficiently developed to deliver the required level of efficiencies in the year. A financial recovery plan was required by NHS England by 9 September 2016 and an extraordinary meeting of the Governing Body would consider the plan on 7 September 2016. The report also considered the financial risk of the ICF in 2016/17 and further details had been included in section 6.

Members of the Board noted that section 2 of the report included details of the financial position of the Tameside Hospital NHS Foundation Trust which provided an members of the Board with an awareness of the overall financial position of the whole Care Together economy and highlighted the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.

In terms of a financial summary, reference was made to Table 1 detailing the 2016/17 budgets, expenditure and forecast outturn of the ICF and Tameside Hospital NHS Foundation Trust. However, there were a number of key risks that had to be managed within the economy during the financial year:

- Achievement of the original £21.5m projected commissioner financial gap (£13.5m Tameside and Glossop CCG and £8.0m Tameside MBC);
- Delivery of the £17.3m projected financial deficit of Tameside Hospital NHS Foundation Trust;
- Management of any potential overspend within Acute services as any overspend would be an additional pressure over and above the financial gap stated above;
- Ensure Parity of Esteem was achieved in relation to Mental Health Services;
- Financial pressures as a result of national changes to the health contribution of funded nursing care payments (40% increase) generating an estimated increased liability to the CCG of approximately £0.6m but this would be confirmed and reported at month 5;
- Management of Care Home placements due to volatility in this area;
- Unexpected and complex dependency placements within Children's Services;
- Emergency in-year reductions to Central Government resource allocations;
- Proactive management of Continuing Healthcare and Prescribing, both of which were subject to volatility;
- Remaining within the running cost allocation for 2016/17.

It was further reported that the Greater Manchester Strategic Partnership Board would be meeting to consider the Tameside and Glossop proposals for Transformational Funds. A revised sum of £23.2m had been requested over the period to 2019/20, £5.2m of which had been requested in 2016/17. A decision on the proposals was expected mid-September.

**RESOLVED**

**(i) That the 2016/17 financial year update on the month 4 financial position at 31 July 2016 and the projected outturn at 31 March 2017 be noted.**

**(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged.**

**(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period which had become more pertinent given the request from NHS England for a CCG financial recovery plan by 9 September 2016.**

## 65. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on CCG assurance and performance based on the latest published data. The June position was shown for elective care and an August snap shot in time for urgent care. Also attached was a CCG NHS Constitution scorecard showing CCG performance across indicators. It also included referral data and a section on care homes.

The assurance framework for 2016/17 had been published nationally. However, the framework from GM Devolution was still awaited.

Particular reference was made to the following matters:

- Performance issues remaining around waiting times in diagnostics and the A & E performance;
- The number of patients still waiting for treatment 18 and over continued to decrease and the risk to the delivery of incomplete standard and zero 52 week waits was being reduced;
- Cancer standards were achieved in June apart from 62 day screening and Quarter 1 performance achieved;
- Endoscopy was till the key challenge in diagnostics particularly at Central Manchester;
- A & E standards were failed at Tameside Hospital Foundation Trust;
- Attendances and NEL admissions at Tameside Hospital Foundation Trust (including admissions via A & E) had increased;
- The number of Delayed Transfers of Care recorded remained higher than planned;
- Ambulance response times were not met at a local or at North West level.

**RESOLVED**

**(i) That the 2016/17 CCG Assurance position be noted.**

**(ii) That the current levels of performance be noted.**

## 66. INTEGRATED NEIGHBOURHOOD BUSINESS PROPOSITION

The Director of Commissioning presented a report which stated that the Neighbourhood Development work stream was leading the design and delivery of an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. The system would work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient / service user satisfaction and reduce dependency on the acute sector.

There would be five Integrated Neighbourhoods across the Tameside and Glossop CCG footprint. Four of the neighbourhoods were co-terminous with the Tameside MBC Neighbourhoods and Glossopdale would be supported by Derbyshire County Council from a social care perspective.

The development of Integrated Neighbourhoods would build upon the recent development of the place based hubs in Tameside, the public sector prevention agenda which went live in May 2016 and bringing together front line providers from across a range of agencies to focus resource where it was needed most and responding to issues in a holistic rather than single agency way. Agencies currently included social services, police, housing, mental health, fire and the voluntary and community sector. The system would be developed over the next 3 to 5 years and in full partnership with patients, staff, voluntary sector, residents and regulators to ensure the model achieved its aims, was well understood and would meet the needs of the population

The Integrated Neighbourhood vision was to support neighbourhoods to deliver asset rich, high quality and connected services, looking after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing. The key objectives were outlined as follows:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention;
- Help people live as independently as possible whilst managing one or more long term conditions;
- Co-ordinate delivery of services from all providers, with teams of multi-skilled professionals based in each of the Neighbourhoods;
- Optimise self-care and family / carers support to enable people to stay at home for as long as possible, independently and safely;
- Focus on improvement condition management to avoid admissions;

- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to.

