SINGLE COMMISSIONING BOARD

Day: Thursday
Date: 25 May 2017
Time: 11.00 am
Place: Rutherford Suite, Hyde Town Hall, Market Street, Hyde

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 11 April 2017.	1 - 8
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance, Single Commission.	9 - 30
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the attached report of the Director of Public Health and Performance.	31 - 74
6.	**COMMISSIONING FOR REFORM**	
a)	**ADULT SOCIAL CARE TRANSFORMATION PROPOSALS** To consider the attached report of Sandra Whitehead, Interim Assistant Executive Director (Adults).	75 - 98
b)	**YOUNG PEOPLE'S EMOTIONAL WELLBEING SERVICE** To consider the attached report of Anna Moloney, Consultant in Public Health Medicine.	99 - 106
c)	**DRUG AND ALCOHOL RECOVERY SERVICE** To consider the attached report of the Director of Public Health.	107 - 112
d)	**COMMISSIONING IMPROVEMENT SCHEME** To consider the attached report of the Director of Commissioning.	113 - 122

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

7. URGENT ITEMS

To consider any items which the Chair is of the opinion shall be considered as a matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended).

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Thursday 22 June 2017 commencing at 2.00 pm.

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

11 April 2017

Commenced: 3.00 pm **Terminated: 4.20 pm**

PRESENT: Alan Dow (Chair) – Tameside and Glossop CCG
Steven Pleasant – Tameside Council Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Christina Greenhough – Tameside and Glossop CCG
Alison Lea – Tameside and Glossop CCG
Jamie Douglas – Tameside and Glossop CCG

IN ATTENDANCE: Sandra Stewart – Director of Governance
Ian Duncan – Assistant Executive Director of Finance
Clare Watson – Director of Commissioning
Anna Moloney – Public Health
Mark Whitehead – Head of Service Operations, Adult Services

146. WELCOME AND CHAIR'S OPENING REMARKS

In opening the meeting the Chair made reference to recent organisational changes for the Tameside and Glossop Clinical Commissioning Group providing opportunities to define the Single Commission going forward. April saw the last Governing Body meeting for the Urgent Care Leads, Dr Saif Ahmed and Dr Naveen Riyaz and all five Neighbourhood Leads were now Integrated Care Organisation Neighbourhood Leads.

He was pleased to advise that following a recruitment process, Carol Prowse had been appointed Governing Body Lay Member for Commissioning. Carol had many years' experience as a Non-Executive Director and Senior Independent Director of Stockport NHS Foundation Trust and was heavily involved in her local community in High Peak and as Chairman of Buxton Opera House.

David Swift had been appointed as Governing Body Lay Member for Governance. David had a long history with Tameside and Glossop from his years as Lead Auditor and more recently from his role as Lay Adviser. He was also continuing to support NHS East Lancashire and NHS Stockport Clinical Commissioning Groups.

He concluded by making reference to an interesting article in a recent Health Service Journal regarding the largest ever NHS services tender for £6bn put on the market by Manchester health leaders in the search for the single 'out of hospital' provider' in a 10 year deal.

147. DECLARATIONS OF INTEREST

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

148. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 March 2017 were approved as a correct record.

149. CARE QUALITY COMMISSON – INSPECTION RESULTS

The Chair welcomed Karen James, Chief Executive, Tameside and Glossop Integrated Care Foundation Trust, who reported that Tameside Hospital NHS Foundation Trust had been awarded an overall score of 'Good' by the Care Quality Commission following their most recent inspection into the quality of services at the Trust in August 2016. The outcome of this report represented a significant step in the organisation's journey to deliver outstanding care services for its patients and was a huge boost for the local people and staff at the organisation.

The CQC had inspected eight core services of the Tameside and Glossop Integrated Care NHS Foundation Trust across two sites – Tameside General Hospital and the Stamford Unit. The Chief Executive presented the key findings of the inspection and the key challenges and risks and advised that actions plans had been put in place to address the areas where the Care Quality Commission would wish to see further improvements made. Reference was also made to the positive results of the 2016 NHS Staff Survey for Tameside and Glossop Integrated Care Foundation Trust. For 29 of the 32 key indicators the Trust was better than the national average and the best in Greater Manchester.

In conclusion, and in looking back at the journey so far, the Chief Executive was immensely proud of what had been achieved and the contribution staff had made to improve services for local people. In appreciating that the organisation had come a long way in three years, she stated the journey would never be complete and efforts would continue to improve the quality of services at the organisation.

Members of the Board joined the Chair in congratulating the Chief Executive and her staff on the outcomes of latest inspection by the Care Quality Commission. This placed the Trust in an excellent position in 2017 to progress plans and implement models of care schemes to enhance the lives of local people through an integrated health and social care system. An example was provided of the development of a Digital Health pilot, a transformation project to support a reduction in the attendances and subsequent admissions to hospital from care homes by connecting health care staff in care homes with an advanced practitioner in the Acute Trust through Skype for Business.

RESOLVED
That the Chief Executive of the Tameside and Glossop Integrated Care Foundation Trust, be thanked for her attendance and presentation.

150. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Assistant Executive Director (Finance) presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the consolidated financial position of the economy. The report provided a 2016/17 financial year update on the month 11 financial position at 28 February 2017 and the projected outturn at 31 March 2017. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position was also included within the report.

The overall financial positon of the Care Together Economy had improved by £0.6m month on month, reducing the whole economy projected year end deficit to £1.21m as at 28 February 2017. This remaining deficit comprised an improvement of £2.8m for the Integrated Care Foundation Trust and a deficit of £4m at Tameside MBC. The Clinical Commissioning Group had now fully met its Quality, Innovation, Productivity and Prevention programme target of £13.5m in 2016/17 but this had mainly been as a result of non-recurrent means as highlighted last month. The Tameside and Glossop Integrated Care NHS Foundation Trust year end forecast was for the planned £14.5m deficit, which was a £2.8m improvement on the plan.

The report also included narrative on the Tameside Better Care Fund approved by NHS England on 1 September 2016. Funding had been released in accordance with the final approved plan and all expenditure was monitored through the Integrated Commissioning Fund.

RESOLVED

(i) That the 2016/17 financial year update on the month 11 financial position at 28 February 2017 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.

151. INTEGRATED COMMISSIONING FUND – SINGLE FINANCE AGREMEENT FROM 1 APRIL 2017

Consideration was given to a report of the Director of Finance, Single Commission, and the Assistant Executive Director, Tameside MBC, setting out the key principles of the single fund (Integrated Commissioning Fund) between the Council and the Clinical Commissioning Group managed by the Single Commissioning Board.

The report provided an update on progress made during 2016/17 together with the 2017/18 value of the Integrated Commissioning Fund. The same report was approved by the Tameside Council Executive Cabinet on 22 March 2017 and the Tameside and Glossop Clinical Commissioning Group Governing Body on 29 March 2017.

Particular reference was made to Section 13 relating to the Integrated Commissioning Fund risk share and the arrangement agreed for 2016/17 was that, whilst working as a single commissioning function, the Council and the Clinical Commissioning Group would retain full responsibility for their own financial risks. After a year of formally working together, the current financial arrangements felt out of step with the concept of a single commissioner.

From 1 April 2017, each organisation would begin to share financial risk in proportion to the respective contributions they made into the Integrated Commissioning Fund resulting in a sharing arrangement of 80% for Tameside and Glossop Clinical Commissioning Group and 20% for the Council.

This would be a significant step for both organisations given the current financial climate and the scale of the savings to be delivered in the short term and the risks that the local health and social care economy face currently.

The variance to the total net budget allocation at the end of each financial year would be financed in proportion to the percentage of the net budget contribution of each organisation to the Integrated Commissioning Fund. However, the variance would be initially adjusted to exclude any Clinical Commissioning Group net expenditure associated with residents of Glossop (13% of the total Clinical Commissioning Group variance) as the Council had no legal powers to contribute to such expenditure. The associated adjusted total variance of both the Clinical Commissioning Group and the Council would then be financed in proportion to the % contributions as detailed in Table 12 in the report.

In addition, a stepped approach would be taken to risk sharing and a cap would be placed on the shared financial exposure that each organisation would be expected to meet. For 2017/18 there would be:

- A cap of £2m placed on Clinical Commissioning Group related risks that the Council would contribute to; and

- A cap of £0.5m placed on Council related risks that the Clinical Commissioning Group would contribute to.

The differential cap recognised that it would be difficult for the Clinical Commissioning Group to assume responsibility for 80% of the Council's risks at a time when it faced the highest Quality, Innovation, Productivity and Prevention programme target across Greater Manchester.

For clarity, the risk sharing arrangement applied to the Section 75 pooled fund, the aligned fund and the 'in collaboration' budget as detailed in Appendix 1 to the report. It was noted that the Council's cap of £2m was over and above the non-recurrent contribution to the Integrated Commissioning Fund of up to £5m in both 2017/18 and 2018/19 on the condition that the Tameside and Glossop Clinical Commissioning Group agreed a reciprocal arrangement in 2019/20 should this be necessary.

RESOLVED

(i) That the content of the report previously approved by the Tameside Council Executive Cabinet on 22 March 2017 and the Tameside and Glossop Clinical Commissioning Group Governing Body on 29 March 2017 be noted.

(ii) That Tameside Council Executive Cabinet and the Tameside and Glossop Clinical Commissioning Group to give delegated authority to the Executive Director for Governance, Resources and Pensions of Tameside Council, to ensure that the terms of the financial framework which governed the Integrated Commissioning Fund were updated for the 2017/18 financial year as necessary be noted.

(iii) That the Integrated Commissioning Fund 2017/18 budget allocations detailed in Appendix 1 be noted.

(iv) That the management of the associated share of financial risk during 2017/18 as stated within section 13 of the report be noted.

(v) That it be noted that Tameside Council would continue to be the host organisation for the Section 75 pooled fund agreement.

152. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health 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 position. This was based on the latest published data to end of January 2017.

The format of the report also included elements on quality from the Nursing and Quality Directorate and a selection of Adult Social Care indicators. The evolving report would align with the other Greater Manchester and Social Care Partnership and national dashboard reports.

Also attached for information was the Draft Greater Manchester Partnership dashboard and the latest NHS England Improvement and Assessment Framework.

The key headlines from the quality and performance dashboard were highlighted in relation to the following:

- Referrals;
- 18 weeks referral to treatment incomplete pathways;
- Diagnostics 6+ week waiters;
- A&E waits total time with 4 hours at Tameside and Glossop Integrated Care Foundation Trust;
- Ambulance response times across the North West Ambulance Service area;
- North West NHS 111 service;
- Improving access to psychological therapies;

- Healthcare associated infections;
- Mixed sex accommodation; and
- Dementia.

The Board discussed the significant performance issues relating to the NHS 111 Service across Greater Manchester and proposals for a revised commissioning arrangement for the North West Ambulance Service and the NHS 111 service had been considered at the Greater Manchester Health and Social Care Partnership Board. In bringing the commissioning responsibilities into Greater Manchester this would hopefully maximise the responsiveness to local challenge. In the meantime, the potential to develop an alternative arrangement in Tameside and Glossop was discussed highlighting local expertise / initiatives including Tameside Community Response Service and the Digital Health pilot.

Reference was also made to a recent meeting of the Quality and Performance Assurance Group who had recommended a systematic review of quality and performance reporting. This was essential to clarifying reporting requirements and expectations across the Single Commissioning Board, Clinical Commissioning Group Governing Body and the Council's Board governance, with a view to minimising duplication and providing assurance at the most appropriate system level.

RESOLVED

(i) That the contents for the performance and quality report be noted.

(ii) That the recommendation of the Quality and Performance to undertake a systematic review of quality and performance monitoring with a view to minimising duplication and providing assurance at the most appropriate system level be supported.

153. PRIMARY CARE QUALITY SCHEME

Consideration was given to a report of the Director of Commissioning outlining the proposed redesign for the Primary Care Quality Scheme as a two year scheme for 2017/18 and 2018/19. This refresh recognised the national strategy around Primary Care, through the General Practice Forward View and also the NHS Operating Planning and Contracting Guidance for 20917-19 along with the Greater Manchester Primary Care Strategy and the local strategy and locality plan.

The operational planning guidance required Clinical Commissioning Groups to identify resources for general practice transformational support and this scheme was designed to facilitate that support together with supporting the Transformation agenda of Care Together. The General Practice Forward View illustrated specific steps to improve general practice provision, both for patients and the workforce, and to address the pressures both in primary care and across the health system.

This proposal would support the development of Quality Improvement skills in GPs and their teams by applying them to real improvement projects embedding Quality Improvement as an underlying competence informing all of the work that practices undertook.

Each practice would receive a payment of £3 per head of their practice population spread over 2 years to deliver three Quality Improvement projects. A maximum of £1.50 per head would be paid in the financial year ending March 2018 and a maximum of £1.50 per head paid in financial year 2018/19 upon satisfactory delivery of agreed actions and achieved metrics. There were six categories of improvement and each practice, in conjunction with a sub-group of Primary Care Development and Improvement Group, would choose two projects from the six categories. In addition, there would be one medicines management proposal that would be a mandatory requirement for all practices.

RESOLVED

(i) That the Primary Care Quality Scheme proposal be supported.

(ii) That each practice would receive a payment of £3 per head of their practice population spread over 2 years to deliver three Quality Improvement projects. A maximum of £1.50 per head to be paid in the financial year ending March 2018 and a maximum of £1.50 per head paid in financial year 2018/19 upon satisfactory delivery of agreed actions and achieved metrics.

154. LEARNING DISABILITY DAY SERVICES REVIEW

Consideration was given to a report of the Head of Service Operations advising that learning disability and autism internally provided day services had been significantly reduced since 2012 as a result of budget reductions. This review was undertaken in response to further savings being set against this area of operations.

The report set out the outcome of the review including extensive service user consultation and proposed a number of options and recommendations for the future provision of services based on current and predicted demand. It also considered demand and capacity in terms of children with disabilities and Looked After Children and the increasing demand for specific services for these groups as well as considering the provision of alternative services for children and young people with special educational needs post 16 in the borough as an alternative to out of borough placements in specialist education establishments.

Agreement in principle was being sought from the Board to secure capital investment to develop the Oxford Park site to become a disability centre and to review internal day service packages to establish if individuals currently in internal services could move into services provided by the sector releasing capacity for more complex individuals. It was envisaged that through collaborative working both financial and non-financial efficiencies would be realised across partner agencies with cost avoidance return on investment being realised within three years of the scheme opening.

Oxford Park, on the outskirts of Ashton, contained gardens, sports pitches and a small sports centre managed and run by Active Tameside. The site was owned by the Council and it was proposed to extend the existing building to accommodate a sensory room, several classrooms, a teaching kitchen and a studio. The scheme would be led by Active Tameside although it was expected that other providers across the borough would be able to access and contribute towards service provision where appropriate to strengthen a more diverse and stronger market locally.

Members of the Board commented favourably on the scheme and the focus on improving outcomes for young people in terms of targeted education around the development of independent living skills, offering pre-employment and employment support and providing varied service options to improve choice and control while reducing costs of provision in the future.

RESOLVED

(i) That agreement be given in principle to progress the Oxford Park development subject to a bid against the Capital Programme to increase day service capacity, improve collaborative, improve a wide range of outcomes and achieve financial and non-financial benefits for a range of services.

(ii) That a review of internal day service packages be undertaken to establish individuals currently in internal services could move into services provided by the sector releasing capacity for more complex individuals.

155. URGENT ITEMS

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

156. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Thursday 25 April 2017 commencing at 11.00 am in the Rutherford Suite at Hyde Town Hall.

CHAIR

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	25 May 2017
Officer of Single Commissioning Board	Kathy Roe – Director of Finance – Single Commission Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 CONSOLIDATED FINANCIAL MONITORING STATEMENT**

Report Summary:

This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy for 2016/2017.

The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The Clinical Commissioning Group and the Council are also required to comply with their constituent organisations' statutory functions.

A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy.

The report also provides details of the savings realised in 2016/2017 together with the significant level of savings required in 2017/2018 to ensure control totals are delivered and financial sustainability is achieved on a recurrent basis thereafter. It should be acknowledged that the delivery of additional savings beyond 2017/2018 will also be required the details of which will be reported to future meetings.

Recommendations:

Single Commissioning Board Members are recommended to note and acknowledge:

1. The final 2016/2017 consolidated financial position of the economy.
2. The significant level of savings delivered in 2016/2017 and required during 2017/2018 (section 4) to achieve confirmed control totals and the financial sustainability of the economy on a recurrent basis thereafter.
3. The significant amount of financial risk associated with the achievement of financial control totals during this period.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	Details contained within the report
CCG or TMBC Budget Allocation	Details contained within the report
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Details contained within the report

Decision Body – SCB, Executive Cabinet, CCG Governing Body	Details contained within the report
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Details contained within the report
Additional Comments The report provides the final consolidated financial position statement of the 2016/17 Care Together Economy for each of the three partner organisations. Each constituent organisation is responsible for the financing of any associated deficit at 31 March 2017. Section 4 of the report provides details of the 2017/2018 funding allocations of each constituent organisation together with details of the significant levels of savings required which have been risk rated. It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations is bound by the terms within the Section 75 and associated Financial Framework agreements.	

Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved

	outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the report.
Access to Information :	Background papers relating to this report can be inspected by contacting :

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

2016/2017 Revenue & Capital Monitoring Statements

Period Ending 31 March 2017 (Month 12)

25 May 2017

Kathy Roe
Claire Yarwood
Ian Duncan

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

Section 1

Care Together Economy

Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year End			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	388,441	381,272	7,169	3,491	3,678
Tameside MBC	69,272	71,904	(2,632)	(4,011)	1,379
Total Single Commissioner	**457,713**	**453,176**	**4,537**	**(520)**	**5,057**
ICFT Deficit	(17,300)	(13,840)	(3,460)	(2,525)	(935)
Total Whole Economy	**440,413**	**439,336**	**1,077**	**(3,045)**	**4,122**

2016/17 position in all 3 organisations has now been finalised. We are currently in the process of completing year end accounts and annual reports as separate statutory organisations. The audit process is underway.

