TAMESIDE AND GLOSSOP
STRATEGIC COMMISSIONING BOARD

19 September 2018

Commenced: 1.00 pm **Terminated:** 2.05 pm

Present:	Dr Alan Dow (Chair) - NHS Tameside and Glossop CCG Steven Pleasant - Tameside MBC Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG Councillor Warrington - Tameside MBC Councillor Fairfoull - Tameside MBC Councillor Bray - Tameside MBC Councillor Feeley - Tameside MBC Councillor Gwynne - Tameside MBC Councillor Ryan - Tameside MBC Dr Vinny Khunger - NHS Tameside and Glossop CCG Dr Alison Lea - NHS Tameside and Glossop CCG Dr Ashwin Ramachandra - NHS Tameside and Glossop CCG Carol Prowse - NHS Tameside and Glossop CCG

In Attendance:	Jeanelle De Gruchy	Director of Population Health
	Kathy Roe	Director of Finance
	Sandra Stewart	Director of Governance and Pensions
	Sandra Whitehead	Assistant Director (Adults)
	Elaine Richardson	Head of Assurance and Delivery
	Simon Brunet	Policy Manager

Apologies for Absence:	Councillor Cooney - Tameside MBC Councillor Wharmby - Derbyshire CC Dr Jamie Douglas - NHS Tameside and Glossop CCG

48. DECLARATIONS OF INTEREST

There were no declarations of interest.

49. MINUTES OF THE PREVIOUS MEETING

That the Minutes of the previous meeting held on 29 August 2018 were approved as a correct record.

50. FINANCIAL CONTEXT

a) Financial Position of the Integrated Commissioning Fund

Consideration was given to a report of the Director of Finance providing an overview on the financial position of the Tameside and Glossop economy in 2018/19 at 31 July 2018 with a forecast projection to 31 March 2019 including the details of the Integrated Commissioning Fund for all Council services and the Clinical Commissioning Group with a total net revenue budget value for 2018/19 of £581 million.

The Commission was currently forecasting that expenditure for the Integrated Commissioning Fund would exceed budget by £5.84 million by the end of 2018/19 due to a combination of non-delivery

savings and cost pressures in some areas, particularly in respect of Continuing Healthcare, Children's Social Care and the Growth directorate. Supporting details of the projected variances were explained, as outlined in Appendix 1 to the report. The excess was offset slightly by savings in other areas, such as the success of the GP Prescribing Costs scheme, a dividend from investment in Manchester Airport and lower than expected borrowing.

In particular the Director of Finance explained that the Clinical Commissioning Group was planning to deliver a surplus of £9.347 million broken down into two parts:-

- £3.668 million mandated 1% surplus; and
- £5.679 million cumulative surplus brought forward from previous years.

The 1% in year surplus was a requirement of business rules and the cumulative surplus brought forward was built up in 2016/17 and 2017/18 when Clinical Commissioning Groups had to contribute to national risk reserves offsetting overspend in the provider sector. There was no national risk reserve in 2018/19 but there was still a significant financial gap nationally, which needed to be addressed. Whilst the cumulative surplus brought forward remained on the Clinical Commissioning Group's balance sheet, there was currently no mechanism through which Tameside and Glossop were able to drawdown or use any of this resource.

However, there were emerging proposals that could potentially allow Clinical Commissioning Groups who were able to increase their 2018/19 surplus to drawdown some of their cumulative surplus in 2019/20. Where a Clinical Commissioning Group agreed to underspend its allocation in a year they would receive a guaranteed surplus drawdown the following year on a two for one basis, subject to the cumulative surplus being available. A draft proposal detailed in the report had been circulated to Clinical Commissioning Groups across Greater Manchester and discussed at the Finance and QIPP Assurance Group in August, where it was suggested to use headroom in the Integrated Care Fund risk share to increase the 2018/19 Clinical Commissioning Group surplus up to £3 million. This would enable a potential drawdown of £6 million in 2019/20, reducing the cumulative surplus and improving the financial position of the integrated commissioner on a recurrent basis. The Director of Finance agreed to keep the Board advised of developments.

RESOLVED

(i) That the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks, which were contributing to the overall adverse forecast, be acknowledged.

(ii) That the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Growth, be acknowledged.

(iii) That the use of headroom in the Integrated Care Fund risk share to increase the Clinical Commissioning Group surplus in 2018/19 to enable drawdown of cumulative surplus in 2019/20 be authorised.

51. COMMISSIONING FOR REFORM

a) Banding Payment System and Age Policy Change for Shared Lives Placements

Consideration was given to a report of the Executive Leader and Assistant Director (Adult Services). The report was seeking permission to introduce a banding payment system for Shared Lives carers to reflect the complexity of need of those cared for, and also change the age of entry into Shared Lives from 18 years of age to 16 years of age to improve transition and continuity of care for young people. This was part of a wider transformation plan focused on improving access to Shared Lives for people with more complex needs and young people coming through transition.

The Council faced significant budgetary challenges over the foreseeable future, which meant it must diversify service delivery by looking at new and innovative approaches to deliver better outcomes

whilst also reducing the cost of provision. This could also include a cost benefit analysis across the health and social care system identifying where efficiencies can be made.