The fundamental principle of the Integrated Neighbourhood approach to care was that individuals were assessed for the level of care they required and took a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need.

The Neighbourhood Development workstream would support and lead the establishment of 5 Neighbourhood Management Teams to lead the implementation of the model. The Model of Care workstream would provide oversight to a robust governance structure, including the development and approval of 'memoranda of understanding' between the Neighbourhoods and the Care Together Programme and Single Commission.

Funding to implement this model had been requested as part of the economy's £23.2m bid from GM Health and Social Care Partnership and a decision was awaited on the outcome of the bid.

**RESOLVED**
**That in principal approval be given to the business proposition for the Integrated Neighbourhood model proceeding to the implementation stage as part of the Care Together Programme pending the outcome of the GM funding decision.**

## 67. INDEPENDENT SERVICES TO TAMESIDE BIRTH PARENTS AND RELEVANT GRANDPARENTS

The Director of Commissioning presented a report outlining the statutory requirement for the provision of independent services for Tameside birth parents and relevant grandparents and seeking authorisation to extend the contract for a period of up to twelve months (effective from 1 September 2015) where there was provision to do so in the contract.

It was explained that during the period 1 April 2015 to 31 March 2016 the supplier, Adoption Matters, had processed 31 Tameside enquiries to the action line and 19 new cases were allocated to an adoption support worker. In addition, the supplier had continued to support a further 16 individuals / couples referred prior to that date, giving a total of 35 ongoing cases during the period. Of the service users supporting during this financial year, 13 had received long term / intensive involvement. The contract appeared approximately the correct size for the level of demand in terms of total number of referrals and provided some capacity for flexibility. The current service provided had shown a commitment to continually improving systems and service delivery to meet the needs of its service users.

**RESOLVED**
**That approval be given to extend the contract for the provision of independent services for Tameside birth parents and relevant grandparents with Adoption Matters for a period of up to twelve months from 1 September 2016.**

## 68. SEND – INSPECTIONS TO LOCAL REPORT

Consideration was given to a report of the Director of Commissioning outlining a new framework for the inspection of local areas' effectiveness in meeting the needs of Children and Young People with Special Education Needs and / or Disability (SEND) had been implemented. It was important to note that this was a local area inspection, not a local authority inspection and included the CCGs, Public Health and the Local Authority. The report detailed the process and exposed the risks that the joint inspection framework could hold.

The Care Quality Commission (CQC) and Ofsted would jointly carry out the inspections of local areas evaluating how effectively the local area identified children and young people with special educational needs and / or disabilities, how it was meeting their needs and improving their outcomes. How well a local area engaged with, and involved children and young people and their parents and carers, both in commissioning services at the strategic level and in assessing individual need would be a key area of inspection focus.

In preparation for the inspection, a Tameside and Glossop CCG Audit was completed in July 2016 providing a framework for considering progress to date and divided into 6 key areas of the role of a CCG in supporting children with SEND. A brief summary result included in the report indicated that the CCG was able to evidence its current baseline compliance within the reforms. However, further actions were needed to ensure clear evidence of the CCG / Single Commission function commitment to implementing the reforms.

**RESOLVED**

**(i) That the content of the report be noted.**

**(ii) That the CCG / Single Commission officers and the Clinical Lead be authorised to continue to take relevant steps, make decisions, and to progress arrangements to further the implementation of the SEND reforms.**

**(iii) That an action plan be developed based on the findings of the CCG SEND diagnostic audit tool and approved through emerging governance structure, ensuring oversight and inspection readiness.**

**(iv) That all relevant providers be briefed in relation to the new inspection framework and its requirements.**

**(v) That a re-audit applying CCG SEND diagnostic audit tool be undertaken in July 2017.**

## 69. NEURO REHABILITATION

Consideration was given to a report of the Director of Commissioning advising that the Greater Manchester Heads of Commissioning, with the Stroke and Neurology Operational Delivery Networks (ODNs) had produced a report providing an update on the work undertaken to date.

It included a proposal for the alignment of stroke and neuro-rehab services by developing a service specification for a combined model, providing a consistent approach to these areas of rehabilitation across Greater Manchester. Tameside and Glossop already commissioned in this way when the specifications for the previous SPRINT (neuro-rehab) and Community Stroke Team merged in 2013-14 to form the Community Neuro-Rehabilitation Team.

The report also outlined the opportunities for GM working to achieve consistency and to identify areas where efficiencies could be made and the following steps were highlighted as essential in preparation for the implementation of a combined model:

- Consultation on a combined service specification;
- Development of eligibility criteria;
- Development of commissioning options with risks and benefits per CCG area;
- Completion of a cost-benefit analysis in order that the benefits of change required were quantifiable and assessable.

Tameside and Glossop were represented at Head of Commissioning and also in the discussions with ODNs on the details of the proposed model and had provided information on the local service provision to inform the content of the report.

The Commissioning Team would ensure that there were no additional cost implications of this work for the Tameside and Glossop Single Commission and would work with the ICO on any redesign implications.

