TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

17 January 2017

Commenced: 3.00 pm **Terminated: 4.40 pm**

PRESENT: Christina Greenhough (in the Chair) – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Graham Curtis – Tameside and Glossop CCG
Alison Lea – Tameside and Glossop CCG
Jamie Douglas – Tameside and Glossop CCG

IN ATTENDANCE: Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Angela Hardman – Director of Public Health and Performance
Michelle Walsh – Interim Director of Nursing, Quality and Patient Safety
Ali Rehman – Public Health
Anna Moloney – Public Health
Chris Easton – Head of Strategy and Development – Tameside and Glossop Integrated Care Foundation Trust
Aileen Johnson – Head of Legal Services
Simon Brunet – Head of Policy and Communications

APOLOGIES: Alan Dow (Chair) – Tameside and Glossop CCG
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer, Tameside and Glossop CCG

109. DECLARATIONS OF INTEREST

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

110. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 December 2016 were approved as a correct record.

111. 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 8 financial position at 30 November 2016 and the projected outturn at 31 March 2017. It was explained that there needed to be careful management of the pressures faced by the each of the Tameside and Glossop Care Together constituent organisations.

The overall financial position of the Care Together economy had improved month on month reducing the projected year end deficit to £5.9m. Work continued to deliver improvement on the CCG Quality Innovation Productivity and Prevention (QIPP) position of the recovery plan and there had been an improvement to the CCGs projected year-end financial position but it was important to note that the majority of this improvement was a result of non-recurrent means. Overall, the Tameside MBC year end forecast position had deteriorated since period 7 predominantly due to

expenditure to address the outcomes of the recent Ofsted Inspection of children's social care services. The Tameside and Glossop Integrated Care NHS Foundation Trust was currently forecast to achieve the planned £17.3m deficit.

Reference was made to the current prescribing positon and future pressure that could be mitigated by sustained efforts to reduce volumes and control spending. This area remained in need of a high level of focus and it was important that meetings planned to monitor progress took place as scheduled.

RESOLVED

(i) That the 2016/17 financial year update on the month 8 financial positon at 30 November 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 be acknowledged.

112. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on quality and performance data as at the end of October 2016 and an update on the System Wide Outcomes Framework. The new report format aimed to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report would align with the Systems Outcome Framework, other Greater Manchester and National dashboard reports.

The format would also include further elements on quality from the Nursing and Quality Directorate as the report evolved. It was also anticipated that the report would include elements of the Single Outcomes Framework and an update on the Framework was included with the report.

The following had been highlighted as exceptions:

- Cancer standards were achieved in October. Quarter 2 performance achieved apart from 62 day consultant upgrade.
- Diagnostic standard improving but still failing the standard. Endoscopy was no longer a challenge in diagnostics at Central Manchester.
- A&E standards were failed at Tameside Hospital Foundation Trust.
- 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.
- Number of patients waiting over 52 weeks.
- Improving access to psychological therapies performance for Access and Recovery remained a challenge.
- 111 performance against Key Performance Indicators.
- MRSA.

In terms of the System Wide Outcome Framework, this was split into three themes detailed as follows:

- Population health;
- Empowering people and communities; and
- System performance and sustainability.

It was explained that the framework should first and foremost be viewed as a transformational approach and in order to deliver the changes in health and social care to meet the challenges faced thought needed to be given to the way services were designed, commissioned and provided.

The Leadership and development of the outcomes framework would sit with the Collaborative Intelligence Function drawing on expertise and capacity from across the Single Commission and Tameside and Glossop Integrated Care Foundation Trust. The health and wellbeing outcomes within the framework applied across all integrated health and social care services. There was an opportunity to report on the outcomes framework at the Health and Wellbeing Board to promote shared priorities by bringing together responsibility and accountability for their delivery.

In relation to next steps, the following was planned.

- A phase of engagement including a development session with key staff and stakeholders to comment on the framework, its content and to identify any omissions;
- Development of reporting approach and dashboards to provide effective reporting of the framework to be aligned with other reporting approaches to avoid duplication;
- Formal publication of the framework along with accompanying narrative for the workforce across the Single Commissioning Function;
- Series of briefing sessions for staff.

Members of the Board discussed and commented on the new format and approach and welcomed the proposed development session providing key staff and stakeholders with an opportunity to comment on the framework.

RESOLVED

(i) That the contents of the performance and quality report and revised format be noted.

(ii) That the update on the System Wide Framework, structure, content and next steps be noted.

