Adults' Health and Wellbeing Commissioning Group

A meeting of Adults' Health and Wellbeing Commissioning Group was held on Monday, 17th August, 2015.

Present: Peter Kelly (Chairman) Cllr Jim Beall, Emma Champley, Liz Hanley, Jayne Herring, Sean McEneany, Mark McGivern (sub for Sarah Bowman-Abouna); Paula Swindale (sub for Karen Hawkins)

Officers: Nigel Hart (DS); Michael Rowntree (TVPH Shared Services); Dave Smith (PH).

Also in attendance: N/A

Apologies: were submitted on behalf of Sarah Bowman-Abouna,Kerry Anderson, Kate Birkenhead, Karen Hawkins, Simon Willson.

1 Declarations of Interest

Councillor Beall declared a personal, non-prejudicial interest in respect of item 5 entitled 'Review of Adult Drug Treatment and Recovery Services 2015; as a result of his grand-daughter who was contracted by Public Health to deliver drug misuse treatment and who were referenced within the report with an outcome to review their area of service alongside Birchtree's.

AGREED that the Declaration of Interest be noted.

2 Minutes of the meeting held on 24 March 2015

The minutes of the meeting held on 24th March 2015 were signed by the Chairman as a correct record.

AGREED that the minutes be approved as a correct record.

3 Minutes of CYP Commissioning Group, CYP Partnership and Adults Health and Wellbeing Partnership

The Group were presented with minutes of the following meetings:

- Adults Health and Wellbeing Partnership – 4 March 2015

- Children and Young People's Health and Wellbeing Commissioning Group – 16 March 2015

- Children and Young People's Health and Wellbeing Partnership – 18 March 2015

- Adults Health and Wellbeing Partnership - 1 April 2015

-Children and Young People's Health and Wellbeing Partnership – 15 April 2015

-Children and Young People's Health and Wellbeing Partnership – 20 May 2015

AGREED that the minutes be noted.

4 Care Home Update

Members were provided with an update in relation to work currently being undertaken by NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group (CCG) in collaboration with the Local Authority.

The current economic situation and increasing demand for services had created a new challenge for both Local Authorities and the CCG, and the CCG recognised it had a responsibility to ensure sufficient supply in the nursing residential care home market to meet individual's needs including how that care and support is delivered when people were unable to remain at home. The CCG was concerned about the decline in beds across their area and neighbouring CCGs and recognised the negative impact provision in the independent sector had on the patient and length of stay in acute services. The dissatisfaction with fees paid, had been cited as a reason why providers may, in the longer term, choose to withdraw nursing beds. This coupled with the issue of bed closures which had arisen from the serious concerns protocol often not associated to fees.

As a result, a paper had been presented to the North of Tees Partnership Board on the 26th June 2015 detailing the current work underway in response to current pressures across nursing residential care providers. The Board inclusive of LA representatives supported both the approach and timescales in response to the current issues and the establishment of a joint Health and Social Care North of Tees Care Home Commissioning Group to take forward the development of a new model of care programme for nursing and residential care homes to ensure a sustainable system that responds to residents needs across the whole sector. The specific tasks of the Group were noted and its Terms of Reference was currently being reviewed by each organisation for agreement.

In addition, the CCG supported by both Hartlepool and Stockton LA's, had undertaken 1:1 meetings with current care home providers to understand in greater detail the current pressures, constraints and barriers experienced by providers. The meetings were seen as a positive step, and the key themes identified were noted and would be reviewed by the North of Tees Care Home Commissioning Group and incorporated into the development and delivery of the new model of care. One of the outcomes being that providers cited dual registration (nursing and residential) as the most appropriate from a resident and provider perspective, with continuity of care and resident choice regarded as a key driver.

Having identified over recent months areas of concern from providers in relation to financial difficulties and issues which had resulted in a number of nursing residential homes going into administration and a few signalling their intention to withdraw from nursing provision transferring their care home status to residential care only, the CCG were in the process of remodelling potential new core payment rates for funded nursing care and fully funded continuing healthcare. A financial feasibility paper containing five options would be presented to the CCG Executive Team and Governing Body in August/September for consideration which if agreed would seek to introduce a new core fee rate from October 2015.