All three organisations have met financial control totals in 2016/17:

- CCG has delivered a 1% surplus. The movement in the table above is in line with latest guidance on treatment of national system risk reserve and is explained in more detail on a separate slide
- The net deficit at outturn relating to the three Council services included within the ICF will be financed from Council reserves. The significant deficit primarily arose within Children's Services and was due to exceptional additional demand during the year. Details of the variations for each service are provided on the Tameside MBC slide
- ICFT had an authorised deficit of £17.3m for 2016/17. The actual normalised deficit was £13.3m, so exceeding the target by almost £4m.

While financial control totals have been met across the economy, this has only been possible because of non-recurrent actions. On a recurrent basis there remains an underlying deficit across the economy, which increases risk in future years.

Tameside & Glossop CCG

Description	Year End Position			Movement	
	Budget £000's	Actual £000's	Variance £000's	Previous Month £000's	Movement in Month £000's
Acute	197,310	197,708	(398)	(526)	128
Mental Health	29,052	28,757	295	99	196
Primary Care	81,657	81,715	(58)	(732)	674
Continuing Care	12,251	13,388	(1,137)	(377)	(760)
Community	27,483	27,530	(47)	(51)	4
Other	35,510	27,763	7,747	4,413	3,334
QIPP		0	0	0	0
CCG Running Costs	5,178	4,411	767	665	102
CCG Expenditure	**388,441**	**381,272**	**7,169**	**3,491**	**3,678**
CCG Surplus	**3,491**	**7,169**	**3,678**		

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The 2016/17 financial position has now been finalised and the CCG has met all of its key financial duties, including:

- Delivery of 1% surplus (£3,491k),
- Full achievement of £13,500k QIPP target.
- Kept 1% of allocation uncommitted to fund a national system risk reserve
- Growth in Mental Health spend of 3% to meet Mental Health Investment Standard
- Remaining within the running costs allocation

We are currently in the process of producing the annual report and accounts and are working collaboratively with our external auditors whilst they undertake the final accounts audit.

Recommendations

- Note the final year end position and the diligent efforts undertaken to meet the 2016-17 QIPP target.
- Acknowledge the significant recurrent savings still required to close the long term financial gap.

Changes in the position since Month 11 include:

- **Acute**: Improvement in position as year end settlements agreed with providers. Details on a separate slide.
- **Mental Health**: Improvement in reported position following discharge from high cost out of area placements. Mental Health Investment standard met.
- **Primary Care**: Absence of a winter spike in prescribing, together with progress against QIPP have resulted in a significant reduction in spend. A detailed report on the current prescribing position is provided later in this report.
- **Continuing Care**: New data has highlighted significant pressure in this area, which is offset slightly by clawback on Personal Health Budgets.
- **Community:** Broadly consistent with position last month
- **Other:** Since the start of this year the CCG has been maintaining a reserve of 1% of its allocation (£3,678) in line with nation planning guidance on uncommitted spend. The intention of this was to create a national system risk reserve which would be used mitigate significant financial risk across the NHS as a whole, in particular within the provider sector.
  A letter was received from Paul Bauman on 15 March asking us to release this reserve, increasing the value of the CCG surplus to £7,169k. In total commissioners across the country have released around £800m to increase CCG surpluses in March. This will be used in national consolidated accounts to help to offset the provider deficit position and help to secure a balanced position for the NHS overall.
- **CCG Running Costs**: Credit note from GM Shared Services, estates savings and reduced payroll cost.

Key Movements & Narrative: CCG

Acute Provider Drilldown

- **Acute Providers**: Yearend positions agreed with providers, favorable movement to full year forecast of £156K.
- **Central Manchester**: Adverse movement against agreed outturn of (£89k) due to Critical Care (£74k) and continued increases within Non Elective Pathways.
- **Stockport:** Favorable movement against agreed outturn of £248k due to projected reductions in Neuro Rehab £136K/Non Elective pathways £60k, remaining savings across multiple pathways.
- **UHSM:** Adverse movement against agreed outturn of (£78K) attributable to Day Cases (£30K)/Outpatients (£32K)
- **SRFT:** Favorable movement against agreed outturn of £178K, full year Neuro Rehab £217k/ Adhoc (£60k).
- **Pennine Acute:** Adverse movement against agreed outturn of (£49k) due to continued increases in Ophthalmology/High Cost patient/Maternity.
- **ICFT:** An agreed end of year settlement is in place which has mitigated any potential over performance.

Provider	Year to Date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
TFT	126,421	126,421	()	126,421	126,421	()
CMFT	22,280	23,533	(1,253)	22,280	23,533	(1,253)
SFT	11,969	10,864	1,105	11,969	10,864	1,105
UHSM	6,568	6,985	(417)	6,568	6,985	(417)
PAHT	4,029	3,970	58	4,029	3,970	58
SRFT	3,226	3,273	(48)	3,226	3,273	(48)
WWL	1,409	1,300	109	1,409	1,300	109
BOLT	80	72	8	80	72	8
Total	175,980	176,418	(438)	175,980	176,418	(438)

Acute Referrals Analysis – UPDATE BELOW

- ICFT GP Referrals are down -9.8% compared to same period 15/16 (Apr-Feb). Other referrals have also improved over the same period -0.9%.
- The main areas of GP referral reduction are shown in the below table

GP Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Reduction in number of referrals
NEUROSURGERY	159	100	-37%	-59
VASCULAR SURGERY	1,043	687	-34%	-356
ENT	4,215	3,035	-28%	-1,180
GENERAL SURGERY	1,568	1,183	-25%	-385
RHEUMATOLOGY	1,145	925	-19%	-220
NEPHROLOGY	274	223	-19%	-51
Unknown/Other	2,563	2,093	-18%	-470
TRAUMA & ORTHOPAEDICS	4,798	3,980	-17%	-818
OPHTHALMOLOGY	2,807	2,374	-15%	-433
UROLOGY	2,681	2,379	-11%	-302

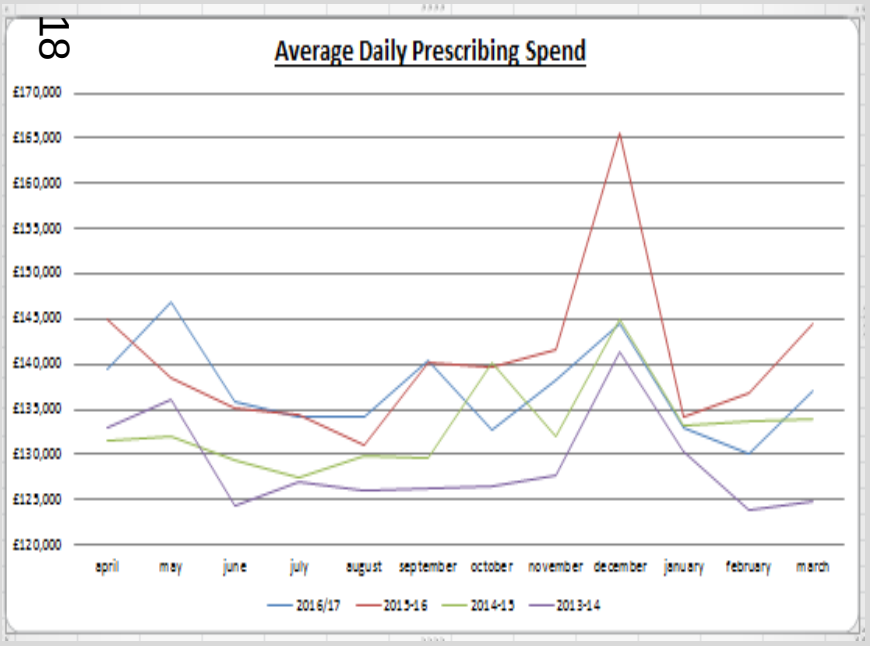
- The main areas of Other referral increase are shown in the below table .

Other Referrals to Tameside & Glossop ICFT				
Specialty	2015/16	2016/17 FOT	% Change	Increase in number of referrals
PAEDIATRIC NEUROLOGY	11	26	138%	15
CARDIOTHORACIC SURGERY	111	145	31%	34
ANAESTHETICS	12	15	27%	3
RESPIRATORY MEDICINE	855	1,075	26%	220
OPHTHALMOLOGY	638	799	25%	161

CCG Key Movements & Narrative: CCG

Prescribing

- As reported previously there has been considerable pressure on the prescribing budget this year. However the year end figure of £41.8m is better than has been anticipated in recent months. This figure includes an accrued figure for March which will prevent a repeat of the cross-year pressure that emerged last year on the prescribing budget .
- The additional pressure on the budget that has been reported in previous months has not fully materialised, which in part is because the winter spike seen in previous years has not been as severe. This is reflected in the graph below which shows the average daily spend for each month.



- The QIPP initiatives implemented by the Medicines Management Team continue to be effective and have resulted in an average daily spend in February of £129,989 on prescribing which is the first time since September 2014 it has fallen below £130k per day.
- Savings on the budget have also been achieved relating to the costs of the Scriptswitch licence and higher than expected rebates being received.
- There is a challenging target for 2017/18 on prescribing which requires additional savings to be achieved if the budget figure of £40.9m is to be achieved. This will require a sustained effort to reduce volumes and will need continued support for both new and existing initiatives implemented by the Medicines Management Team.
- It has been identified that where a reduction in usage of certain drugs has been achieved there has been an increase applied in the prices meaning little impact is seen in overall costs for those drugs. This is indicative of one of the external variables that continue to make accurately forecasting the prescribing position difficult and results in a situation where this particular cost centre will be subject to a degree of volatility that others are not.
- Prescribing remains an area in need of a high level of focus.

Key Movements & Narrative: CCG

Continuing Health Care

- A preliminary review of Continuing Health Care (CHC) costs took place a number of months ago. The data at the time indicated that there was not a significant pressure to the CHC budgets.
- However, at year end, when the full actuals have been extracted from SBS there is an increase than those earlier indications. Also, the charges from TMBC were significantly higher than those expected when the previous review was done.
- The average monthly CHC spend has increased from the first half of the year to the second half of the year. The first 6 months of the year there was an average monthly spend of circa £1.3m across all the CHC cost centres. The second 6 months of the year there was an average monthly spend of more than £1.395m. This surge of costs along with increase in full year costs from TMBC, has a created a further pressure on the CHC budgets than those anticipated.
- Fast Track patients are creating a significant part of this pressure and some of these patients are exceeding the short term timeframe.
- There is an added pressure to next years CHC budgets from the increase in cost of care fees across the economy. There is a increasing concern that the budget set for 2017/18 is already insufficient.

Personal Health Budgets

- The movement in month in Adults PHBs is due to a review of unused funds of some patients. The monies unused have been claimed back from the patients following a detailed clinical review. There is a slight increase in the children's PHBs due to a back payment of one patient's package.

Better Care Fund

- There is a total better care fund of £17,301k in Tameside. Separately the CCG contributes £448k toward the Derbyshire BCF. Total spend has been in line with budgets and is reported to NHS England via the Health & Wellbeing board. Final Q4 metrics are currently being assessed and will be available by June.

Tameside MBC

Narrative	Year End			Movement	
	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Adult Social Care & Early Intervention	41,995	41,956	39	(1,165)	1,204
Children's Services, Strategy & Early Intervention	25,877	28,684	(2,807)	(2,846)	39
Public Health	1,400	1,264	136	0	136
TMBC Sub Total	**69,272**	**71,904**	**(2,632)**	**(4,011)**	**1,379**

The Council year end financial position has shown an improvement of **£1.379m** from the previously reported figure at month 11. Details of the year end variation's are provided below :

Children's Services (£2.807m deficit)

- Savings initiatives unrealised (£0.9m)
- Increases in the cost of Looked After Children placements due to exceptional additional demand (£1.2m) and agency staff recruitment to address social work caseloads (£0.6m).

Public Health (£0.136m surplus)

- Savings have been realised within Public Health contracts and associated overhead related expenditure.

Adult Social Care (£0.039m surplus)

- There has been a significant improvement in the Adult Social Care financial position. The main improvements are ;
- Additional Homecare expenditure of c£0.303m that had been expected to incur in the final quarter of the financial year did not materialise. This is as a result of commissioned hours being significantly in excess of actual hours provided.
- February 2017 and March 2017 income from client contributions towards community based care packages was higher than expected. This is a significant increase on the previous year's position (£0.250m)
- Funded Nursing Care placements income was greater than projected (£0.356m)
- There have been further reductions in Direct Payments expenditure due to a reduction in client numbers (£0.100m)

Tameside and Glossop ICFT

Description	Month 12 Year End Position			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	202,453	212,355	9,902	210,439	(1,916)
Expenditure	210,365	217,166	(6,801)	216,186	(980)
EBITDA	**7,912**	**4,811**	**3,101**	**5,747**	**(936)**
Financing	9,388	8,509	879	8,509	0
Normalised Surplus/(Deficit)	**17,300**	**13,320**	**(3,980)**	**14,256**	**(936)**
Exceptional Items	**0**	**520**	(520)	**520**	0
Net Deficit after Exceptional Costs	**17,300**	**13,840**	**(3,460)**	**14,776**	**(935)**

Financial Position

- For 2016/17 the ICFT has delivered a normalised deficit of £13.3m against its control total which is £3.98m better than plan.
- An exceptional item in relation to the impairment of the value of buildings has increased the Trust's net deficit position to £13.8m.
- In delivering this position the ICFT has:
  - Delivered the Efficiency savings target.
  - Successfully appealed for Q3 and Q4 STF associated with the A&E trajectory.
  - Matched STF for delivery of an improved deficit against plan.
  - Agreed and finalised the Block with Tameside and Glossop CCG
  - Small over performance on associate PbR contracts and we have not fixed these positions.
  - Broadly delivered agency expenditure within the NHSI agency ceiling.

Key Risks going forward.

- The impact of IR35 and renegotiation of rates.
- Delivery of key performance targets and potential increases to the expenditure run rate.

Key Information

- The Trust has successfully appealed the reduction of STF funding relating to delivery of the A&E trajectory for Q3 & Q4.
- Due to the timing of the receipt of any additional cash, a short term uncommitted loan was agreed to fund the deficit.
- The Trust received an additional £1m of STF from NHSI in month 12 to reflect the Trust delivering a deficit better than the plan.

The Financial Gap

Establishing the Financial Gap

- The financial gap as outlined in the locality plan across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 2020/21.
- In 2016/17 the opening gap was £45.7m which consists of £13.5m CCG, £8m council and £24.2m ICO. Progress towards closing these gaps has been made throughout the year.
- The provider gap represents the non-recurrent financial position for the ICFT. The Trust is forecasting receipt of £8.3m of sustainability and transformation funding in 2016/17 resulting in a forecast year end deficit of £14.5m.
- A detailed savings tracker is currently being developed to include an economy wide position of progress made in bridging the financial gap. This will comprise a variety of informative dashboards which will be used to track progress and highlight any areas of concern and risk. This will be presented to the next meeting.

CCG QIPP Target

- The CCG has fully met the £13.5m financial gap in 2016/17:

Summary of QIPP £'000s	2016/17 R	A	G	Total
PRIORITY 1 - Prescribing	0	0	0	**0**
PRIORITY 2 - Effective Use of Resources / Prior Approval	0	0	0	**0**
PRIORITY 3 - Demand Management	0	0	500	**500**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	0	553	**553**
PRIORITY 5 - Back Office Functions and Enabling Schemes	0	0	200	**200**
PRIORITY 6 - Governance	0	0	0	**0**
Other Schemes in progress/achieved:	R	A	G	Total
Neighbourhoods	0	0	459	**459**
Primary Care	0	0	698	**698**
Mental Health	0	0	232	**232**
Acute Services - Elective	0	0	500	**500**
Enabling Schemes to facilitate QIPP	0	0	0	**0**
Technical Finance & Reserves	0	0	6,167	**6,167**
Other efficiencies	0	0	4,191	**4,191**
Grand Total:	0	0	13,500	**13,500**

- The majority of the gap in 2016/17 was closed on a non-recurrent basis.