113. NEW CONTRACTUAL AND PARTNERSHIP RELATIONSHIP BETWEEN TAMESIDE AND GLOSSOP'S CARE TOGETHER SYSTEM AND PENNINE CARE IN RELATION TO THE DELIVERY OF MENTAL HEALTH SUPPORT

Consideration was given to a report of the Director of Commissioning setting out the current position in relation to the commissioning of mental health services in Tameside and Glossop. The proposal, in line with a number of other Greater Manchester Clinical Commissioning Groups was that the Single Commissioning Function would move from its current multi-lateral mental health contract with Pennine Care NHS Foundation Trust to a bi-lateral contract with the current provider with effect from 1 April 2017.

The report explained the position currently faced in securing a long term mental health partner for the Care Together system, working with the Integrated Care Foundation Trust. It proposed a way forward over the next two years that allowed the continuation of mental health services in the area whilst a review and redesign of an all age mental health service was undertaken to deliver savings and work towards integrating mental health within the Integrated Care Foundation Trust.

RESOLVED

(i) That the approach set out in the report with Pennine Care NHS Foundation Trust resulting in a bi-lateral contract for the delivery of mental health services for a two year period from 1 April 2017 be approved.

(ii) That the review and redesign of mental health services within the Care Together Programme as part of the journey towards integration within the Integrated Care Foundation Trust be approved.

114. PRIMARY CARE – PRIORITIES AND SCOPE

Consideration was given to a report briefing on the priorities and scope for primary care over the next two to five years based on a number of national and regional documents as follows:

- The Five Year Forward View;
- The General Practice Forward View;
- New Care Models: The multispecialty community provider emerging care model and contract framework;
- NHS Operational Planning and Contracting Guidance 2017-19;
- Greater Manchester Primary Care Strategy Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.

These documents were closely aligned and interlinked and all outlined the need for system wide changes to ensure the NHS could deliver the right care, in the right place, with optimal value. The framework was first outlined in the Five Year Forward View with the clear task to '*drive improvements in health care; restore and maintain financial balance; and deliver core access and quality standards*'. This was translated to describe localities position in their Sustainability and Transformation Plans.

Strengthening and transforming general practice would play a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims of the GP Forward View into these plans. CCGs would need to document the aims and key local elements of the GP Forward View into more detailed local operations plans and submit one GP Forward View plan to NHS England on 23 December 2016. Plans needed to reflect local circumstances, but at a minimum set out:

- How access to general practice would be improved;
- How funds for practice transformational support would be created and deployed to support general practice;
- How ring fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, would be deployed.

In terms of local implementation, although the neighbourhood model of peer support had been in place for a number of years more recently this had developed and expanded to promote new ways of working across and by, neighbourhoods. The ambition of this was to improve efficiency and achieve the care delivered by population based models approach and further alignment of commissioning staff to neighbourhoods had strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model was being implemented locally through this extended support and it was anticipated that this would become embedded in practice culture.

The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, was moving forward and would further develop over the coming years.

Neighbourhoods were designing models of care for their population based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods had been formed across all neighbourhoods bringing together providers to work in collaboration. Different models of working and widening the range of professionals within the primary care workforce was a key strand throughout all national documentation and this was being taken forward locally. New models of care and the direction of the GP Forward View and GM Strategy had been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model was not yet available, the context in which the contracts were being re-procured and the future vision for these practices had been outlined and would form part of the assessment of bids.

The Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape both financial and policy. This redesign must therefore address the direction for primary care outlined through the documentation to support the formation of new models of care and deliver people empowered care and place based, population based models. This redesign would address the 'must do's' and mandates from the planning guidance outlined in the report as well as ensuring

Tameside and Glossop fulfilled its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people accessed services would also be reflected, ensuring people powered change could be achieved. This refresh was underway and would go through a period of patient and practice consultation.

RESOLVED

(i) That the scale of the ambition for Primary Care nationally be noted.

(ii) That the delivery of this ambition through local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme be supported.

(iii) That the competing priorities on scarce financial resource and the CCG investment already in place as part of the Primary Care Quality Scheme, noting the refresh of this aligned to national policy and GM standards and the investment in respect of neighbourhoods through the Transitional Fund be acknowledged.

115. NEIGHBOURHOOD PRIMARY CARE INNOVATION SCHEME

Consideration was given to a report of the Director of Commissioning, which explained that the NHS Planning Guidance issued in December 2013 – 'Everyone Counts – Planning for Patients 2014/15 to 2018/19' set out proposals for the investment of the NHS budget 'so as to drive continuous improvement and to make high quality care for all, now and for future generations into a reality'. This included a section on 'wider primary care – provided at scale' and specified that: CCGs would be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They would be expected to provide additional funding to commission additional services which practices, individually or collectively, had identified would further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equated to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund.