With the profile of Care Homes having risen over the past few years with an

increasing focus on the quality of service delivered within them, the Quality and Patient Safety team for the CCG had the responsibility to support and assure the quality of care delivery across the nursing residential care home sector. The standard of care was currently monitored through an annual audit programme of quality monitoring visits across nursing care home providers and from intelligence gathered from information sharing across Hartlepool and Stockton-on-Tees LA's and the Care Quality Commission (CQC).To complement the current audit process and drive up quality standards, the CCG was in the process of developing a clinically based assessment tool that would be part of an initiative to financially incentivise providers of nursing residential care homes. The scheme would financially reward nursing residential providers who demonstrated the provision of high quality care which exceeded the core contract arrangement fee.

To reduce the overlap and address the perceived burden of 'inspection' visits by care home providers, the North of Tees Care Home Commissioning Group had also agreed to work in collaboration to streamline and align both the LA's Quality Standard Framework QSF) and the CCG's Clinical Quality Assurance Tool (CQA) audits. Although the practicalities of implementation remained to be agreed between the LA's and CCG, it was envisaged that the CQA tool would be offered to nursing residential care home providers from April 2016.

The Group noted the above steps as the commencement of a much longer process and requested that the outcome of the imminent discussions regarding the financial modelling be advised to both LH/SM and that this Group receive future progress updates initially for the next two quarters.

AGREED that:-

1.The progress to date be noted along with the following next steps:-

•To present financial modelling paper to CCG Delivery Team (DT) 18th August 2015 for consideration and agreement.
•Develop with partners the production of a programme of work to support a new model of care in relation to commissioning and delivery nursing and residential care homes 30th September 2015.
•Complete development of Clinical Quality Assurance Tool and governance process – 31st October 2015

2.LH/SM be advised of the outcome of financial modelling paper presented to the CCG Delivery Team on 18th August and this Group receive future progress updates initially for the next two quarters.

5 Review of Adult Drug Treatment and Recovery Service 2015

A report had previously submitted to this Group outlining the intention of NHS England to carry out a review of the registered element of the Alternative Provider Medical Services (APMS) Contract which would inform their future commissioning intentions. In view of Public Health also funding a substance misuse provision within this contract, it was necessary to carry out a review of this provision to again determine future commissioning intentions for substance

misuse for this particular patient group.

It was noted that at that time the contract was due to expire on 31 March 2015 and a request to NHS England from Public Health to take up an option to extend for at least 12 months was pending. NHS England had now agreed an extension to the contract, and it would now expire on 30th September 2016.

Public Health Commissioners had also decided to include within the scope of this review the remaining Provider commissioned to provide adult substance misuse treatment and support (CRI). This would allow for a systematic review of adult substance misuse within the Borough and ensure any future model met the needs of its population, increases the chances of recovery from substance misuse and demonstrated value for money. The contract with CRI would therefore now be aligned with the expiry date of the Birchtree Practice contract.

A project steering group had also been established led by Stockton Public Health to ensure that the project was executed to time, cost and acceptance criteria. NHS England would contribute jointly in all aspects of the project that related to the jointly commissioned “Birchtree Practice” service.

The project would recommend models of delivery and commissioning options to the relevant commissioning groups in the local authority / NHS England and stakeholders with a view to implementing decisions that would
ensure that a fit for purpose service model, aligned to consultation findings and VFM, was in place prior to going out to tender. The three commissioning model options identified were:

i.Keep the current model combining primary healthcare and substance misuse management (specialist) with joint commissioning with NHS England;
ii.Broaden and increase the existing “Shared Care” provision across the Borough and disperse patients from their primary healthcare at Birchtree Practice to GP’s providing an enhanced service for substance misuse within a Public Health contract;
iii.Disperse patients from Birchtree Practice to existing GP practices within the Borough and manage their substance misuse by increasing capacity of the substance misuse provider identified through a competitive tender process.

The next stage would entail a health impact and an equality impact assessment being completed for each commissioning model option with a focus on potential risks to recovery rates. A joint communications and consultation plan was also being developed with NHS England and details of some of the key stakeholders to be consulted were provided with the aspiration that consultation would be concluded Nov/Dec 2015. It was suggested that given the risk factors associated, both the Childrens’ and Adult Safeguarding Boards, along with the Safer Stockton Partnership, should also be formal consultees.

Clarification was sought as to whether the Commissioned Carers Service should be included within this review and it was the view of this Group that it should be included, as well as any others deemed appropriate.

Responsibilities of both Public Health and NHS England were still to be identified. NHS England would also represent the CCG and be responsible for accountability of their involvement within this project and feedback relevant

issues to the steering group. It was suggested that the project should include an agreed plan setting out the responsibilities of each partner.