Recurrent vs Non Recurrent Savings	R	A	G	Total
Recurrent Savings	0	0	1,744	**1,744**
Non Recurrent Savings	0	0	11,756	**11,756**
Total	0	0	13,500	**13,500**

Integrated Commissioning Fund 2016/17

	Year to Date (M12)			Year End			Movement	
Narrative	Budget	Actual	Variance	Budget	Actual	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Acute	197,310	197,708	(398)	197,310	197,708	(398)	(526)	128
Mental Health	29,052	28,757	295	29,052	28,757	295	99	196
Primary Care	81,657	81,715	(58)	81,657	81,715	(58)	(732)	674
Continuing Care	12,251	13,388	(1,137)	12,251	13,388	(1,137)	(377)	(760)
Community	27,483	27,530	(47)	27,483	27,530	(47)	(51)	4
Other	35,510	27,763	7,747	35,510	27,763	7,747	4,413	3,334
CCG Running Costs	5,178	4,411	767	5,178	4,411	767	665	102
CCG Sub Total	**388,441**	**381,272**	**7,169**	**388,441**	**381,272**	**7,169**	**3,491**	**3,678**
Adult Social Care & Early Intervention	41,995	41,956	39	41,995	41,956	39	(1,165)	1,204
Children's Services, Strategy & Early Intervention	25,877	28,684	(2,807)	25,877	28,684	(2,807)	(2,846)	39
Public Health	1,400	1,264	136	1,400	1,264	136	0	136
TMBC Sub Total	**69,272**	**71,904**	**(2,632)**	**69,272**	**71,904**	**(2,632)**	**(4,011)**	**1,379**
GRAND TOTAL	**457,713**	**453,176**	**4,537**	**457,713**	**453,176**	**4,537**	**(520)**	**5,057**

A: Section 75 Services	**236,568**	**232,790**	**3,778**	**236,568**	**232,790**	**3,778**
CCG	194,544	190,954	3,590	194,544	190,954	3,590
TMBC	42,024	41,836	188	42,024	41,836	188
B: Aligned Services	**188,468**	**188,312**	**155**	**188,468**	**188,312**	**155**
CCG	161,220	158,244	2,975	161,220	158,244	2,975
TMBC	27,248	30,068	(2,820)	27,248	30,068	(2,820)
C: In Collaboration Services	**32,677**	**32,074**	**603**	**32,677**	**32,074**	**603**
CCG	32,677	32,074	603	32,677	32,074	603
TMBC	0	0	0	0	0	0

Risk and Other Issues

- 2016/17 financial year is now complete and we have delivered all required financial targets. Accounts have not yet been audited, but we do not anticipate any issues in this process.
- The main financial risks to the recurrent position of the the Integrated Commissioning Fund are listed below.
- Detailed registers including further information on risk and mitigating actions are regularly reviewed at Audit Committee. Copies are available on request.
- IR35 – With effect from 6 April 2017, the legislation associated with employing 'off payroll' workers will change. This has a potential financial risk due to a reduction in the availability of 'off payroll' workers which could lead then to higher related costs if they are subsequently employed by the Economy. This is a particular risk to staffing at the A&E department.

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding been developed and was signed on 16 December 2016. The year 1 funding of £5.2m has now been made available to the economy and it is expected that this money has been fully accounted for in 2016-17.

Financial risk impacting recurrent position of ICF	Probability	Impact	Risk	RAG
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	4	4	16	R
Over spend against Continuing Health Care budgets	4	4	16	R
Operational risk between joint working.	1	5	5	A
Over spend on PbR contracts	3	4	12	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	1	4	4	G
In year cuts to Council Grant Funding	2	3	6	A
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates and potential legal challenge	4	3	12	A
IR35 – the potential impact of reduced availability of 'off payroll' workers from 6 April 2017 and the increased cost impact if they are subsequently employed by the Economy.	4	4	16	R

Section 2

Care Together Economy

Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total	Approved 2016/2017 Allocation	Total Expenditure 2016/2017	2016/2017 Outturn Variation	Scheme Comments
	£'000	£'000	£'000	£'000	
Children's Services - In Borough Residential Properties	**912**	**912**	**786**	**126**	Purchase of 2 additional in-borough properties including associated property adaptations. Options to provide an Edge of Care establishment are currently being considered.
Public Health - Leisure Estate Reconfiguration	**20,268**	**3,814**	**3,580**	**234**	**Active Dukinfield (ITRAIN**) - The scheme is complete and the facility fully operational. **Active Longdendale (Total Adrenaline) -** The scheme is complete and the facility is fully operational **Active Hyde (Pool Extension)** – Enabling works have been completed. The scheme is out to tender and will take 8 months to complete from contract award. **Denton Wellness Centre –** Key Decision being developed which seeks approval for proposals to secure the timely delivery of the Denton Wellness Centre project. Its is anticipated that work will start in late 2017.
Adult Services - Disabled Facilities Grant - Adaptations	**1,978**	**1,978**	**1,474**	**504**	The residual value of grant remaining will be utilised in 2017-18 to ensure as many people as possible are supported to live independently within their own homes.
Total	**23,158**	**6,704**	**5,840**	**864**	

Section 3

GM Transformation Fund

Progress Update

GM Transformation Funded Schemes

Scheme Description	Progress
Home First	Underway – delivering reduced length of stay
Digital Health	Underway – pilot commenced in March 2017
Neighbourhoods	Recruitment to some posts completed. Caseload reviews commenced in April 2017
System Wide Self Care	Delivery commenced 1 April 2017 in Glossop. Tender launched 31 March 2017 for Tameside
Flexible Community Beds	Beds opened in November 2016
Home Care	In Development
Organisational Development	Economy OD engagement events taken place. Future sessions in neighbourhoods to be arranged
Estates	Underway

Section 4

Tameside & Glossop

2017/2018 Funding Allocations

2017/2018 FUNDING SUMMARY

Economy Summary	2017/2018 Net Resource	2017/2018 Net Expenditure Forecast	Control Total Deficit / (Surplus)	Savings Target
	£'000	£'000	£'000	£'000
CCG	381,491	401,895	(3,496)	23,900
TMBC	96,438	96,438	0	773
ICFT	204,752	239,424	24,347	10,325
Total				34,998

RAG Rating Of Savings Target

	RED	AMBER	GREEN	TOTAL
	£'000	£'000	£'000	£'000
CCG	4,098	3,437	16,365	23,900
TMBC	0	347	426	773
ICFT	3,421	3,757	3,147	10,325
Total	7,519	7,541	19,938	34,998

CCG

Savings presented are after the application of optimism bias
Unidentified savings are categorized as red
Does not factor in impact of post budget setting pressures (e.g. CHC & Healthier Together)

TMBC

Related overheads are excluded
The additional funding for Adult Social Care announced by the Government on 8 March 2017 is also excluded

ICFT

The ICFT 2017/18 plan is for a deficit of £24.3m.
The Trust therefore requires a £24.3m revenue loan from the Department of Health to provide the cash to fund the deficit. There is a risk this could be repayable in future years.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	25 May 2017
Reporting Member / Officer of Single Commissioning Board	Angela Hardman, Executive Director, Public Health and Performance Anna Moloney, Consultant in Public Health
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**
Report Summary:	This paper provides the Single Commissioning Board with a quality and performance report for comment. Assurance is provided for the NHS Constitutional indicators. In addition Clinical Commissioning Group information on a range of other indicators are included to capture the local health economy position. This is based on the latest published data (at the time of preparing the report). This is as at the end of February 2017. The format of this report will include elements on quality from the Nursing and Quality directorate. As this report evolves. This report also includes Adult Social Care indicators. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following have been highlighted as exceptions: • Diagnostic standard improving but still failing the standard; • A&E Standards were failed at Tameside Hospital Foundation Trust; • Ambulance response times were not met at a local or at North West level; • Improving Access To Psychological Therapies (IAPT) performance for Recovery remains a challenge; • 111 Performance against Key Performance Indicators; • MRSA Bacteraemia. Attached for information is the Draft Greater Manchester Partnership dashboard and the latest NHS England Improvement And Assessment Framework (IAF) Dashboard. Also appended to the report is a presentation on improving urgent care compiled by Tameside and Glossop Care together.
Recommendations:	The Single Commissioning Board are asked to note the contents of the performance and quality report, and comment on the revised format.

Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.
Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account and understanding best where to focus resources and oversight. This report and framework continues to be developed to achieve this.
How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17.

Access to Information :

The background papers relating to this report can be inspected by contacting Ali Rehman,

Telephone: 01613663207

e-mail: alirehman@nhs.net

1. INTRODUCTION

1.1 The purpose of this iterative report is to provide the Board with a quality and performance report for comment. The quality and performance report format aims to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports.

1.2 The format of this report will include further elements on quality from the Nursing and Quality Directorate as this report evolves.

1.3 It should be noted that providers can refresh their data in accordance with national guidelines and this may result in changes to the historic data in this report.

2. CONTENTS – QUALITY AND PERFORMANCE REPORT

2.1 NHS Tameside & Glossop Clinical Commissioning Group: NHS Constitution Indicators (February 2017).

2.2 Adult Social services indicators. (Quarter 3 2016/17). These will be further expanded on in future iterations of this report.

2.3 Exception Report - the following have been highlighted as exceptions:

- Diagnostic standard improving but still failing the standard;
- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Ambulance response times were not met at a local or at North West level;
- Improving Access To Psychological Therapies (IAPT) performance for Access and Recovery remain a challenge;
- 111 Performance against Key Performance Indicators;
- MRSA Bacteraemia.

The exception reports in future reports will evolve as clarity is provided on the comparators.

2.4 Greater Manchester Combined Authority (GMCA)/NHS Greater Manchester (NHSGM) Performance Report:

- Better Health
- Better Care
- Sustainability
- Well Led

2.5 NHS England Improvement and Assessment Framework (IAF) dashboard.

2.6 There are a number of indicators where the CCG is deemed to be in the lowest performance quartile nationally. These indicators have been highlighted in light orange on the dashboard and are as follows:

2.7 **Better Health**

- Maternal Smoking at delivery
- People with diabetes diagnosed less than a year who attend a structured education course
- Utilisation of the NHS e-referral service to enable choice at first routine elective referral
- People with a long-term condition feeling supported to manage their condition(s)

- Inequality in emergency admissions for urgent care sensitive conditions
- Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Quality of life of carers

2.8 **Better Care**

- One-year survival from all cancers
- Proportion of people with a learning disability on the GP register receiving an annual health check
- Choices in maternity services
- Emergency admissions for urgent care sensitive conditions
- Delayed transfers of care per 100,000 population
- Population use of hospital beds following emergency admission
- Management of long term conditions

2.9 **Sustainability**

- Digital interactions between primary and secondary care

2.10 Tameside and Glossop Care together improving urgent care.

2.11 Also appended to the report is a presentation compiled by Tameside and Glossop Care Together on improving urgent care.

3. KEY HEADLINES-HEALTH

3.1 Below are the key headlines from the quality and performance dashboard.

Referrals

3.2 GP referrals have decreased this month compared to last month and have continued to decrease overall and have decreased compared to the same period last year. Other referrals have decreased compared to last month and have decreased compared to the same period last year. Year to date GP referrals have decreased by 9.8% compared to the same period last year and other referrals have decreased by 0.9% compared to the same period last year for referrals at Tameside and Glossop Integrated Care Foundation Trust. Referrals to all providers have decreased by 6.0% compared to the same period last year and other referrals have decreased by 3.6%.

18 Weeks RTT Incomplete Pathways

3.3 Performance continues to be above the national standard of 92%, currently achieving 92.6% during February. The specialties failing are Urology 90.11%, Trauma and Orthopaedics 89.16%, Neurology 90.00%, and Plastic Surgery 71.81%. There were no patients waiting longer than 52 weeks during February.

Diagnostics 6+ week waiters

3.4 This month the Clinical Commissioning Group failed to achieve the 1% standard with a 1.36% performance. Of the 63 breaches 23 occurred at Central Manchester (CT, Respiratory physiology, colonoscopy, flexi sigmoidoscopy, gastroscopy and MRI). 26 at Care UK (Dexa scan), 10 at Tameside and Glossop Integrated Care Foundation Trust (audiology assessments, colonoscopy, cystoscopy and neurophysiology). 3 at Salford Trust (MRI), and 1 at North West CATS Inhealth (MRI). Central Manchester performance is due to an ongoing issue with endoscopy which Greater Manchester are aware of. Tameside and Glossop Integrated Care Foundation Trust performance is primarily due to audiology struggling with capacity.

A&E Waits Total Time with 4 Hours at Tameside and Glossop Integrated Care Foundation Trust

3.5 The A&E performance for February was 86.9% which is below the target of 95% nationally. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need.

Ambulance Response Times Across the North West Ambulance Service Area

3.6 In February the North West position (which we are measured against) was not achieved against the standards. Locally we also did not achieve any of the standards. Increases in activity have placed a lot of pressure on North West Ambulance Service and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

111

3.7 The North West NHS 111 service is performance managed against a range of Key Performance Indicators reported as follows for February:

- Calls Answered (95% in 60 seconds) = 79.5%;
- Calls abandoned (<5%) = 6.2%;
- Warm transfer (75%) = 29.3%;
- -Call back in 10 minutes (75%) = 37.1%.

3.8 The benchmarking data shows that the North West NHS 111 service was ranked 42nd out 42 for calls answered in 60 seconds (79%). This is compared to South East London which is the highest ranked for calls answered in 60 seconds (97%).

3.9 Looking at the dispositions we are also ranked 41st out of 42 for % recommended to dental/pharmacy (2%) compared to the highest ranked provider York and Humber (11%). Percentage recommended home care (4%) we are ranked 40th out 42 compared to the highest ranked provider, East London and City (8%).

3.10 In February the NW NHS 111 service experienced a number of issues which lead to poor performance in the month against the four KPIs. Performance was particularly difficult to achieve over the weekend periods.

Cancer

3.11 All of the cancer indicators achieved the standard during February.

Improving Access to Psychological Therapies

3.12 Performance continues to be above the Quarterly Standard for the Improving Access to Psychological Therapies (IAPT) access rate (75%) achieving 3.90% during Quarter 3. However, the Quarter 3 performance for IAPT recovery rate remains below the standard at 42.20%. In terms of IAPT waiting times the Quarter 3 performance is above the standard against the 18 week standard (95%) which was reported as 100%. The Quarter 3 performance for the 6 week wait standard (75%) was reported as 78.4%.

Healthcare Associated Infections

3.13 Clostridium Difficile: The number of reported cases during February was below plan. Tameside & Glossop Clinical Commissioning Group had a total of 4 reported cases of clostridium difficile against a monthly plan of 7 cases. For the month of February this places Tameside and Glossop Clinical Commissioning Group 3 under plan. Of the 4 reported cases, 3 were apportioned to the acute (2 at Tameside and Glossop Integrated Care Foundation Trust and 1 at Central Manchester Foundation Trust) and 1 to the non-acute. To date (April to February 2017) Tameside and Glossop Clinical Commissioning

Group had a total of 72 cases of clostridium difficile against a year to date plan of 89 cases. This places Tameside and Glossop Clinical Commissioning Group 17 cases under plan. Of the 72 reported cases, 39 were apportioned to the acute (29 at Tameside and Glossop Integrated Care Foundation Trust, 5 at Central Manchester Foundation Trust, 2 at Christie Hospital Foundation Trust, 1 at The Royal Orthopaedic Hospital Foundation Trust, 2 at Stockport Foundation Trust) and 33 to the non-acute. In regards to the 2016/17 financial year, Tameside and Glossop Clinical Commissioning Group have reported 72 cases of clostridium difficile against an annual plan of 97 cases. This currently places the Clinical Commissioning Group 25 cases under plan with 1 month of the financial year remaining.

3.14 MRSA: In February 2017 Tameside and Glossop Clinical Commissioning Group have reported 2 cases of MRSA against a plan of zero tolerance. To date (April 2016 to February 2017) Tameside and Glossop Clinical Commissioning Group have reported 10 cases of MRSA against a plan of zero tolerance. Breakdown includes 6 acute cases (2 at Tameside and Glossop Integrated Care Foundation Trust, 3 at Central Manchester, 1 at South Manchester Foundation Trust) and 5 non acute cases.

Mixed Sex Accommodation

3.15 This month there were no breaches reported against the Mixed Sex Accommodation standard of zero breaches for Tameside and Glossop Clinical Commissioning Group patients.

Dementia

3.16 We continue to perform well against the estimated diagnosis rate for people aged 65+ for February which was 75.3% against the 66.7% standard.

4. ADULT SOCIAL CARE INDICATORS

Introduction

4.1 Performance in Adult Social Care is supported by the Adult Social Care Outcomes Framework (ASCOF). The framework contains nationally published qualitative and quantitative indicators. The qualitative indicators are informed by the completion of an annual national survey of a selection of service users and a biannual survey of a selection of Carers- both surveys are administered locally

4.2 It is widely recognised that the quantitative indicators in the ASCOF do not adequately represent the service delivery of Adult Social Care, therefore in response, data sets have been developed regionally and locally in order to provide performance data that supports service planning and decision making for Adult Social Care in Tameside.

Proportion of People Using Social Care who Receive Direct Payments
Performance Summary

4.3 This measure supports the drive towards personalisation outlined in the Vision for adult social care and Think Local, Act Personal, by demonstrating the success of councils in providing personal budgets and direct payments to individuals using services.

4.4 Performance in Tameside in 2015/2016 was 15.43% compared to 23.5% regionally and 28.1% nationally.

4.5 Tameside performance as at Quarter 3 2016/2017 is showing 13.62%, which is a reduction of 23 people since 2015/2016.

4.6 **Actions**

- Review the Direct Payments offer and how this is promoted by front line staff.
- Review the capacity of Direct Payment Officers.
- Gain views from Service Users as to why Direct Payments may not be considered.

People With Learning Disabilities In Employment
Performance Summary

4.7 The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits.

4.8 Performance in Tameside in 2015/2016 was 2% compared to 4.1% regionally and 5.8% nationally. 6 GM authorities have less than 3% of People with Learning Disabilities in Employment, with only Trafford, Stockport and Rochdale achieving above 4%.

4.9 Nationally and regionally we are seeing a steady decline in this indicator - 2012/2013 region 5.5%, national 7%.

4.10 Tameside performance at Quarter 3 2016/2017 is showing 1.89%, although the number of people in employment has actually remained the same, the number of people known to social care has increased which has affected the performance out turn.

4.11 If Tameside were to be at the National average of 6%, this would mean an additional 20 People with Learning Disabilities into Employment.

4.12 If Tameside were to be at the same level as Trafford 14%, this would mean an additional 58 People with Learning Disabilities into Employment. Performance in this area has been a concern for some time and has been impacted upon the reduction of the Learning Dissabilities Employment Support Team due to financial restraints.

4.13 **Actions**

- Make Contact with Trafford to share best Practice.
- We have moved the remaining Employment staff into the Employment and Skills corporate team to ensure a more focused approach to employment and access to wider resource and knowledge base.
- The development of a new scheme focused on supporting people with pre-employment training and supporting people into paid employment including expansion of the Supported Internship Programme for 16-24 year olds.