The request from the GM Heads of Commissioning was that each CCG take this proposal through local governance for approval.

**RESOLVED**

**(i) That the update report be noted.**

**(ii) That the intention for a combined service mode at GM level be confirmed.**

**(iii) That the proposal for the completion of an Impact Assessment including a cost benefit analysis be approved.**

**(iv) That Tameside and Glossop's involvement in this commissioning project be confirmed.**

**(v) That NHS Tameside and Glossop CCG would continue to commission a combined stroke and neuro-rehab service from Tameside NHS Foundation Trust.**

## 70. INTEGRATED NEIGHBOURHOOD PHARMACY PROPOSAL

Consideration was given to a report of the Director of Commissioning outlining a model for pharmacy and medicines management support to the integrated neighbourhood model. As part of the consultation process for the emergent Integrated Neighbourhood Offer the single commission and care together programme had held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue that had arisen as a priority from discussions in all 5 neighbourhoods was the need for pharmacy and medicines management support. This scheme complemented the Integrated Neighbourhood offer and the Care Homes policy.

The key outcome of this new service would be improved care and health outcomes for patients as well as improved access to care in general practice. Pharmacists would work as part of the Integrated Neighbourhood Team to help identify patients at risk and intervene to reduce this risk as well as make interventions to help those in frequent contact with health services, this would include those in care homes. They would support patients to self-manage their wellbeing and long term conditions through optimising medicines and enabling improved medicine related communication between general practice, hospital and community pharmacy. It was also expected that this service would release savings in primary care budgets through a reduction in medicine related non-elective admissions. The CCG spent £14,230 on unplanned admissions last year. As noted, literature suggested that between 5 to 8% of all unplanned hospital admissions were due to issues related to medicines.

Reference was also made to the current practice pharmacist situation, potential barriers to the effectiveness of service offerings, interventions, inter-pharmacy liaison and the overarching benefits.

It was reported that the provision of approximately 2 WTE per neighbourhood at a total cost of £640,500 was roughly in line with the figure quoted in the GP forward view of a pharmacist per 30,000 population and supported the Integrated Neighbourhood offer.

There was much evidence nationally and locally to promote the benefit of using the skills of clinical pharmacists in general practice and community teams. The proposed approach would 'top slice' any GM transformation funding awarded to the Integrated Neighbourhood model to enable a Neighbourhood Pharmacy Support Team to be commissioned working across all 5 Neighbourhoods. The benefits of this approach would include:

- Ability to deliver key pharmacy interventions providing financial and clinical efficiency in prescribing;
- Delivery of an identified priority for Integrated Neighbourhoods;
- Improve the recruitment and retention of pharmacists;
- Cover all ages and not just specific age groups;
- Release of BCF funding to support other Neighbourhood based initiatives;

- Foundation for wider development and further expansion of pharmacy support as a key function / intervention for the ICO with potential to work across primary and secondary care.

**RESOLVED**
**That the proposal to develop a Neighbourhood Pharmacy model to support the model for Integrated Neighbourhood working be approved.**

## 71. ENHANCED APPROACH TO 'DO NOT PRESCRIBE', GREY LIST AND RED MEDICINES

The Director of Commissioning presented a report setting out a proposed approach for the application of prescribing guidance in the local health economy. Whilst Tameside and Glossop CCG sought to ensure that all patients had access to the most appropriate medicines and treatments to maintain their health and wellbeing, some medicines had been identified as not providing adequate value for the local health economy and the prescribing of any such medicines or appliances might be restricted. This could be as a general Do Not Prescribed (DNP) message, prescribed under limited circumstances (Grey list) or not be prescribed in primary care (Red status).

Reference was made to the NHS Act and the NHS Constitution in line with the NHS Standard Contract set a number of broad principles in place when considering the use of treatment within the NHS which were detailed in the report.

The aim of the approach was to promote recognition of DNP, Grey and Red list criteria at time of requesting so they could be highlighted and challenged before any GP prescribing occurred. Often it was practice staff who were the first point of contact for these requests and having a reference point available for GPs to back up their decisions not to prescribe would help prevent prescribing contra to the DNP, Grey, Red prescribing lists. Such lists were available on the Greater Manchester Medicines Management Group website but the information was not always easy to find and it was intended that the localised version of these lists would be accessible for the public / GPs / practice staff on the CCG website.

The proposed policy for consideration for inclusion in the DNP, Grey list was attached at **Appendix 1**. Any prescriber would be able to input ideas into the development of the DNP and Grey list which would be received on a regular basis. It was proposed that those medicines or appliances which were agreed as going forward for inclusion would then be signed off for such by the Quality Committee and thereafter updated on the CCG website.

**RESOLVED**
**(i) That the approach for the application of prescribing guidance in the local health economy be approved.**
**(ii) That the Single Commission Management Team (via medicines management teams) work with prescribers in the local economy to implement the model.**

## 72. URGENT ITEMS

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

## 73. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 4 October 2016 commencing at 3.00 pm at New Century House, Denton.

**CHAIR**