Following completion of the review and consideration of consultation findings, recommendations regarding a model of delivery, based upon the identified commissioning options, including procurement options, would be reported to this Group in December 2015. It was suggested that as the CCG would ultimately be responsible for this service under co-commissioning from April 2016, a representative of the CCG should be involved on the steering group.

Discussion ensued around the decision making process in the event that there was any conflict in the priorities of both Public Health and NHS England and it was noted that this would need further consideration at a later stage in order to provide ultimate clarity.

AGREED that:

1.The Commissioning Group note the content of the report.

2.The Commissioning Group receive regular update reports on project progress and help to resolve issues/risks identified through the process, and a further update be provided in October.

3.The Commissioning Group accept a recommendation report and agree a preferred commissioning approach for the provision of services from October 2016 in Stockton-On-Tees subject to further consideration of the detail of the route map for reaching final approval and which bodies within the Council, eg Health & Wellbeing, Cabinet, Council etc, need to be involved.

4.A representative of the CCG be invited to be represented on the Steering Group and the project brief include an agreed plan setting out the responsibilities of both Public Health, NHS England and the CCG.

5.Both the Childrens' and Adult Safeguarding Boards, along with the Safer Stockton Partnership, be added to the list of formal consultees.

6.The scope of the review be extended to include the Commissioned Carers Service along with any others deemed appropriate.

6 Falls Service

The Group noted the outcome of the service review undertaken to examine and review the performance of the current Falls Service in congruence with the current contractual agreement between Stockton Borough Council and North Tees and Hartlepool Foundation Trust (NTHFT).

The service review drew attention to the current performance of NTHFT in relation to the service structure and current demand and supply of the service. The report was written to inform future commissioning decisions and highlight options. The review revealed that:-

•The service activity in Stockton clearly indicated that the number of contacts had reduced;
•There was a high proportion of non-face to face activity;
•A reduction in service activity had had an impact on the waiting times which had increased.
•Lack of clarity on roles and responsibilities with regard to the falls function;
•Wide scope of service offer which perpetuated waiting lists;
•Lack of outcome data;
•Pathway analysis required to clearly understand the interdependencies relating to the service.

Working with the current financial climate coupled with the potential for increased referrals, it was considered an appropriate time to take stock and consider the Councils responsibilities with regard to funding a non-mandated preventative service for all interdependent stakeholders. Options available were:

•Maintain the function externally sourced;
•Co-commission with CCG;
•Decommission and integrate a resource internally;
•Decommission without a replacement.

The commissioning options required further understanding around the interdependencies associated with the service. The configuration and integration of the Falls Service within CIAT also required further consideration and agreement with regard to what preventative elements the Council would provide.

The Group noted that NTHFT had suggested that the following would occur if there was a total decommissioning of the service and all referrals stopped:

•Increase in patients falling in Stockton;
•Increase in morbidity and mortality of frail elderly population;
•Increase in social support requirements;
•Potential increase in number of residential care home placements required;
•Increase in need for residential rehab and residential rehab beds;
•Increase in need for admission/readmission of patients into acute care.

If referrals continued into CIAT with reduced staffing, the following was likely to result:

•Increase in waiting times for all non-urgent therapy referrals, dependant on volumes the waiting times could double coupled with the current increase in referrals this could happen very quickly.
•Ability for the service to deliver 7 day working would be compromised leading to increased times for urgent therapy patients to be seen;
•Increase in number of patients falling whilst waiting for assessment/ treatment
•Negative impact on quality of care and patient experience leading to an increase in patient complaints.

There was a lack of outcome data and evidence to support the concerns cited and therefore further joint working with stakeholders, such as CCG, was

suggested in order to ascertain the situation and understand all factors affecting the service. Responsibilities with regard to Public Health and CCG also needed to be agreed as a way forward in respect of prevention/ treatment model(s) and the patient's pathways.

Consequently, it was proposed that a further contract be agreed for a period of six month which would provide the Council with appropriate time to further understand the interdependencies and plan accordingly. If the service was to be decommissioned, there was also a need to have clear strategy in place to ensure that the consequences of any decisions were met, all stakeholders and informed and any remedial actions completed.

AGREED that:-

1.The content of the report be noted.

2.The Group approve agreement of a further six month contract to allow the Council to consider the range of options available in congruence with detailed pathway and interdependency information.

3.Further work with CCG be embarked upon to map out and clearly identify pathways and the impact on frontline services, and both LH/SM be kept appraised of this work.

4.A full exit plan be completed in conjunction with relevant stakeholders to ensure that all service users are provided with alternative services.