5. CONSIDERATIONS OF THE QUALITY AND PERFORMANCE ASSURANCE GROUP

5.1 The Quality and Performance group recommended a systematic review of quality & performance reporting. This is essential to clarify reporting requirements and expectations across the Single Commissioning Board, Clinical Commissioning Group Governing Body and Council Board governance, with a view to minimising duplication and providing assurance at the most appropriate system level.

6. RECOMMENDATIONS

6.1 As set out on the front of the report.

Key Messages

Positive trends

18 Weeks RTT Incomplete Pathways: Performance continues to be above the national standard of 92%, currently achieving 92.6% during February.
18 Weeks RTT 52+ Week Waits: There were no patients waiting longer than 52 weeks during February.
Cancer: All of the cancer indicators achieved standard during February.
IAPT Access Rate: Performance continues to be above the Quarterly standard (3.75%) achieving 3.90% during Quarter 3.
IAPT Waiting Times: Quarter 3 performance is above standard for 18 week waiting times and 18 week waits is reported as 100% (Standard 95%)
IAPT Waiting Times: Quarter 3 performance is above the standard for 6 week waiting times. IAPT 6 week waits is reported as 78.4% (standard 75%).
Healthcare Associated Infections Clostridium Difficile: The number of reported cases during February (4) was below plan.
Dementia: Estimated diagnosis rate for people aged 65+ for February was 74.8% against the 66.7% standard.
Referrals: GP referrals have decreased this month compared to last month and have continued to decrease overall and have decreased compared to the same period last year. Other referrals have decreased compared to last month and have decreased compared to the same period last year.

Challenges

Please note a more detailed exception report is available for each of these indicators later in this report.

A&E Waits Total Time Within 4 Hours At T&G ICFT: February performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 86.9%. A total of 6,352 patients attended A&E in the month, of which 835 did not leave the department within 4 hours.
Diagnostics 6+ Week Waiters: Performance was higher (worse than) the national standard of 1.00%, currently achieving 1.36% during February.
Ambulance Response Times Across NWAS Area: Performance against all three response times across the North West Ambulance Service (NWAS) area are worse than the national standards in February. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 61.8% and 58.8%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 85.7%.
Healthcare Associated Infections MRSA: There have been 10 reported cases of MRSA during the year. 2 further cases reported in the month of February.
111: The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Feb:- Calls Answered (95% in 60 seconds) = 79.46%- Calls abandoned (<5%) = 6.18%- Warm transfer (75%) = 29.33% Call back in 10 minutes (75%) = 37.09%
IAPT Recovery Rate: Quarter 3 performance was below the standard (50%) achieving 42.20%.

NHS Tameside & Glossop CCG: NHS Constitution Indicators (May 2017)

Key: H=Higher L=Lower <> =N/A

Better Health

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Exceptions	GM	England	Trend
	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	M	T&G CCG	H							11.8%	11.6%	11.2%	11.1%	11.6%	10.4%	10.7%	10.0%	10.1%	11.1%	13.3%			51.1% (Sept)	
	Number of women Smoking at Delivery.	Q	T&G CCG	L	England	14.4%	16.1%			15.8%	13.6%			16.9%			15.3%						13.3% (Q3)	10.60%	
	Personal health budgets	Q	T&G CCG	H			4.0				4.0			4.1			3.6						30 (Q2)	18.7 (Q2)	
	Percentage of deaths which take place in hospital	Q	T&G CCG	<>			50.7%				47.6%			49.0%			50.4%						50% (Q4 15/16)	47.1% (Q1 16/17)	
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q	T&G CCG	L			1475																	929	
	Inequality in emergency admissions for urgent care sensitive conditions	Q	T&G CCG	L			3269																	2168	
	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Q	T&G CCG	<>										1.1										1.1	
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Q	T&G CCG	<>										7.8%										9.10%	
	Injuries from falls in people aged 65 and over	A	T&G CCG	L					2116				2159											1985	

Description	Indicator		Level	Better is...	Threshold	09/10	10/11		11/12		12/13		13/14		14/15		15/16					Exceptions	GM	England	Trend
	Percentage of children aged 10-11 classified as overweight or obese	A	T&G CCG	L									33.3%		34.1%								34.6% FY 14/15	33.2% FY 14/15	
	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	A	T&G CCG	H											46.8%								41.8% FY 14/15	39.8% FY 14/15	
	People with diabetes diagnosed less than a year who attend a structured education course	A	T&G CCG	H											0.0%								1.9% FY 14/15	5.7% FY 14/15	
	People with a long-term condition feeling supported to manage their condition(s)	A	T&G CCG	H					66.6%		63.9%		62.9%		62.4%		61.4%							64.30%	
	Quality of life of carers	A	T&G CCG	H					80.4%		80.7%		77.70%		80.00%		77.5%						90.5% (2015)	80.0% (2016)	

Key: H=Higher L=Lower <> =N/A

Better Care

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Exceptions	GM	England	Trend
Cancer 2 Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&G CCG	H	93%	97.5%	97.4%	97.7%	96.3%	96.4%	95.8%	97.1%	96.1%	94.3%	94.6%	95.4%	96.5%	97.5%	98.1%	94.4%	95.6%		96.90%	94.00%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&G CCG	H	93%	98.4%	96.1%	98.2%	98.9%	93.0%	93.9%	98.0%	95.8%	94.0%	96.7%	97.3%	100.0%	100.0%	98.8%	100.0%	93.6%		96.30%	93.80%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&G CCG	H	96%	100.0%	100.0%	100.0%	100%	99.1%	100.0%	98.9%	100.0%	100.0%	98.8%	98.9%	98.0%	98.2%	100.0%	98.9%	100.0%		97.80%	96.50%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%		96.60%	94.20%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&G CCG	H	98%	100.0%	96.2%	100.0%	100%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.	99.60%	98.90%	
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.6%	100.0%	100.0%		100%	96.00%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&G CCG	H	85%	88.2%	96.1%	93.3%	93.8%	89.9%	89.7%	88.6%	91.5%	89.6%	91.3%	74.4%	91.1%	90.4%	88.0%	89.1%	87.3%	There were 10 breaches out of a total of 39 seen in Sept 16.	88.30%	79.50%	
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&G CCG	H	90%	100.0%	100.0%	100.0%	100.0%	95.3%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%		90.00%	90.60%	
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	M	T&G CCG	H	85%	85.7%	100.0%	92.3%	88.2%	88.9%	83.3%	86.7%	94.4%	82.4%	100.0%	53.8%	78.3%	94.4%	78.6%	75.0%	87.5%	For Jan 17 20 patients treated with 4 being treated over the target. For Dec 16 14 patients treated with 3 being treated over the target. For Sept 16 there were 13 patients treated with 6 being treated over the target	86.50%	87.00%	
18 Weeks RTT	Patients on incomplete non emergency pathways (yet to start treatment)	M	T&G CCG	H	92%	91.8%	91.8%	92.1%	91.9%	91.6%	92.4%	92.5%	92.4%	92.4%	92.1%	92.1%	92.1%	92.7%	92.6%	93.0%	92.6%	CCG target (92%) achieved. Failing specialties are Urology (90.11%), Trauma & Orthopaedics (89.16%), Ear, Plastic Surgery (71.81%), Neurology (90.00%).	92.30%	89.90%	
	Patients waiting 52+ weeks on an incomplete pathway	M	T&G CCG	L	Zero Tolerance	1	0	2	0	12	1	0	1	1	1	0	1	0	0	0	0	In Oct-16 there was 1 patient waiting over 52 weeks for treatment on an incomplete pathway. This patients is waiting under the speciality plastic surgery and has now been seen.			
Diagnostics < 6 Weeks	Patients waiting for diagnostic tests should have been waiting less that 6 weeks from referral	M	T&G CCG	L	1%	2.5%	2.68%	1.83%	2.88%	2.17%	2.55%	1.55%	2.36%	1.70%	1.20%	1.24%	1.34%	1.29%	1.85%	1.88%	1.40%	CCG target not achieved, 63 breaches. Failing for CCG are T&G ICFT for Cystoscopy, Neurophysiology - peripheral neurophysiology, Audiology - Audiology Assessments, CMMC for Magnetic Resonance Imaging, Respiratory physiology - sleep studies, Computed Tomography, Flexi sigmoidoscopy, Gastroscopy, Colonoscopy, Salford FT for Magnetic Resonance Imaging, NORTH WEST CATS - INHEALTH for Magnetic Resonance Imaging and Ashton Primary Care Centre for DEXA Scan.	1.50%	1.70%	
Dementia	Estimated diagnosis rate for people aged 65+	M	CCG	H	66.70%	68.90%	70.30%	71.60%	71.10%		69.60%	69.80%	70.50%	70.3%	71.3%	72.8%	75.3%	74.4%	74.9%	74.8%	75.3%		77.30%	67.30%	
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	M	THFT	H	95%	73.0%	73.4%	76.0%	93.1%	84.9%	92.5%	92.2%	86.5%	85.0%	90.5%	82.7%	84.1%	86.6%	76.2%	76.7%	86.9%	2015-16 performance shows that 12,737 patients waited more than 4 hours (denominator 84,303). Breached by 8,522 patients. June 2016 performance is 86.54% breached by 967 patients. July 2016 performance is 84.98% breached by 1143 patients. August 2016 performance is 90.5% breached by 646 patients. September performance is 82.7% breached by 1224 patients. October performance is 84.1% breached by 1,176 patients. November performance is 86.6% breached by 943 patients. December performance is 76.2% breached by 1703 patients. January performance is 76.7% breached by 1638 patients. February performance is 86.85% breached by 835 patients.	86.00%	77.60%	
	Delayed transfers of care per 100,000 population	M	T&G CCG	L											21.2			24					16.3	15	

	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	M		H				0.0%	11.1%		33.3%	45.5%	62.1%	65.4%	66.7%	73.3%	75.0%	89.0%					78.0%	77.20%	
	Achievement of milestones in the delivery of an integrated urgent care service	M		H											4										
IAPT-Improving Access to psychological services	Access	Q	T&G CCG	H	3.75%	4.30%	4.41%			4.3%	3.95%			3.92%			3.90%							4.00%	
	Recovery	Q	T&G CCG	H	50%	44.00%	40.14%			40.0%	45.75%			46.00%			42.20%							47.50%	48.40%	
	Waiting times less than 6 weeks	Q	T&G CCG	H	75%	52.60%	60.14%			56.3%	62.75%			73.40%			78.40%							79.30%	84.82%	
	Waiting times less than 18 weeks	Q	T&G CCG	H	95%	89.61%	90.54%			90.4%	91.50%			98.60%			100.0%							95.40%	97.47%	
	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q		L			65				62													62 (Q1)	58 (Q1)	
	Emergency admissions for urgent care sensitive conditions	Q		L			3269																		2359	
	Population use of hospital beds following emergency admission	Q		L			1.3				1.2														1.0	
	Management of long term conditions	Q		L			1276																		795 Q4 15/16	
	People eligible for standard NHS Continuing Healthcare	Q		H							63.9			62.7										53.5	46.2	

Description	Indicator		Level	Better is...	Threshold	2009	2010	2011	2012	2013	2014	2015				Exceptions	GM	England	Trend
	Cancers diagnosed at early stage	A	T&G CCG	H					44.1	43.7	44.2						48.90%	50.70%	
	One-year survival from all cancers	A	T&G CCG	H		64.9	65.7	66.6	67.6	67.6							69.50%	70.20%	
	Cancer patient experience	A	T&G CCG	H							9.1	8.7					9 (2014)	8.9 (2014)	
	Women's experience of maternity services	A	T&G CCG	H								77.6						79.7	
	Choices in maternity services	A	T&G CCG	H								61.4%							

Description	Indicator		Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16				Exceptions	GM	England	Trend
	Neonatal mortality and stillbirths	A	T&G CCG	L			5.9	5.1	6.4	7.8	7.8						8.0 fy 14/15	7.1 FY 14/15	
	Dementia Care Planning and Post-Diagnostic Support	A	T&G CCG	H							79.4%						79.6% FY 14/15	77.0% FY 14/15	
	Patient experience of GP services	A	T&G CCG	H				85.6%	85.7%	83.4%	81.2%	83.2%					85.40%	83.20%	
	Proportion of people with a learning disability on the GP register receiving an annual health check	A	T&G CCG	H						44.6%	34.0%						47.5% FY 13/14	37.1% FY 15/16	

Description	Indicator		Level	Better is...	Threshold	2010	2011	2012	2013	2014	2015	2016				Exceptions	GM	England	Trend
	Primary care workforce	A	T&G CCG	H							0.9	1.0						1.0	

Key: H=Higher L=Lower <> =N/A

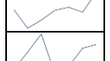
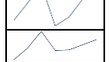
Better Care - Adult Social Care

Description	Indicator	F	Level	Better is...	Threshold	3rd Quarter 2015-16		4th Quarter 2015-16 Out-turn			1st Quarter 2016-17			2nd Quarter 2016-17			3rd Quarter 2016-17			Exceptions	GM	England *	Trend
						Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16				
ASCOF 1C - Proportion of people using social care who receive self-directed support, and those receiving direct payments.	**Part 1a - % of service users who receive self directed support**	Q	LA	H	86.9	97.80%		97.77%			97.59%			97.51%			96.63%			Cumulative year to date performance reported	-	86.9	
	Part 1b - % of carers who receive self directed support	Q	LA	H	77.7	92.89%		91.10%			99.57%			99.79%			100.00%			Cumulative year to date performance reported	-	77.7	
	Part 2a - % of service users who are in receipt of direct payments	Q	LA	H	28.1	16.38%		15.43%			14.91%			14.74%			13.62%			Cumulative year to date performance reported	-	28.1	
	Part 2b - % of carers who are in receipt of direct payments	Q	LA	H	67.4	91.38%		74.63%			77.87%			73.43%			75.93%			Cumulative year to date performance reported	-	67.4	
ASCOF 1E - Proportion of adults with learning disabilities in paid employment.	**Total number of Learning Disability service users in paid employment**	Q	LA	H	5.8	2.20%		2.00%			1.99%			1.92%			1.89%			Cumulative year to date performance reported	-	5.8	
ASCOF 1G - Proportion of adults with learning disabilities who live in their own home or with their family.	**Total number of Learning Disability service users in settled accomodation.**	Q	LA	H	75.4	94.29%		93.79%			94.69%			93.80%			93.90%			Cumulative year to date performance reported	-	75.4	
ASCOF 2A - Permanent admissions to residential and nursing care homes, per 100,000 population.	**Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64**	Q	LA	L	13.3	9.69 (13 Admissions)		11.92 (16 Admissions)			1.49 (2 Admissions)			2.98 (4 Admissions)			7.44 (10 Admissions)			Cumulative year to date performance reported	-	13.3	
	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	Q	LA	L	628.2	481.61 (182 Admissions)		643.03 (243 Admissions)			153.87 (59 Admissions)			307.75 (118 Admissions)			453.8 (174 Admissions)			Cumulative year to date performance reported	-	628.2	
	Total number of permanent admissions to residential and nursing care homes aged 18+	Q	LA	H	-	195		259			61			122			184			Cumulative year to date performance reported	-	-	
ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.	**Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital**	Q	LA	H	82.7	-		86.44			-			-			-			Based on a sample period of discharges from hospital between October - December each year.	-	82.7	
	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital compared against the HES data (hospital episode stats)	Q	LA	H	2.9	-		4.02			-			-			-			Based on a sample period of discharges from hospital between October - December each year.	-	2.9	
Early Help	**Number of people supported outside the Social Care System with prevention based services.**	Q	LA	H	-	8609		8503			8406			8308			8180			Cumulative year to date performance reported	-	-	
Helped To Live At Home	**Number of people helped to live at home and remain independent with support from Adult Services in community based services**	Q	LA	H	-	2945		2971			3027			3000			3008			Cumulative year to date performance reported	-	-	
Early Help - Re-ablement Services	**% of people completing re-ablement who leave with either no package or a reduced package of care.**	Q	LA	H	-	90.29%		90.40%			85.98%			87.76%			87.94%			Cumulative year to date performance reported	-	-	
REVIEWS D40 - Proportion of service users with a completed review in the financial year	**Service users needs change and frequent reviews ensure that they receive services which are suitable for their needs, and that LA's can utilise resources in the most efficient and appropriate way.**	Q	LA	H	-	60.07%		72.78%			22.39%			41.09%			62.78%			Cumulative year to date performance reported	-	-	

* Rag ratings are based on thresholds where appropraite otherwise based quarter on quarter and year on year comparisons.
England data is 15/16.

Key: H=Higher L=Lower <> =N/A

Sustainability

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Exceptions	GM	England	Trend
Referrals	GP Referrals-Total	M	T&G CCG	L		5116	5180	5723	5636	67180	6018	5494	5724	5359	5142	5310	5086	5192	4421	5132	4951	Variance from Monthly plan			
	Other referrals- Total	M	T&G CCG	L		2694	2670	2871	2837	34656	2904	2748	2730	2751	2853	2786	3060	3085	2434	2822	2508	Variance from Monthly plan			
	GP referrals- T&G ICFT	M	T&G CCG	L		3804	3817	4242	4129	48782	4088	3971	4053	3766	3452	3611	3566	3673	3142	3615	3469	Variance from previous year			
	Other referrals - T&G ICFT	M	T&G CCG	L		1418	1419	1639	1540	19274	1640	1428	1521	1637	1670	1612	1836	1854	1431	1626	1412	Variance from previous year			
Activity	Outpatient Fist Attend	M	T&G CCG	L	Plan	6561	6591	6698	6554	80783	6852	7137	7441	6755	6903	7205	7265	7606	6394	6620	6406	Variance from Monthly plan			
	Elective Inpatients	M	T&G CCG	L	Plan	2642	2799	2898	2717	34015	2799	2890	3022	2871	2876	2915	2956	3201	2624	2778	2766	Variance from Monthly Plan			
	Non-Elective Admissions	M	T&G CCG	L	Plan	2562	2407	2372	2636	28906	2361	2409	2314	2267	2336	2244	2337	2431	2444	2470	2256	Variance from Monthly Plan			
	In-year financial performance	Q		H																					
	Outcomes in areas with identified scope for improvement	Q		H																			58.30%		
	Digital interactions between primary and secondary care	Q		H										52.6			53.7								
	Local strategic estates plan (SEP) in place	A		H							Yes														
	Financial plan	A		H							AMBER														

Key: H=Higher L=Lower <> =N/A

Well Led

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Exceptions	GM	England	Trend
	Quality of CCG leadership	Q		H																					

Description	Indicator		Level	Better is...	Threshold	2009	2010	2011	2012	2013	2014	2015				Exceptions	GM	England	Trend
	Staff engagement index	A		H								3.9						3.8	
	Progress against workforce race equality standard	A		L								0.3						0.2	

Description	Indicator		Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16				Exceptions	GM	England	Trend
	Effectiveness of working relationships in the local system	A		H								66.9							

Indicates the lowest performance quartile nationally.