Tameside and Glossop CCG had made the decision to allocate a budget of £1.2m to support member practices in the delivery of schemes to meet the criteria outlined above. Practices were invited to present proposals for approval via PIQ (Planning Implementation and Quality Committee) at either an individual practice level, or as groups of practices (up to neighbourhood level).

During 2014/15 – 2015/16 a number of schemes had been designed, developed and implemented across the locality, with learning and results shared to inform future developments. The practices had been supported by CCG officers from the finance and commissioning teams, and by their neighbourhood clinical leads. In 2015/6 a decision had been made that from 1 April 2017 any schemes would need to be on a neighbourhood level, in line with the development of the Integrated Neighbourhood element of the locality's integration plans.

RESOLVED

That the Neighbourhood Primary Care Innovation Scheme be approved but the funding for the scheme should be a call on the Transformation funding from GM earmarked for the Integrated Neighbourhood model rather than a separate commissioner held budget.

116. PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF LIFTS AND HOISTS

Consideration was given to a report of the Director of Commissioning advising that the service was jointly commissioned with Oldham MBC for an initial two year period from 20 January 2015 with the option to extend for up to an additional 12 months provided for within the contract.

The contract had been performance managed regularly over the first two years and overall the contractor had performed well for both Tameside MBC and Oldham MBC. Call outs and repairs were falling due to the fact that the stock was now in a better state of repair than at the beginning of the contract and this was resulting in fewer call-outs, thereby reducing costs.

In 2015/16 the spend was £119,000 and £74,000 for Tameside MBC and Oldham MBC respectively and spend for 2016/17 was projected to be the same or less than the previous year and was within the procured financial envelope for both authorities.

Oldham MBC had indicated that they were willing to continue with the current joint working arrangements and also participate in the re-procurement of a new contract which would commence in the new financial year. Of the submissions received when the contract was market tested in late 2014, the current contractor's costings were the lowest. Authorisation was being sought to extend the contract for a period of up to 12 months from 20 January 2017.

RESOLVED
That authorisation be given to extend the contract for a period of 12 months from 20 January 2017.

117. TENDER FOR THE PROVISON OF AN ADVOCACY HUB

Consideration was given to a report of the Director of Commissioning detailing the intention to go out to tender for the provision of Independent Mental Health Advocacy, Independent Care Act Advocacy and independent complaints advocacy, all of which represented a statutory duty, along with generic advocacy to be delivered via a single point of access from 1 April 2017.

It was explained that the current advocacy contract commenced in July 2012 and was due to cease on 3 July 2017. Over the summer, meetings had been held with the commissioners in Oldham MBC to explore the possibility of a collaborative approach to commissioned advocacy services. Unfortunately, although there was some scope for small-scale efficiencies, a model could not be agreed that accommodated the different circumstances pertaining in each borough and it was agreed to continue to commission services locally.

The approach commissioned in Tameside was consistent with the move, certainly across Greater Manchester, towards advocacy hubs that meant an individual could, if need be, be supported by the same individual advocate through a set of different circumstances and disciplines so ensuring a degree of consistency.

The current contract cost £148,900 per annum and there had been an agreement with the current contractor during negotiations in April 2015 regarding Care Act Advocacy that referral levels would be monitored and, if necessary, spot purchase Care Act provision if it tipped their work load beyond the capacity of the staffing model originally purchased. Thus far, due to the low level of referrals and the fact that the contractor had picked these up as part of the generic element of their advocacy offer, this had not been an issue but, with Care Act referrals likely to rise steadily over the next five year period, this could prove to be an issue in terms of the budget available.

It was explained that authorisation was being sought to go out to tender with a five year contract to deliver advocacy provision via a hub model. The service required little in the way of redesign and remained fit for purpose.

RESOLVED
That authorisation be given to proceed with the tendering a number of advocacy services, to be delivered through a single point of access, a hub model, and a single contract.

118. MENTAL HEALTH SUPPORTED ACCOMMODATION

Consideration was given to a report of the Director of Commissioning seeking authorisation to extend the current contract for up to 24 months from 1 April 2017 to 31 March 2019 as allowed for within the contract.

The contact to provide supported accommodation to people recovering from mental health problems was awarded following a restricted tender exercise and commenced on 1 April 2014 for a period of three years and included provision to extend for up to an additional two years. It provided a 24 hour support service across three properties in the Borough and as such was an integral part of a comprehensive community based service. The properties were provided by registered social landlords. It was aimed at equipping service users with the life skills necessary to move on to more independent living whilst reducing the need for more expensive residential placements and/ or hospital admissions.

Performance monitoring for the contract had reported a high level of satisfaction from commissioners, people who were supported by the service and families. In addition, the providers had noted a number of successes in supporting people's recovery journey and a move to general let tenancies with community mental health team support.