5.An update report be provided to this Group in December and PK be advised should there be any slippage with this project.

7 Transforming Care for people with learning disability

The Group noted the content of the joint letter from NHS England, the LGA, ADASS, Health Education England, CQC and the Department of Health who were collaborating on a cross-system Transforming Care Programme for People with Learning Disability that sought to reshape services away from institutional models of care, close some inpatient provision, and strengthen the support available in the community.

The Council/CCG had been invited to be part of one of five fast track areas that would be able to access a share of the £10M transformation fund available nationally to expedite the programme.

The deadline for the submission of a joint plan for transforming services was the 7th September 2015 and a copy of the plan would be submitted to the September meeting of this Group.

AGREED that the Council's/CCG participation within the Transforming Care Programme for People with Learning Disability be noted and a copy of the

submitted joint plan be submitted to the September meeting of this Group for consideration.

8 NHS Health Checks

Consideration was given to an update on the progress of the review of NHS Health Check provision.

The NHS Health Check programme aimed to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who had not already been diagnosed with one of these conditions or have certain risk factors, were to be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and should be given support and advice to help them reduce or manage that risk.

In Stockton (and the other Tees Authorities) the majority of NHS Health Checks were currently provided by General Practices with additional capacity to extend provision of Health Checks into workplace, community and other outreach settings via use of a Nurse Bank. In the first 5 years of the programme across Tees, 149,054 were invited and 106,230 received a Check. To date there have been over 35,647 Health Checks provided in Stockton-on-Tees.

On behalf of the 5 Tees Valley Local Authorities, the Tees Valley Public Health Shared Service were currently managing a service review looking at the cost and quality of current delivery models, identifying opportunities for improvement; and making recommendations on future model(s) of delivery and scoping commissioning options.

Public Health England (PHE), who now provided strategic oversight and leadership for the NHS Health Check programme, undertook a review of the evidence base for the programme in 2013 which set out the economic case for continued investment in NHS Health Check's citing rising health and social care costs. They were also of the view that the most effective strategic approach to tackling cardiovascular disease was likely to be a combination of both individual and universal approaches and believed that by finding and managing those at high risk of vascular disease it was likely to be both clinically effective and cost-effective; and the NHS Health Check programme could be seen as 'adding value'. The investment in NHS Health Checks as a universal offer was not however without challenge and there had been some criticism of the potential effectiveness of the programme within the media and health journals, an argument which had been defended by PHE who continuously reviewed the programme against the emerging data and added best practice guidance to support Local Authorities to implement the programme at a local level.

As of April 2015, there were an estimated 53,195 residents eligible for a NHS Health Check(based on GP Practice).

It was noted that there were no nationally prescribed targets in relation to NHS Health Checks however the PHE had suggested that Local Authorities should aim to offer checks to 20% of their eligible population every year and achieve an uptake of 66% rising to 75% (in line with national screening programmes). PK suggested that it would be preferable to introduce a targeted approach that

would see the highest target (75%) set aside for the quintile with the greatest need and conversely, the lowest target set against the quintile with the least need at a local level based on an assessment of known risk.

The Group also noted the current position with regard to analysis of performance in terms of both offers of health checks made and resulting uptake; the quality of performance and the contribution of GP and Community Outreach provision; along with interim findings/recommendations from the review to date. A further detailed report would be concluded and submitted to this Group late September/October.

AGREED that:-

1.The content of the report be noted.

2.The Group express its support and endorsement for the introduction of a targeted approach towards the offer of NHS Health Checks to ensure that the highest target (75%) was set aside for the quintile with the greatest need and conversely, the lowest target be set against the quintile with the least need, at a local level based on an assessment of known risk.

3.A further detailed report of the review findings be presented to this Group late September/October.

9 Forward Plan

The Group considered the Forward plan and suggested the following amendments:

- Independent Living Services be re- scheduled for the meeting on 26 October 2015

- Substance Misuse services be scheduled for 26 October 2015

- Care Home Updates be scheduled for October and January

-Falls Service Update be scheduled for 8 December 2015

JB requested clarification regarding progress of the VCSE Commissioning arrangements as both he and EC were members of the Steering Group. PS advised that she would enquire on progress with the relevant lead within CCG and provide an update for the next meeting. PK referred to the fact that the ability of the Authority to participate fully within such a review was likely to be severely curtailed if not halted by the in-year cuts to the Public Health grant.

AGREED that the forward plan be noted and amended as outlined.