Key: H=Higher L=Lower <> =N/A

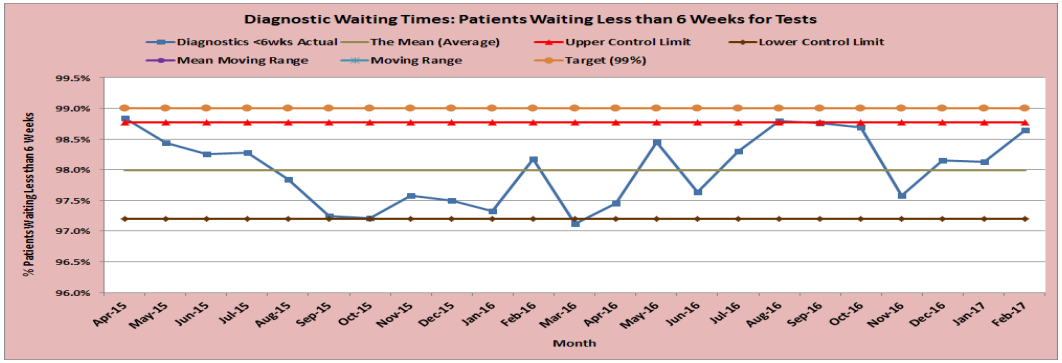
Other Indicators

Description	Indicator	F	Level	Better is...	Threshold	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Exceptions	GM	England	Trend
Mixed Sex Accommodation	MSA Breach Rate	M	T&G CCG	L	0	0	0	0	0	0	0	0	0.1	0.2	0	0	0	0.1	0	0.3	0.0	Total of 1 breach in June 16, 2 breaches in July 16, 1 breach in Nov 16 and 2 breaches in Jan17 for T&G CCG. This is an unjustified mixing in relation to sleeping accommodation. Data shows the breach rate per 1,000 finished consultant episodes.		0.65	
Cancelled Operations (Elective)	The number of last minute cancelled elective operations in the quarter for non-clinical reasons where patients have not been treated within 28 days of last minute elective cancellation	Q	THFT	L	0	4	2			12	2			0			0					Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85, Q2 = 60, Q3 = 78		1229	
Care Programme Approach (CPA)	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	Q	T&G CCG	H	95%	96.3%	100%			96.7%	94.5%			96.7%			100.0%					16-17 Q1 52 patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care out of a total of 55 patients = 94.5%		96.70%	
	Other Indicators																								
Other Indicators	Avoidable admissions- People		T&G CCG	L		-14.25%	14.22%	14.95%	29.21%																
	Avoidable admissions-Cost		T&G CCG	L		41.00%	12.51%	15.90%	-2.92%																
	Re admissions		T&G CCG	L																					
	Average LOS	M	T&G CCG	L								5.38	5.22	5.00	4.20										
	DTOCS (Patients)	M	LA	L		19	43	42	37		38	49	37	47	42	47	71	52	61	55	54				
	DTOCS (Patients)	M	Trust	L		16	43	36	25		26	38	25	32	29	38	61	45	50	42	35				
	Other Indicators-111																								
111 KPIs	Calls answered (60 Seconds)	M	NW	H	95.00%	55.00%	56.00%	58.00%	49.00%		80.00%	85.00%	90.00%	83.0%	90.0%	89.0%	71.4%	67.5%	64.7%	77.5%	79.5%			90.60%	
	Calls abandoned	M	NW	L	<5%	15.00%	16.00%	15.00%	23.00%		6.00%	4.00%	2.00%	4.0%	2.0%	2.0%	6.4%	6.9%	10.8%	7.1%	6.2%			2.30%	
	Warm Transfer	M	NW	H	75%	38.0%	39.0%	38.0%	31.0%		35.0%	33.0%	32.0%	33.0%	35.0%	36.0%	33.2%	35.0%	31.3%	32.9%	29.3%			50.10%	
	Call back in 20 mins	M	NW	H	75%	36.00%	32.00%	34.00%	32.00%		39.00%	41.00%	40.00%	38.0%	39.0%	34.0%	34.7%	36.0%	33.5%	38.4%	37.1%			43.40%	
	Ambulance																								
Ambulance	Red 1 < 8 Minutes (75% Target)	M	T&G CCG	H	75.00%	76.60%	54.50%	67.00%	73.20%		81.50%	71.10%	69.50%	75.6%	66.7%	65.9%	68.3%	60.4%	61.3%	59.4%	63.6%	High levels of demand and lengthening turn around times.	63.00%	66.70%	
	Red 2 < 8 Minutes (75% Target)	M	T&G CCG	H	75%	65.30%	60.90%	55.80%	68.30%		64.90%	58.00%	63.10%	58.60%	65.80%	60.00%	60.48%	54.76%	53.50%	54.50%	56.91%	High levels of demand and lengthening turn around times.	57.10%	58.50%	
	All Reds <19 Minutes (95% Target)	M	T&G CCG	H	95%	91.2%	89.1%	87.9%	92.3%		90.7%	89.9%	91.1%	89.9%	91.0%	89.1%	86.4%	83.1%	82.9%	83.3%	88.4%	High levels of demand and lengthening turn around times.		87.60%	
	Red 1 < 8 Minutes (75% Target)	M	NWAS	H	75%	78.5%	69.3%	70.5%	74.8%		76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%	62.8%	61.6%	61.8%	64.7%	High levels of demand and lengthening turn around times.	63.00%	66.70%	
	Red 2 < 8 Minutes (75% Target)	M	NWAS	H	75%	69.5%	63.5%	61.1%	70.4%		67.5%	66.3%	66.2%	62.7%	65.3%	61.8%	63.0%	60.4%	57.3%	58.8%	61.0%	High levels of demand and lengthening turn around times.	57.10%	58.50%	
	All Reds <19 Minutes (95% Target)	M	NWAS	H	95%	92.70%	89.90%	88.10%	92.60%		92.00%	91.50%	91.50%	89.8%	91.1%	89.0%	88.2%	86.8%	85.4%	85.7%	88.4%	High levels of demand and lengthening turn around times.		87.60%	
	Quality																								
Quality	Clostridium Difficile-Whole Health Economy	M		L	Plan	1	4	5	3	71	4	7	3	9	10	5	13	6	6	5	4			1004	
	Clostridium Difficile-Acute	M		L	Plan	0	1	4	0	29	2	2	2	4	5	2	8	5	4	2	3			410	
	Clostridium Difficile-Non-Acute	M		L	Plan	1	3	1	3	42	2	5	1	5	5	3	5	1	2	3	1			594	
	MRSA-Whole Health Economy	M		L	0	2	0	0	1	8	0	0	2	1	3	0	0	0	0	2	2		4	92	
	MRSA-Acute	M		L	0	1	0	0	0	3	0	0	2	0	2	0	0	0	0	1	1			39	
	MRSA-Non Acute	M		L	0	1	0	0	1	5	0	0	0	1	1	0	0	0	0	1	1			53	

Exception Report

Tameside & Glossop CCG- May

Diagnostics- Patients Waiting for Diagnostic test. **Lead Officer:** Elaine Richardson **Lead Director:** Clare Watson **Governance:** Contracts



Key Risks and Issues:

As a CCG
This month the CCG failed to achieve the 1% standard with a 1.36% performance.
Of the 63 breaches. 23 occurred at Central Manchester (CT, Respiratory physiology, colonoscopy, flexi sigmoidoscopy, gastroscopy and MRI). 26 at Ashton Primary Care Centre (Dexa Scan). 10 at T&G ICFT (audiology assessments, colonoscopy, Cystoscopy and Neurophysiology). 3 at Salford Trust (MRI), and 1 at NorthWest CATS Inhealth (MRI).

Central Manchester performance is due to increased demand and issues around decontamination have impacted endoscopy performance which GM are aware of. Performance in 2017/18 is expected to be impacted when work is undertaken to ensure they achieve the JAG rating as 6 week waits may build up again.

T&G ICFT performance is primarily due to audiology struggling with capacity.

As lead Commissioner.
T&G ICFT as a provider are achieving the standard.

Actions:

CMFT whilst not back on track have improved and further improvement is expected for March.
CARE UK had only 3 Dexa clinics rather than 4 in February but the reduction in capacity was due to slots being vacant. The backlog in activity from January along with the fact patients were unwilling to take up slots in February are the reasons for the failure. This may be linked to half term so should be resolved in March.
T&G ICFT is working to resolve the audiology waits.

Operational and Financial implications:

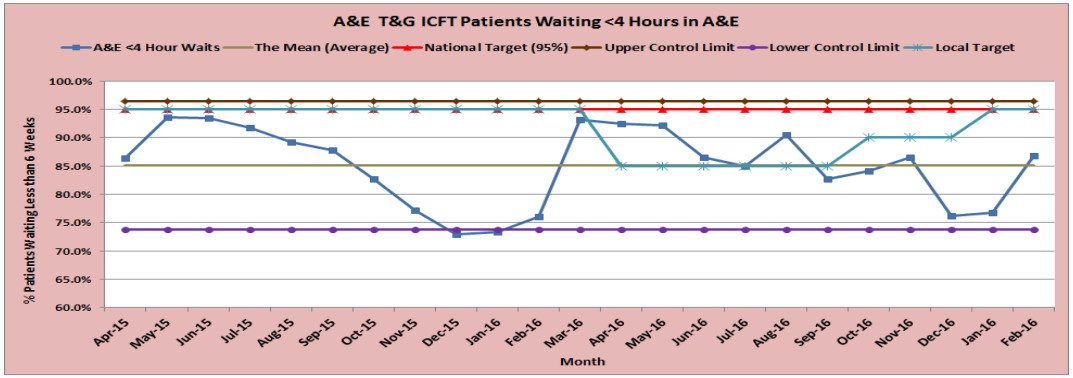
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

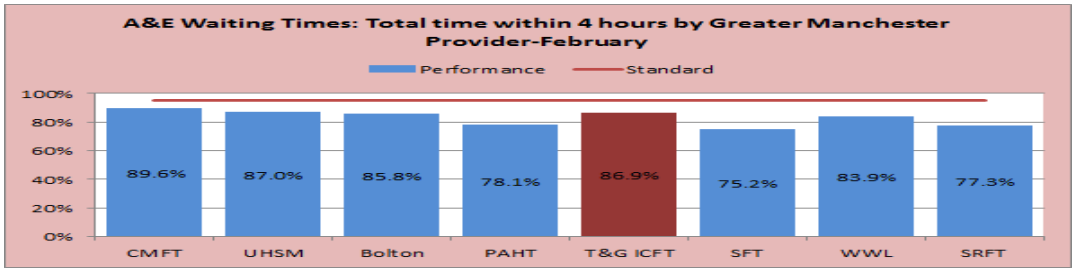
Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG

	Feb-17			
CCG	**Waiting > 6 Weeks**	**Total Waiting List**	**Performance**	**Standard**
NHS Central Manchester CCG	71	2837	2.2%	1%
NHS North Manchester CCG	48	3186	1.1%	1%
NHS Tameside and Glossop CCG	67	4643	1.4%	1%
NHS Bury CCG	33	3607	0.7%	1%
NHS Oldham CCG	35	3697	0.8%	1%
NHS South Manchester CCG	28	2830	0.8%	1%
NHS Trafford CCG	45	5473	0.7%	1%
NHS HEYWOOD, MIDDLETON AND ROCHDALE C	70	4054	1.6%	1%
NHS Bolton CCG	27	3705	0.6%	1%
NHS Salford CCG	50	4228	1.0%	1%
NHS Stockport CCG	54	5196	0.8%	1%
NHS Wigan Borough CCG	52	5521	0.8%	1%

Unvalidated -Next month FORECAST

A&E: Patients waiting < 4 hours | **Lead Officer:** Elaine Richardson | **Lead Director:** Clare Watson | **Governance:** A&E Delivery board





February Performance: 86.9%

15/16 ytd: 84.07%

16/17 ytd: 85.44%

Key Risks and Issues:

The A&E performance for February was 86.9% which is below the target of 95%.
Late asssment is the main reason for breaches.
Issues include middle grade capacity.
The level of acute beds occupied by people who should have been discharged is higher than it should be which reduces Medical bed capacity.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.

The local trjectory submitted to get back to the 90s in 1917/18 is Q1, Q2 and Q3 90% and 95% in March 18.

Actions:

Actions include:
NHSI's Head of Service Improvement 'significantly assured' about the Trust's response to the challenges relating to emergency flow;
Silver Command, including the deployment of Ward Liaison Officers, in place during February;
Additional medical staffing resources deployed, especially on days of expected increased activity (Monday/Tuesday);
Continuation of the Emergency Flow Service Improvement Project

Operational and Financial implications:

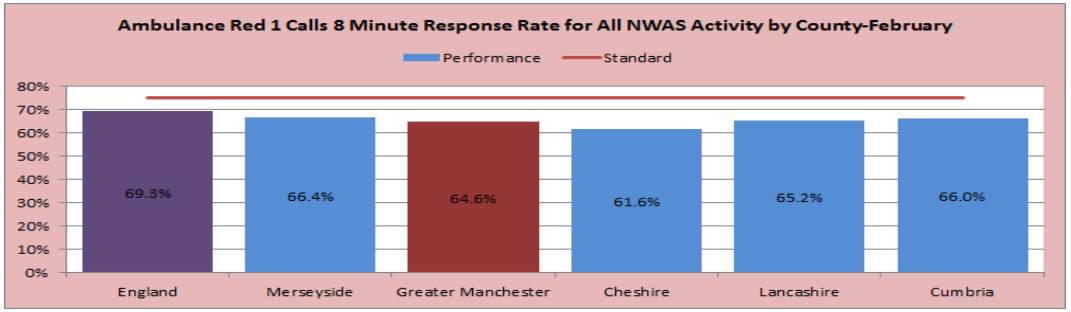
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).
STP

Next month FORECAST

* Please note that Tameside Trust local trajectory for 16/17 is Q1 85%, Q2 85% Q3 90% And Q4 95%.

Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



February Performance: 63.55%

15/16 ytd: 75.56%

16/17 ytd: 67.94%

Key Risks and Issues:

In February the north west position (which we are measured against) was 63.55% however locally we achieved 64.71% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Ambulance Red 1 Calls 8 Minute Response Rate for All NWAS Activity by CCG

	Feb-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Central Manchester CCG	52	71	73.9%	75%
NHS South Manchester CCG	44	58	75.4%	75%
NHS North Manchester CCG	78	105	74.3%	75%
NHS Heywood Middleton & Rochdale CCG	53	87	60.9%	75%
NHS Salford CCG	64	99	64.3%	75%
NHS Wigan Borough CCG	77	111	69.4%	75%
NHS Oldham CCG	58	87	66.3%	75%
NHS Stockport CCG	50	92	54.3%	75%
NHS Tameside and Glossop CCG	69	109	63.6%	75%
NHS Bolton CCG	69	99	70.1%	75%
NHS Bury CCG	36	62	58.1%	75%
NHS Trafford CCG	34	78	43.6%	75%

Unvalidated next month FORECAST

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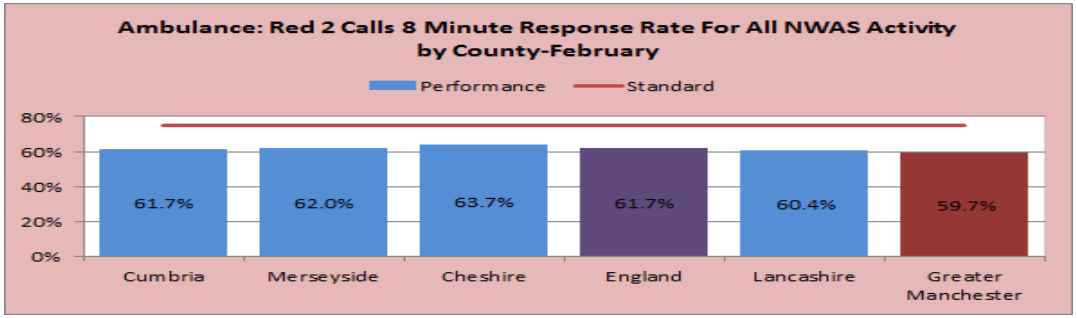
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



February Performance: 56.91%

15/16 ytd: 71.57%

16/17 ytd: 62.60%

Key Risks and Issues:

In February the north west position (which we are measured against) was 56.91% however locally we achieved 60.96% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
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Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. Contract penalties applied by lead commissioner (Blackpool CCG).