PRG raised concerns on the development around one of the properties that had been identified by all partners as not fit for purpose in the long term. Discussions had commenced to establish the notice period required to the landlord in line with the housing management agreement, working with tenants to move on and how the levels of service would be utilised within the contract in terms of delivering community support.

RESOLVED
That authorisation be given to extend the current contract for up to 24 months from 1 April 2017 to 31 March 2019.

119. DERMATOLOGY AND GUIDANCE AND INTERCEPTOR SERVICE

Consideration was given to a report of the Director of Commissioning advising that the need to manage demand from General Practice was fundamental to the delivery of the CCG Financial Recovery Plan. Following the initial financial analysis of the Referral Management Service, the need for a smaller scale was identified. The decision was taken to build on existing peer support amongst GPs and invite Orbit and Go To Doc to submit a proposal.

The proposal suggests a five month pilot of Dermatology referrals using Glossop Neighbourhood activity as a control and all other neighbourhoods being required to submit non-cancer referrals to an Interceptor service that could clinically assess the referrals and provide advice and guidance for Primary Care Management or referrals to the nurse or consultant led services.

GPs would send referrals and images to the service following consent and a clinical review will be undertaken and appropriate advice regarding the referral given within 3 working days.

The pilot will be evaluated using activity, costs, a set of metrics and soft intelligence to establish quality and cost effectiveness following four complete months of operation and would inform the decision whether to transfer the pilot to business as usual or cease the service. The cost effectiveness would consider the benefit to the whole health and social care economy.

RESOLVED
That the implementation of the five month pilot be approved, including an evaluation of the cost effectiveness going forward and a recommendation to the Single Commissioning Board of future commissioning.

120. PROPOSAL FOR AN INTERCEPTOR FOR KEY EUR PROCEDURES

Consideration was given to a report of the Director of Commissioning explaining that a benchmarking exercise across Greater Manchester (GM) had highlighted that the level of patients who received some of the Effective Use of Resources (EUR) procedures was much higher than other CCGs. Ten key procedures had been identified where a more robust process to intercepting referrals / decisions to undertake the procedure could deliver significant reductions and bring the activity in line with other CCGs.

Two options were set out in the report. The first utilised the Clinical Speciality Unit (CSU) GM EUR process and changed the Monitored Approval activity to Individual Prior Approval. The second option utilised an internal interceptor which retained the existing criteria but would allow all GP referrals to be intercepted and other referrals from Tameside and Glossop Integrated Care Foundation Trust, GM EyeCare, Hyde Physio, Pioneer and North West Clinical Assessment and Treatment Service. An implementation plan for both options was detailed in the report.

A cost benefit analysis was detailed, taking into account the additional costs at CSU or the Single Commissioning Function to manage the referrals, additional capacity at Tameside and Glossop Integrated Care Foundation Trust to support additional administration (Band 3) and the reduction in spend for the activity. It was recognised that it might not be possible to realise all of the costs at Tameside and Glossop Integrated Care Foundation Trust and a conservative estimate had been used.

Approval was sought for the implementation of the internal EUR Interceptor as set out in option 2 for 12 months which would require capacity for band 3 posts. If funding could not be found across the whole economy, then there would be backfill funding as outlined in the business case to offer a secondment as an invest to save as highlighted in the report. There would be a four month evaluation of the impact as part of a wider paper that included options for the future commissioning / decommissioning of all EUR procedures.

RESOLVED
That the implementation of Option 2, a proposed Internal EUR Interceptor for the ten specified procedures and the recruitment of the additional Band 3s for a 12 month period at both the Trust and the CCG, be approved.

121. EVIDENCE BASED DECISION MAKING – AN APPROACH TO EQUALITY, QUALITY AND CONSULTATION

Consideration was given to a report of the Director of Governance and the Interim Director of Nursing, Quality and Patient Safety explaining a number of requirements to be met to assist the new single commissioning function in making robust evidence based decisions. The report summarised the requirements and the support available to contract and commissioning managers to ensure they discharged their obligation to provide robust and evidential reports to decision makers. The three areas covered were highlighted as follows:

- Equality and diversity;
- Quality and risk; and
- Consultation and engagement (including ongoing patient participation).

It was proposed to run a series of workshops for relevant staff on the approach outlined and the need for robust evidence decision making.

RESOVLED
(i) That the content of the report be noted.
(ii) That the approach outlined be agreed and supported.

(iii) That the proposal for workshops to be held for relevant staff on the approach outlined and the need for robust evidential decision making be supported.

122. URGENT ITEMS

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

123. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 14 February 2017 commencing at 3.00 pm at Dukinfield Town Hall.

CHAIR