Shared Lives supported some of the most vulnerable individuals across the borough to maximise their independence through a family based community support network. Throughout the service offer Shared Lives carers could support service users to maintain independence in the community and as a support to family carers to maintain their roles. As people progressed into long term placements Shared Lives carers offered an asset based approach as a less costly alternative to traditional services. The Shared Lives Scheme was currently in a period of transformation to expand the provision to a more diverse range of Service Users and relieve pressure on other provisions. Recruitment of skilled carers was pivotal to these aims.

The proposed banding payment system for Shared Lives carers ensured the payment made to carers was reflective of the levels of need of the service users in their care, and providing a choice to carers of the amount of assistance they wanted to, or could, provide at a certain cost.

A banding payment system would also support the attraction of a larger number of prospective carers to meet the varying degrees of need. There was a need to review the fixed payments that were currently offered to carers and consider a payment mechanism that was more reflective of the complexity of service users that carers currently supported, and could support in the future as services were expanded. It would also support recruiting more carers to the service. Some individuals might be willing to provide accommodation but not much support while others might be willing and want to provide a substantial amount of support on the basis that the level of support and commitment was financially recognised. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role.

By changing the age of access to 16 years this allowed a wider range of young people to consider Shared Lives as a viable alternative to other support approaches. This would include Looked After Children and also young people with complex needs who were currently in placements or with Foster carers. Foster carers who cared for young people with complex needs would, in the interests of continuity, be encouraged to become Shared Lives carers. As the young person became an adult the banding system would offer a more comparable payment system reflecting the complexity of need that a fixed rate system did not recognise.

The aim was to expand the Shared Lives offer to provide more person centred care as an alternative to other high cost alternatives such as placements in supported housing or out of area placements.

All service users would be reviewed against the proposed banding scheme that would be implemented by 1 April 2019 and existing Shared Lives carers payments would be protected if the banding for an existing service user was assessed at a lower rate than their existing payment for the duration that they were caring for that individual.

It was proposed that in an emergency carers would receive the higher banding rate until the banding assessment had been completed. If the person's banding was lowered carers would not be expected to refund the difference. The decision of which band would be applicable to the service user would be agreed between the Shared Lives Social Worker and the Care Coordinator who had assessed the needs of the individual.

RESOLVED

(i) That a new banding payment system for Shared Lives carers be introduced.

(ii) That the age of entry to Shared Lives be changed from 18 to 16 years in the Shared Lives Policy.

(iii) That existing Shared Lives arrangements be protected if the banding for an existing service user was assessed as being Band 1.

(iv) That the banding system be implemented by 1 April 2019.

(v) That where an emergency place was made this would initially be paid at the higher rate until an assessment was completed.

b) NHS England Consultation on Evidence Based Interventions: GM Response

The Interim Director of Commissioning presented a report summarising the NHS England consultation on evidence based interventions and proposed a Greater Manchester response that would be submitted on behalf of Tameside and Glossop and other Greater Manchester Clinical Commissioning Groups.

It was stated that the NHS England proposal was to stop routinely funding four category one interventions and set qualifying criteria for a further thirteen category two interventions, which were detailed in the report. Greater Manchester had policies for three of the four category one interventions with a local policy for the fourth and policies for 12 of the 13 category two interventions with stricter criteria than what was being proposed by NHS England. It was confirmed that Tameside and Glossop was not in the top 50 Clinical Commissioning Groups for spend in this area and Tameside and Glossop Integrated Care Foundation Trust was not one of the top 50 providers for activity in this area.

The interventions would not be routinely offered to NHS funded patients or offered only if specific criteria applied. However, clinicians would be able to apply for funding for category one interventions if they could demonstrate exceptionality and for prior approval for all category two interventions. The expectation was that the GP would apply for funding rather than the provider clinician.

Category one interventions would be removed from the scope of National Tariff price or a national variation would be used so that providers were not paid for activity unless they had an individual funding request number. The proposal was that this would apply from April 2019.

With effect from 1 April 2019 the NHS Standard Contract would be amended to mandate compliance with the Evidence-Based Interventions policy. The proposed additions to the Contract would require both commissioners and providers to comply with the Evidence-Based Interventions policy and enable the commissioner to withhold payment for the relevant procedure where the provider treats a patient without evidence of individual funding request approval (category one) or other prior approval (category two).

NHS England proposed aligning the e-referral system with the new programme by excluding category one interventions from the e-referral system except where an individual funding request has been agreed. They intended to work with Clinical Commissioning Groups and GPs on how best to implement this.

The proposed Greater Manchester response to the NHS England consultation on Evidence Based Interventions, as outlined in section 6 of the report, was discussed with the Board.

RESOLVED
(i) That the report and implications be noted.
(ii) That the response to NHS England as set out in section 6 of the report be agreed.

52. CLOSING REMARKS

Dr Alison Lea advised that as she would be stepping down from the Governing Body of the Clinical Commissioning Group, this was her last Strategic Commissioning Board meeting. Members of the Board joined the Chair in thanking Dr Lea for her contribution to the work of Strategic Commissioning Board.

53. URGENT ITEMS

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

54. DATE OF NEXT MEETING

It was noted that the next meeting of the Strategic Commissioning Board would take place on Wednesday 24 October 2018.

CHAIR