Ambulance: Red 2 Calls 8 Minute Response Rate For All NWAS Activity by CCG

	Feb-17			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS South Manchester CCG	748	1066	70.1%	75%
NHS North Manchester CCG	992	1548	64.1%	75%
NHS Central Manchester CCG	629	981	64.1%	75%
NHS Heywood Middleton & Rochdale CCG	742	1244	59.6%	75%
NHS Wigan Borough CCG	976	1614	60.5%	75%
NHS Bury CCG	609	1014	60.1%	75%
NHS Tameside and Glossop CCG	814	1430	56.9%	75%
NHS Salford CCG	779	1363	57.1%	75%
NHS Stockport CCG	794	1407	56.4%	75%
NHS Oldham CCG	819	1395	58.7%	75%
NHS Bolton CCG	792	1366	58.0%	75%
NHS Trafford CCG	566	1077	52.5%	75%

Unvalidated next month FORECAST

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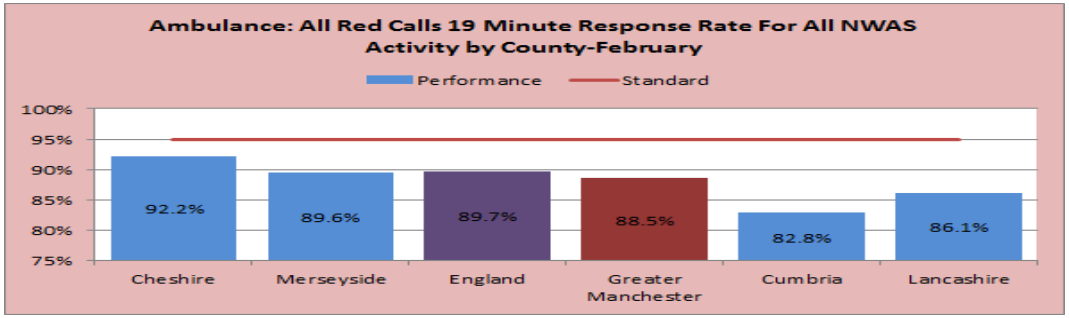
Ambulance performance- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: A&E Delivery Board**



Ambulance: All Red Calls 19 Minute Response Rate For All NWAS Activity by CCG

	Feb-17			
CCG	**<19 Mins**	**Total**	**Performance**	**Standard**
NHS South Manchester CCG	1031	1124	91.7%	95%
NHS Central Manchester CCG	937	1052	89.1%	95%
NHS Stockport CCG	1357	1499	90.5%	95%
NHS North Manchester CCG	1453	1653	87.9%	95%
NHS Salford CCG	1311	1462	89.6%	95%
NHS Trafford CCG	991	1155	85.8%	95%
NHS Oldham CCG	1324	1482	89.3%	95%
NHS Wigan Borough CCG	1525	1725	88.4%	95%
NHS Tameside and Glossop CCG	1360	1539	88.4%	95%
NHS Bolton CCG	1312	1465	89.6%	95%
NHS Heywood Middleton & Rochdale CCG	1138	1331	85.5%	95%
NHS Bury CCG	921	1076	85.6%	95%

February Performance: 88.38%

15/16 ytd: 93.19%

16/17 ytd: 88.93%

Key Risks and Issues:

In February the north west position (which we are measured against) was 88.38% however locally we only achieved 88.38% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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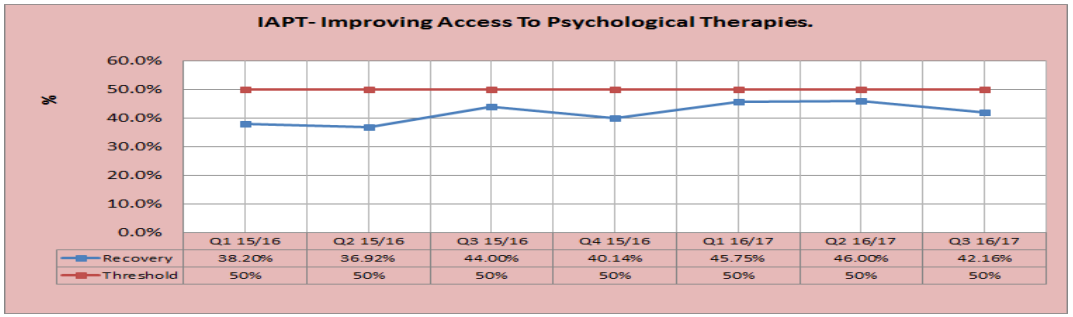
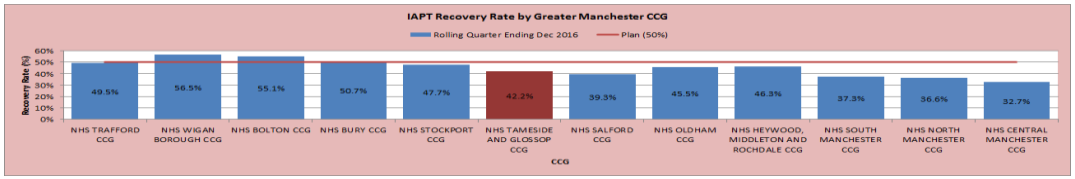
Improving Access To Psychological Therapies (IAPT)- **Lead Officer: Pat McKelvey** **Lead Director:** Clare Watson **Governance: Contracts**



	IAPT Recovery Rate	
Greater Manchester CCG	**Rolling Quarter Ending Dec 2016**	**Plan (50%)**
NHS TRAFFORD CCG	49.49%	50.00%
NHS WIGAN BOROUGH CCG	56.54%	50.00%
NHS BOLTON CCG	55.15%	50.00%
NHS BURY CCG	50.71%	50.00%
NHS STOCKPORT CCG	47.66%	50.00%
NHS TAMESIDE AND GLOSSOP CCG	42.16%	50.00%
NHS SALFORD CCG	39.33%	50.00%
NHS OLDHAM CCG	45.53%	50.00%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	46.34%	50.00%
NHS SOUTH MANCHESTER CCG	37.25%	50.00%
NHS NORTH MANCHESTER CCG	36.56%	50.00%
NHS CENTRAL MANCHESTER CCG	32.65%	50.00%



Key Risks and Issues:
Recovery.
A drop in October brought down Q3 overal. Provider reported Q4 position show trajectory has recovered.

Actions:
Recovery.
A range of improvement measure are having an impact. Monthly monitoring meetings are in place.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. Information is awaited from provider regarding growth required to meet the standards in 2017/18 and going forward.

Unvalidated next QTR FORECAST

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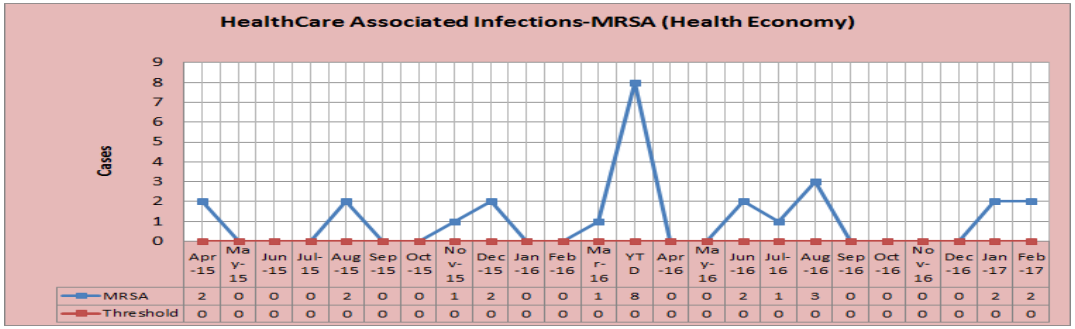
MRSA- **Lead Officer: Lynn Jackson** **Lead Director:** Gill Gibson **Governance: Contracts**



Key Risks and Issues:

There were 2 reported cases in February.
T&G CCG have reported 10 cases of MRSA; 6 acute cases (2 at T&G ICFT, 3 at Central Manchester, 1 at South Manchester FT) and 5 non acute cases, against a plan of zero tolerance.
The PIR (Post Incident Review) investigations, for all cases that T&G CCG are responsible for, were reviewed by the HCAI WHE Quality Improvement Group and confirmed that all cases were unavoidable with no lapses in care identified.

Actions:
Investigations have been completed for all cases that the CCG are responsible for; all have been reviewed by the HCAI WHE Quality Improvement Group and concluded that all cases were unavoidable with no lapses in care identified.

The MRSA case for T&G CCG was on the 25th Jan 2017. Early findings from the PIR investigation show no lapses in care identified; this will reviewed for assurance at the HCAI quality improvement group.
Learning from MRSA and CDIF investigations form the WHE HACI action plan which aims to achieve the WHE strategic objectives of 1) to improve antibiotic stewardship and 2) to improve infection prevention practice.

The CCG has also commissioned a 2 year quality initiative with T&G ICFT which aims to supporting residential and care homes with nursing to improve their infection prevention practice and reduce avoidable HCAIs.
The CCG also reviews monthly HCAI Quality Assurance Framework submitted by providers as part of the contracting process.

Operational and Financial implications:
The CCG can Levey penalties through contract with those providers who fail the target.

Next month FORECAST

Greater Manchester CCGs MRSA

Organisation Name	Code	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Total
NHS BOLTON CCG	00T	0	1	0	2	3	1	3	1	1	3	0	**15**
NHS TAMESIDE AND GLOSSOP CCG	01Y	0	0	2	1	3	0	0	0	0	2	2	**10**
NHS NORTH MANCHESTER CCG	01M	1	2	0	0	0	1	0	2	0	0	0	**6**
NHS CENTRAL MANCHESTER CCG	00W	0	0	0	0	0	0	0	1	1	1	1	**4**
NHS OLDHAM CCG	00Y	1	0	0	0	1	1	0	1	0	0	0	**4**
NHS SALFORD CCG	01G	1	0	0	2	0	0	1	0	0	0	0	**4**
NHS STOCKPORT CCG	01W	1	1	1	0	0	0	0	0	1	0	0	**4**
NHS WIGAN BOROUGH CCG	02H	0	0	0	0	0	0	0	1	1	1	0	**3**
NHS SOUTH MANCHESTER CCG	01N	1	0	0	0	0	0	0	0	1	0	0	**2**
NHS TRAFFORD CCG	02A	0	0	0	0	0	0	0	1	0	1	0	**2**
NHS BURY CCG	00V	0	0	1	0	0	0	0	0	0	0	0	**1**
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	01D	0	0	0	0	0	0	0	0	0	1	0	**1**
Total		**5**	**4**	**4**	**5**	**7**	**3**	**4**	**7**	**5**	**9**	**3**	**56**

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111- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: Contracts**

Indicators - access & quality		NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
Calls per month per 1,000 people		21.7	22	Isle of Wight	38.6	East London and City	11.8
Calls per month via 111 per 1,000 people		21.7	21	Isle of Wight	38.4	East London and City	11.8
Of all calls offered, % abandoned after at least 30 seconds[1]		6%	1	NW inc. Blackpool	6%	South East London	0%
Of calls answered, % in 60 seconds		79%	42	South East London	97%	NW inc. Blackpool	79%
Of calls answered, % triaged		89%	17	Luton	122%	East London and City	68%
Of answered calls, % transferred to clinical advisor		21%	32	South East Coast	41%	Bedfordshire	14%
Of transferred calls, % live transferred		44%	13	Isle of Wight	97%	York & Humber	15%
Average NHS 111 live transfer time[1]		00:00:06					
Average warm transfer time		NCA					
Of calls answered, % passed for call back		12%	30	Devon	21%	Isle of Wight	1%
Of call backs, % within 10 minutes		37%	21	Cambridge and Peterborough	73%	North Central London	10%
Average episode length		00:15:48					
Of answered calls, % calls to a CAS clinician		21%	35	North Central London	57%	Bedfordshire	14%

Dispositions as a proportion of all calls triaged	T&G CCG	NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
111 dispositions: % Ambulance dispatches	16%	14%	7	Cornwall	18%	South Essex	9%
111 dispositions: % Recommended to attend A&E	8%	8%	29	East London and City	14%	Leicestershire and Rutland	4%
Recommended to attend primary and community care	57%	57%	35	Berkshire	67%	North Central London	52%
Of which - % Recommended to contact primary and community care		43%	20	Banes & Wiltshire	47%	Nottinghamshire	35%
- % Recommended to speak to primary and community care		12%	24	Cambridge and Peterborough	19%	Outer North East London	5%
- % Recommended to dental / pharmacy		2%	41	York & Humber	11%	Devon	1%
111 dispositions: % Recommended to attend other service	2%	2%	31	Leicestershire and Rutland	10%	Banes & Wiltshire	1%
111 dispositions: % Not recommended to attend other service	18%	18%	6	Inner North West London	20%	Mainland SHIP	8%
Of which - % Given health information		4%	1	NW inc. Blackpool	4%	Staffordshire	0%
- % Recommended home care		4%	40	East London and City	8%	Nottinghamshire	4%
- % Recommended non clinical		10%	11	York & Humber	13%	Cambridge and Peterborough	2%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Feb:
- Calls Answered (95% in 60 seconds) = 79.46%
- Calls abandoned (<5%) = 6.18%
- Warm transfer (75%) = 29.33%
Call back in 10 minutes (75%) = 37.09%

In February the NW NHS 111 service experienced a number of issues which lead to poor performance in the month against the four KPIs. Performance was particularly difficult to achieve over the weekend periods.

Actions:

NWAS has agreed a further remedial action plan with commissioners.
NWAS has continued to deploy all available staff, and is actively managing staff absence and attrition in order to best meet the service needs.
A range of process changes are being implemented this includes patients using telephone key pads to identify the most appropriate call handler e.g. call regarding children automatically go to a nurse and issues such as coughs and colds receive self care and advise.
Greater Manchester is working with NWAS and Out Of Hours providers to implement the clinical assessment service that will help ensure A&E and primary care dispositions are correct.

Operational and Financial implications:

Poor patient experience could impact on willingness to use the service and increase A&E and primary care presentations.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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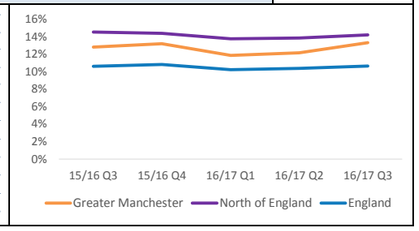
Better Health

Fewer GM Babies Will Have a Low Birth Weight Resulting in Better Outcomes For The Baby & Less Costs To The Health System

Maternal Smoking at Delivery

Better Is **Lower**

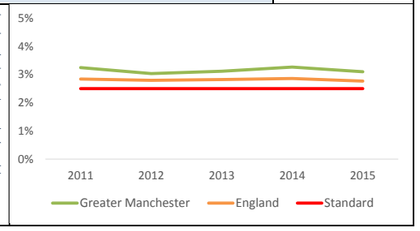
Central	6.6%
Trafford	7.4%
Bury	10.9%
Stockport	11.2%
Bolton	13.9%
Oldham	14.2%
Salford	15.0%
South	15.2%
T&G	15.3%
Wigan	15.9%
North	16.6%
HMR	16.8%



Low Birth Weight of Term Babies

Better Is **Lower**

Stockport	2.2%
Bury	2.5%
Rochdale	2.9%
Salford	2.9%
Trafford	2.9%
Wigan	3.1%
Bolton	3.2%
Mancheste	3.3%
Oldham	3.5%
Tameside	4.1%

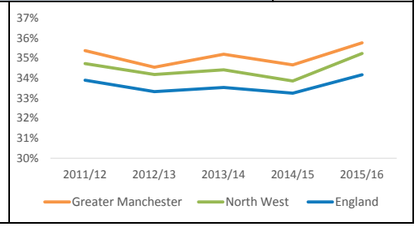


More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally

Children Aged 10-11 Classified as Overweight or Obese

Better Is **Lower**

Stockport	30.3%
Trafford	30.9%
Tameside	33.9%
Bury	34.5%
Bolton	35.4%
Wigan	35.7%
Rochdale	35.7%
Oldham	36.7%
Salford	39.6%
Mancheste	40.2%

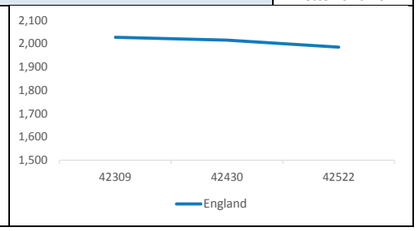


More People Will Be Supported To Stay Well and Live at Home for as Long as Possible

Injuries From Falls in People Aged 65 and Over

Better Is **Lower**

Bolton	1,610
Bury	1,910
Central	2,821
HMR	2,326
North	2,899
Oldham	2,375
Salford	3,328
South	2,743
Stockport	2,563
T&G	2,159
Trafford	2,175
Wigan	2,776

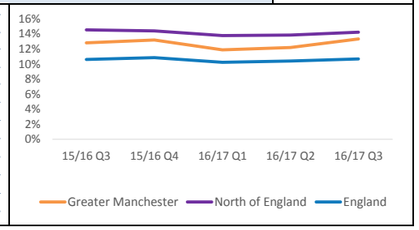


Fewer People Will Die Early From: Cardio-Vascular (CVD); Cancer; and Respiratory Disease

Maternal Smoking at Delivery

Better Is **Lower**

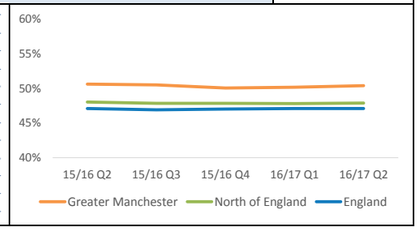
Central	6.6%
Trafford	7.4%
Bury	10.9%
Stockport	11.2%
Bolton	13.9%
Oldham	14.2%
Salford	15.0%
South	15.2%
T&G	15.3%
Wigan	15.9%
North	16.6%
HMR	16.8%



Percentage Of Deaths Which Take Place In Hospital

Better Is **Lower**

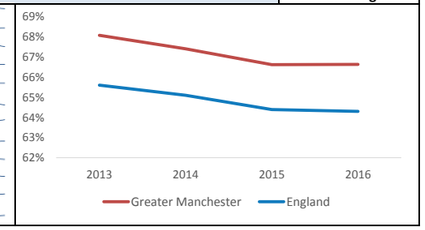
Bury	45.8%
HMR	46.2%
Oldham	47.4%
Bolton	47.5%
Stockport	49.8%
Salford	50.1%
T&G	50.4%
North	52.1%
Wigan	52.5%
South	54.7%
Central	56.1%
Trafford	56.4%



People With a Long-Term Condition Feeling Supported to Manage Their Condition(s)

Better Is **Higher**

Stockport	66.2%
Wigan	65.4%
Trafford	64.9%
Bolton	66.2%
Salford	65.7%
HMR	59.4%
South	66.0%
Central	60.9%
T&G	61.4%
Bury	63.1%
Oldham	65.4%
North	59.8%

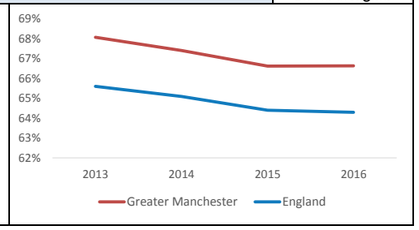


Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

People With a Long-Term Condition Feeling Supported to Manage Their Condition(s)

Better Is **Higher**

Stockport	66.2%
Wigan	65.4%
Trafford	64.9%
Bolton	66.2%
Salford	65.7%
HMR	59.4%
South	66.0%
Central	60.9%
T&G	61.4%
Bury	63.1%
Oldham	65.4%
North	59.8%

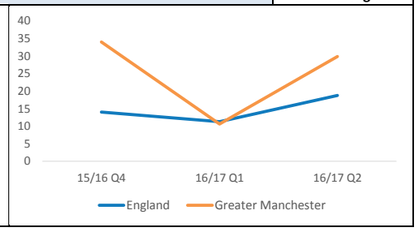


(Placeholder TBC)

Personal Health Budgets Per 100,000 Population

Better Is **Higher**

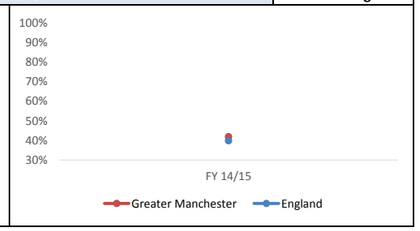
HMR	222
Trafford	25
North	24
Central	24
South	24
Wigan	20
Bury	17
Stockport	8
T&G	7
Bolton	7
Oldham	4
Salford	0



Diabetes Patients That Have Achieved All The NICE-Recommended Treatment Targets: Three (Hba1C, Cholesterol And Blood Pressure) For Adults And One (Hba1C) For Children

Better Is **Higher**

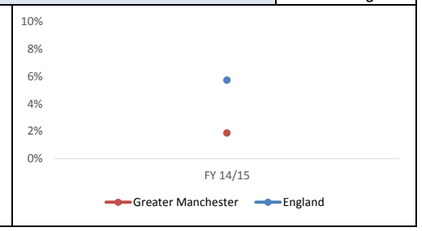
Wigan	48.0%
T&G	46.8%
Stockport	46.6%
Salford	44.0%
Trafford	42.5%
South	41.6%
Bolton	38.7%
Oldham	38.2%
North	38.1%
Central	32.7%
Bury	0.0%
HMR	0.0%



People With Diabetes Diagnosed Less Than A Year Who Attend A Structured Education Course

Better Is **Higher**

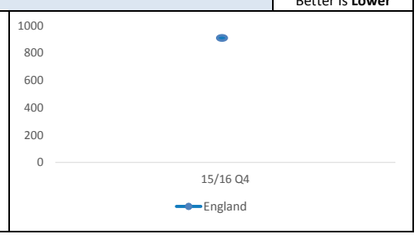
Wigan	5.7%
Trafford	3.4%
North	2.5%
Stockport	1.6%
Salford	1.0%
Oldham	0.8%
South	0.6%
Bolton	0.1%
T&G	0.0%
Bury	0.0%
Bury	0.0%
HMR	0.0%



Inequality In Unplanned Hospitalisation For Chronic Ambulatory Care Sensitive Conditions

Better Is **Lower**

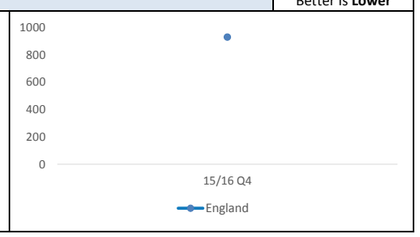
Bury	1,837
Trafford	1,939
Oldham	2,354
Bolton	2,418
HMR	2,479
Wigan	2,762
T&G	3,144
Salford	3,156
Central	3,409
South	3,422
North	3,583
Stockport	3,735



Inequality In Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

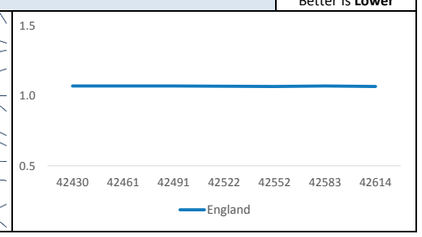
Bury	904
Wigan	1,048
Oldham	1,057
Bolton	1,103
Trafford	1,126
HMR	1,185
Salford	1,386
Stockport	1,422
T&G	1,475
North	1,700
Central	1,834
South	1,922



Anti-Microbial Resistance: Appropriate Prescribing Of Antibiotics In Primary Care

Better Is **Lower**

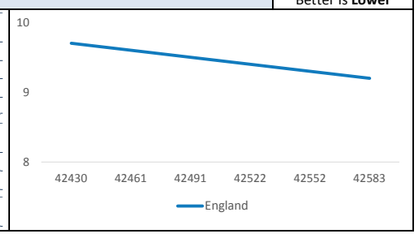
Central	1.1
Trafford	1.1
T&G	1.1
Wigan	1.1
Bury	1.2
South	1.2
Stockport	1.2
Salford	1.2
Bolton	1.2
North	1.3
HMR	1.3
Oldham	1.4



Anti-Microbial Resistance: Appropriate Prescribing Of Broad Spectrum Antibiotics In Primary Care

Better Is **Lower**

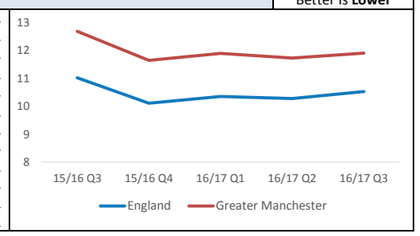
Stockport	5.0
Bury	6.0
T&G	7.7
North	7.8
South	7.9
HMR	7.9
Central	8.0
Wigan	8.1
Bolton	8.2
Oldham	9.0
Salford	9.7
Trafford	12.2



Prescribing Costs per ASTRO-PU

Better Is **Lower**

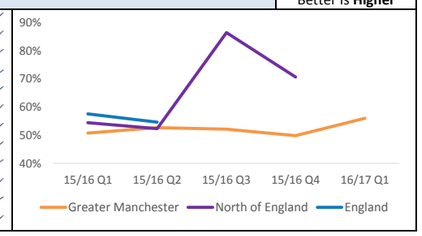
Bury	9.8
Stockport	10.4
Trafford	11.3
Central	11.3
Salford	11.4
Bolton	11.5
HMR	12.1
Wigan	12.2
South	12.3
T&G	12.5
Oldham	12.8
North	13.6



Bowel Screening Uptake Aged 60-74

Better Is **Higher**

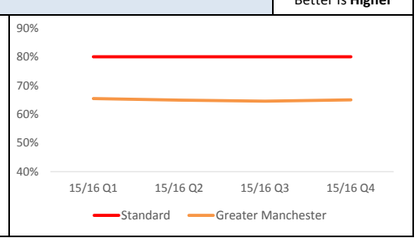
Oldham	60.8%
Bury	60.3%
Wigan	58.2%
Stockport	57.4%
Bolton	57.0%
HMR	56.9%
Trafford	56.5%
T&G	56.4%
Salford	54.1%
North	48.2%
South	46.1%
Central	42.9%



Breast Screening Coverage Aged 50-70

Better Is **Higher**

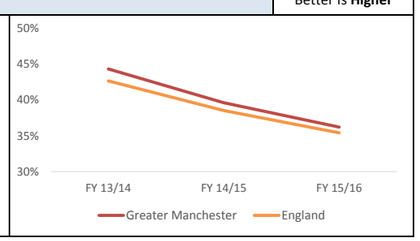
Bury	72.7%
Bolton	71.5%
Wigan	71.0%
Stockport	70.3%
HMR	69.2%
Oldham	68.7%
Trafford	67.0%
T&G	63.9%
South	59.4%
Salford	58.4%
North	58.4%
Central	50.1%



Flu Immunised 2 Year Olds

Better Is **Higher**

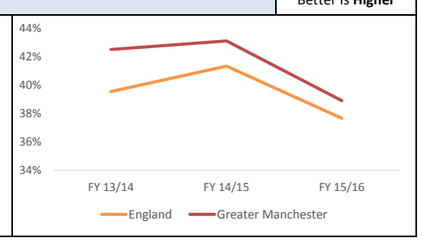
Trafford	49.1%
Stockport	41.2%
T&G	40.0%
Wigan	38.8%
HMR	36.9%
Bury	35.7%
Oldham	34.7%
Central	32.8%
North	32.6%
Bolton	32.4%
Salford	32.3%
South	25.2%



Flu Immunised 3 Year Olds

Better Is **Higher**

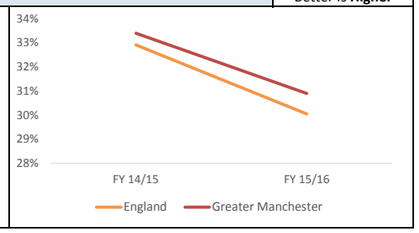
Trafford	47.6%
Stockport	46.8%
T&G	42.4%
Wigan	41.3%
Oldham	40.0%
Bury	39.6%
HMR	39.3%
Central	35.4%
North	34.8%
Bolton	34.1%
Salford	32.3%
South	29.9%



Flu Immunised 4 Year Olds

Better Is **Higher**

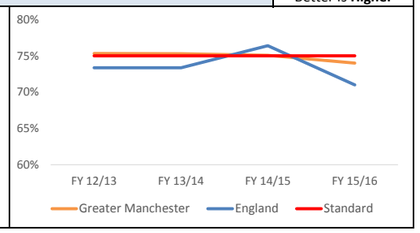
Trafford	41.8%
Stockport	37.1%
T&G	32.1%
Wigan	32.7%
Oldham	31.1%
Bury	28.6%
HMR	32.3%
Central	27.4%
North	28.0%
Bolton	27.2%
Salford	28.3%
South	20.2%



Flu Immunised aged 65 and over

Better Is **Higher**

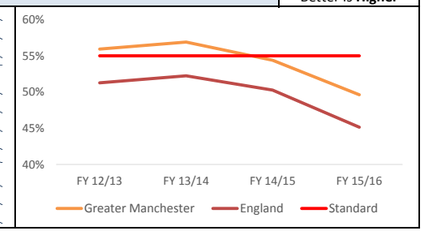
Trafford	77.4%
Stockport	76.8%
Bury	75.1%
T&G	75.0%
HMR	74.6%
Salford	73.8%
Bolton	73.3%
Oldham	73.2%
Wigan	72.0%
North	70.6%
Central	70.4%
South	69.2%



Flu Immunised in clinical risk groups

Better Is **Higher**

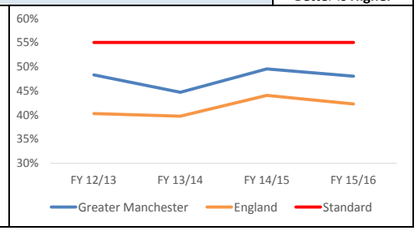
Stockport	56.5%
HMR	54.1%
T&G	52.8%
Trafford	51.7%
Oldham	49.6%
Bolton	49.6%
North	49.2%
Central	48.1%
Bury	47.9%
South	46.3%
Wigan	45.2%
Salford	42.8%



Flu Immunised in pregnant women

Better Is **Higher**

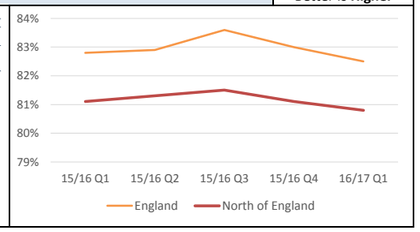
Stockport	63.7%
T&G	52.3%
Oldham	50.6%
HMR	50.4%
Trafford	50.3%
Bury	48.3%
South	47.1%
Bolton	46.1%
Wigan	45.4%
Central	44.1%
North	41.7%
Salford	37.7%



Diabetic Eye Screening

Better Is **Higher**

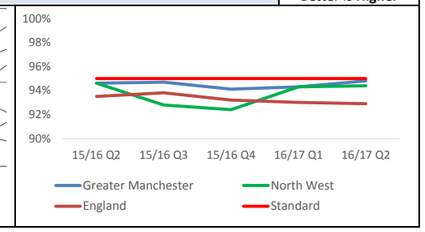
Bolton	85.0%
Wigan	89.9%
North East	79.9%
South Man	77.9%



Diphtheria, Tetanus, Polio, Pertussis, Hib (DTaP/IPV/Hib) 12 months

Better Is **Higher**

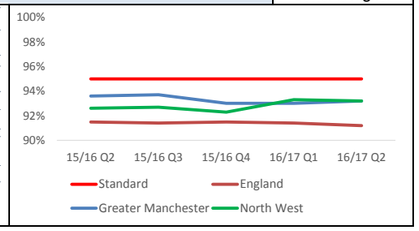
Wigan	97.4%
T&G	97.3%
Trafford	96.8%
Oldham	96.6%
Bolton	96.5%
Salford	95.7%
HMR	95.6%
Bury	94.7%
Stockport	94.4%



Mumps, Measles & Rubella (MMR)

Better Is **Higher**

T&G	97.3%
HMR	95.8%
Salford	95.2%
Wigan	95.1%
Trafford	94.7%
Bolton	94.6%
Oldham	94.4%
Stockport	93.5%
Bury	90.8%
Manchester	87.8%



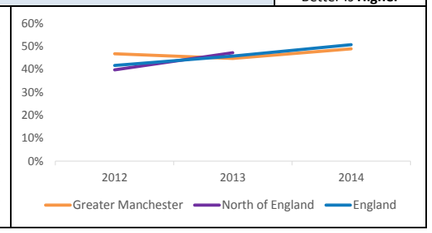
Better Care

Fewer People Will Die Early From: Cardio-Vascular (CVD); Cancer; and Respiratory Disease

Cancers Diagnosed at Early Stage

Better Is **Higher**

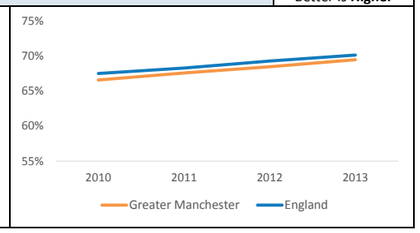
Bury	53.7%
Wigan	51.7%
Bolton	51.5%
Stockport	50.8%
HMR	50.1%
Oldham	49.4%
North	48.2%
Trafford	47.3%
South	47.2%
Salford	46.3%
T&G	44.2%
Central	37.4%



One-Year Survival From All Cancers

Better Is **Higher**

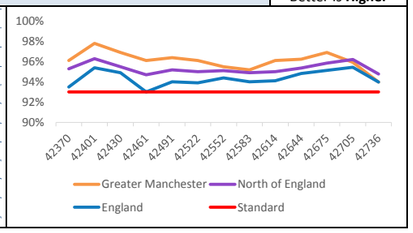
Stockport	72.3%
Trafford	72.0%
Bury	70.7%
Central	70.1%
South	69.9%
Wigan	69.5%
Bolton	69.2%
HMR	69.1%
Salford	68.8%
Oldham	67.9%
T&G	67.6%
North	66.9%



Cancer - Two week wait from cancer referral to specialist appointment

Better Is **Higher**

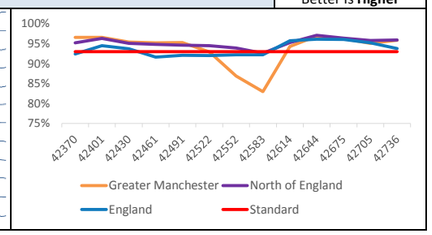
Wigan	99.3%
Bolton	98.5%
Stockport	97.5%
South	95.5%
Trafford	94.8%
T&G	94.4%
Salford	92.0%
HMR	91.3%
Bury	90.8%
Central	90.5%
Oldham	90.3%
North	86.7%



Cancer - Two week wait (breast symptoms - cancer not suspected)

Better Is **Higher**

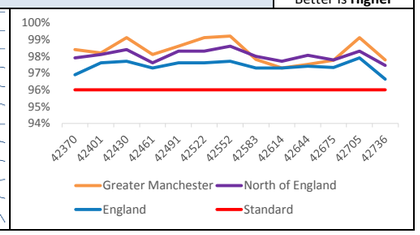
South	100.0%
T&G	100.0%
Bolton	96.9%
North	96.8%
Bury	96.0%
Salford	95.8%
Trafford	95.8%
Wigan	95.2%
Stockport	94.8%
Oldham	94.4%
Central	92.3%
HMR	91.7%



Cancer - 31-day wait from decision to treat to first treatment

Better Is **Higher**

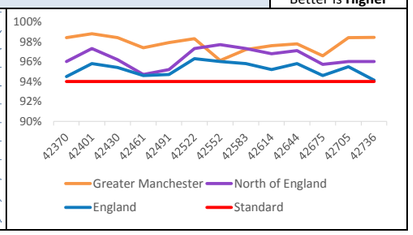
North	100.0%
South	100.0%
Bolton	100.0%
T&G	98.9%
Salford	98.1%
Wigan	97.6%
HMR	97.6%
Trafford	97.5%
Oldham	97.3%
Bury	97.1%
Stockport	96.7%
Central	89.5%



Cancer - 31-day wait for subsequent surgery

Better Is **Higher**

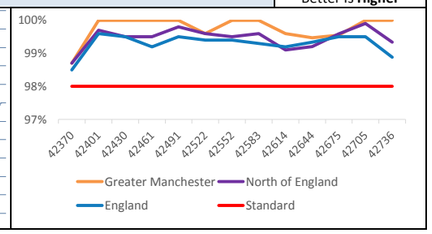
T&G	100.0%
South	100.0%
Salford	100.0%
Bury	100.0%
Stockport	100.0%
Central	100.0%
Trafford	100.0%
Bolton	100.0%
Oldham	100.0%
Wigan	96.0%
North	90.0%
HMR	85.7%



Cancer - 31-day wait for subsequent anti-cancer drug regimen

Better Is **Higher**

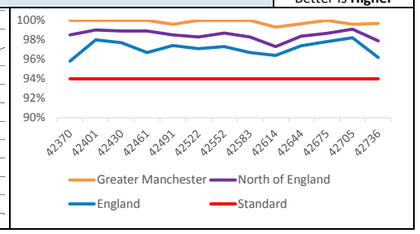
South	100.0%
Wigan	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	100.0%
Bolton	100.0%
Oldham	100.0%



Cancer - 31-day wait for subsequent radiotherapy

Better Is **Higher**

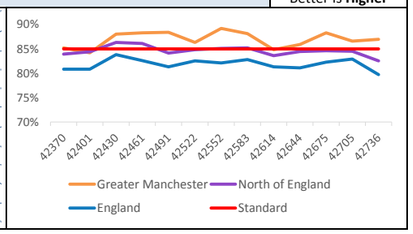
South	100.0%
Bolton	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	100.0%
Oldham	100.0%
Wigan	97.9%



Cancer - 62-day wait from referral to treatment

Better Is **Higher**

Bolton	97.9%
Wigan	93.8%
T&G	89.4%
Oldham	89.2%
Stockport	88.9%
Trafford	87.2%
Bury	84.6%
Salford	80.0%
South	80.0%
HMR	79.1%
Central	77.8%
North	77.8%

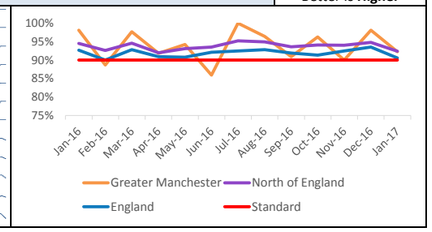


Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

Cancer - 62-day wait for treatment following a referral from a screening service

Better Is **Higher**

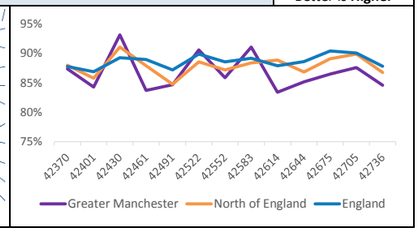
Trafford	100.0%
Stockport	100.0%
South	100.0%
Central	100.0%
T&G	100.0%
North	100.0%
Wigan	100.0%
Salford	88.9%
Bolton	88.2%
Bury	83.3%
Oldham	80.0%
HMR	66.7%



Cancer - 62-day wait for treatment following a consultant upgrade

Better Is **Higher**

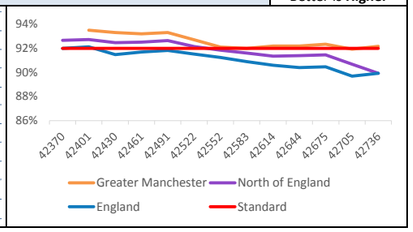
South	100.0%
Central	100.0%
Trafford	92.9%
Wigan	89.3%
Stockport	85.7%
Bolton	85.0%
Salford	84.2%
Bury	77.8%
T&G	75.0%
HMR	66.7%
North	66.7%
Oldham	62.5%



Referral to Treatment - 18 weeks

Better Is **Higher**

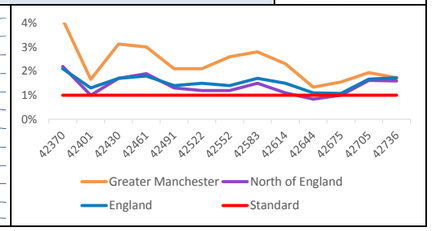
Wigan	94.5%
Oldham	93.3%
Salford	93.4%
Bury	92.9%
HMR	92.1%
T&G	93.0%
Bolton	92.2%
Stockport	92.5%
Central	91.8%
North	91.6%
Trafford	89.1%
South	87.4%



Diagnostics Test Waiting Times

Better Is **Lower**

Wigan	1.1%
Stockport	1.2%
Salford	1.2%
Bolton	1.3%
HMR	1.3%
Trafford	1.4%
South	1.5%
Oldham	1.6%
Bury	1.8%
T&G	1.9%
North	2.3%
Central	5.9%



Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

Primary Care Access (Placeholder)

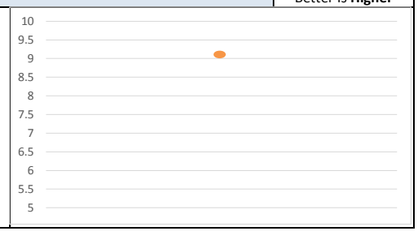
Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Cancer Patient Experience

Better Is **Higher**

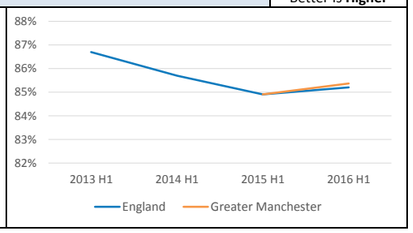
Bolton	8.8
Bury	8.7
Central	8.6
HMR	8.8
North	8.7
Oldham	8.7
Salford	9.0
South	8.7
Stockport	8.7
T&G	8.7
Trafford	8.6
Wigan	8.8



Patient Experience Of GP Services

Better Is **Higher**

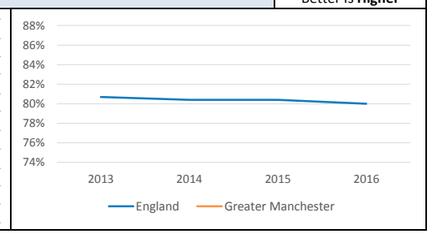
Bolton	87.2%
Bury	86.9%
Central	81.8%
HMR	82.3%
North	81.5%
Oldham	84.7%
Salford	85.3%
South	84.0%
Stockport	88.9%
T&G	83.2%
Trafford	86.5%
Wigan	88.2%



Quality Of Life Of Carers - Health Status Score (EQ5D)

Better Is **Higher**

Trafford	79.0%
Bury	77.8%
Wigan	77.0%
Stockport	81.1%
Bolton	76.7%
South	79.9%
Central	77.2%
Oldham	77.3%
North	75.6%
HMR	76.5%
Salford	78.2%
T&G	77.5%

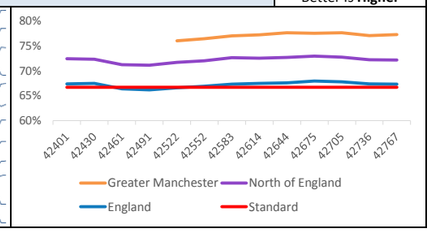


Improved Outcomes For People With Learning Disabilities/Mental Health Needs

Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

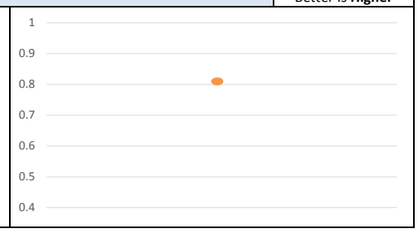
North	98.3%
Central	91.1%
Salford	86.1%
Bury	85.3%
Oldham	81.9%
Bolton	80.0%
T&G	75.3%
South	73.4%
Stockport	74.0%
Trafford	72.0%
Wigan	68.3%
HMR	66.9%



Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

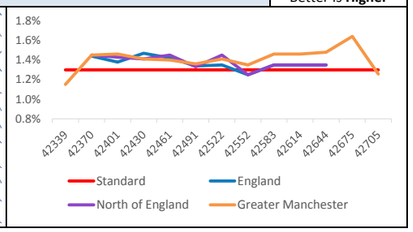
Bolton	83.4%
Bury	84.3%
Central	84.8%
HMR	77.5%
North	81.4%
Oldham	77.0%
Salford	79.0%
South	79.1%
Stockport	80.5%
T&G	80.6%
Trafford	80.2%
Wigan	77.3%



Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

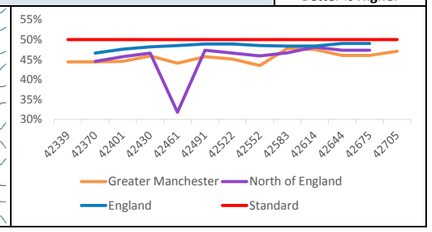
Oldham	2.03%
Salford	1.62%
T&G	1.38%
Wigan	1.20%
Bury	1.19%
Stockport	1.18%
Trafford	1.11%
Central	1.02%
HMR	1.00%
South	0.96%
North	0.89%
Bolton	0.80%



Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

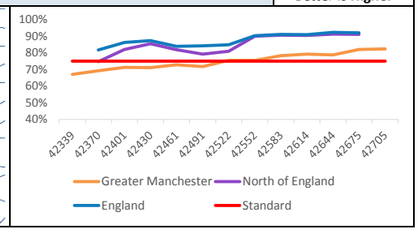
Wigan	60.2%
Bolton	57.9%
Trafford	51.9%
Oldham	51.5%
Bury	51.2%
HMR	48.6%
T&G	47.1%
Stockport	42.5%
North	40.6%
Salford	38.2%
Central	31.6%
South	31.4%



Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

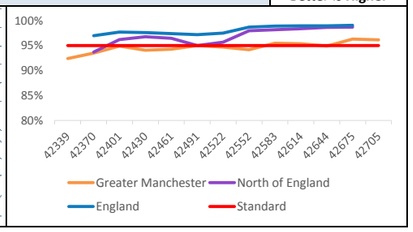
Wigan	100.0%
Oldham	94.1%
HMR	89.5%
Stockport	90.7%
Bury	84.1%
Salford	86.7%
Trafford	86.2%
T&G	82.4%
Bolton	80.5%
North	66.7%
South	48.6%
Central	52.5%



Improving Access to Psychological Therapies Seen Within 18 Weeks

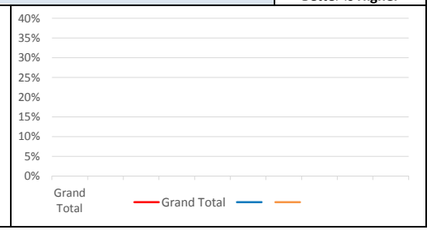
Better Is **Higher**

Wigan	100.0%
T&G	100.0%
Bury	100.0%
Oldham	100.0%
Salford	98.3%
Stockport	97.7%
Bolton	97.6%
HMR	97.4%
Trafford	96.6%
North	90.9%
Central	90.0%
South	78.4%



People with 1st Episode of Psychosis Starting Treatment With a NICE-Recommended Package of Care Treated Within 2 Weeks of Referral

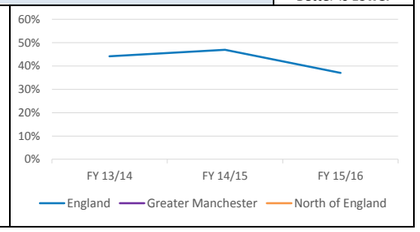
Better Is **Higher**



Proportion of People With a Learning Disability on the GP Register Receiving an Annual Health Check

Better Is **Lower**

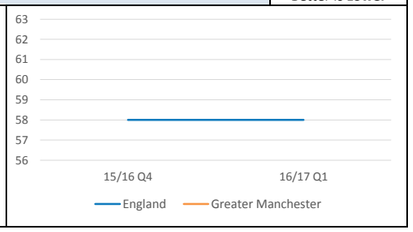
Bolton	64.1%
Bury	47.4%
Central	14.8%
HMR	28.8%
North	40.6%
Oldham	38.7%
Salford	23.1%
South	19.9%
Stockport	27.4%
T&G	41.4%
Trafford	31.9%
Wigan	41.2%



Reliance on Specialist Inpatient Care for People With a Learning Disability and/or Autism

Better Is **Lower**

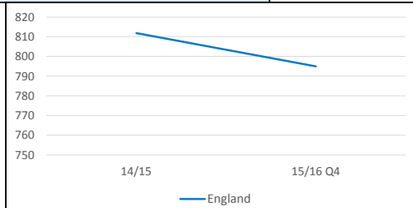
Bolton	63
Bury	63
Central	63
HMR	63
North	63
Oldham	63
Salford	63
South	63
Stockport	63
T&G	63
Trafford	63
Wigan	63



Management Of Long Term Conditions

Better Is **Higher**

Bolton	880
Bury	859
Central	1,536
HMR	1,151
North	1,563
Oldham	1,027
Salford	1,210
South	1,467
Stockport	1,100
T&G	1,279
Trafford	955
Wigan	919



Out Of Area Placements For Acute Mental Inpatient Care - Transformation

Better Is **Higher**

Bolton	100.0%
Bury	100.0%
Central	50.0%
HMR	25.0%
North	50.0%
Oldham	50.0%
Salford	100.0%
South	50.0%
Stockport	87.5%
T&G	100.0%
Trafford	50.0%
Wigan	50.0%

Children And Young People's Mental Health Services Transformation

Better Is **Higher**

Bolton	85.0%
Bury	85.0%
Central	80.0%
HMR	85.0%
North	70.0%
Oldham	90.0%
Salford	75.0%
South	70.0%
Stockport	0.0%
T&G	0.0%
Stockport	DQ Issue
Tamside	DQ Issue

Crisis Care And Liaison Mental Health Services Transformation

Better Is **Higher**

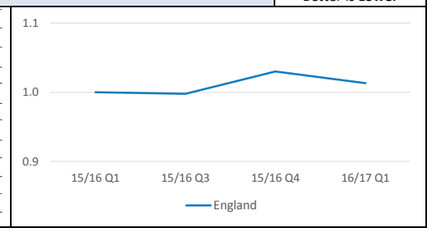
Bolton	87.5%
Bury	72.5%
Central	67.5%
HMR	70.0%
North	67.5%
Oldham	80.0%
Salford	97.5%
South	67.5%
Stockport	65.0%
T&G	80.0%
Trafford	82.5%
Wigan	60.0%

Decreased Need For Hospital Services With More Community Support

Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

Bolton	1.0
Bury	0.9
Central	1.4
HMR	0.9
North	1.2
Oldham	0.9
Salford	1.2
South	1.3
Stockport	1.2
T&G	1.2
Trafford	1.5
Wigan	0.9



Emergency Admissions For Urgent Care Sensitive Conditions

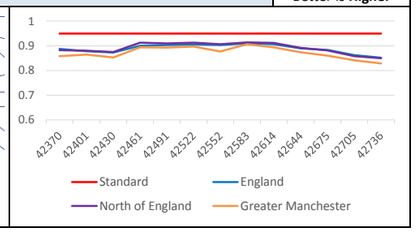
Better Is **Lower**

Bolton	2,523
Bury	2,229
Central	3,271
HMR	2,814
North	3,271
Oldham	2,753
Salford	3,503
South	3,234
Stockport	3,022
T&G	3,269
Trafford	2,336
Wigan	2,671

Percentage Of Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours

Better Is **Higher**

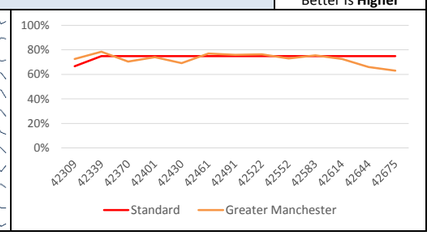
Bolton NHS	79.2%
Pennine Ac	76.7%
Salford Roy	76.7%
Stockport N	70.5%
Tameside N	76.7%
UHSM NHS	84.1%
WWL NHS	76.6%
CM NHS FT	88.9%



Ambulance in Red 1 in 8 mins

Better Is **Higher**

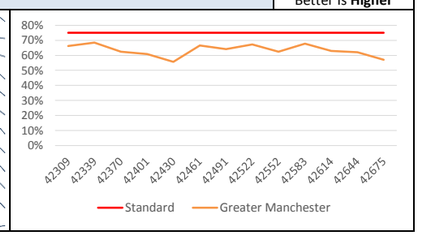
Bolton	65.2%
Bury	64.5%
Central	72.0%
HMR	50.6%
North	66.2%
Oldham	65.1%
Salford	61.6%
South	61.1%
Stockport	66.7%
T&G	60.4%
Trafford	49.2%
Wigan	67.3%



Ambulance in Red 2 in 8 mins

Better Is **Higher**

Bolton	58.7%
Bury	60.1%
Central	62.6%
HMR	55.2%
North	60.0%
Oldham	55.3%
Salford	54.3%
South	64.4%
Stockport	52.8%
T&G	54.8%
Trafford	49.6%
Wigan	58.6%

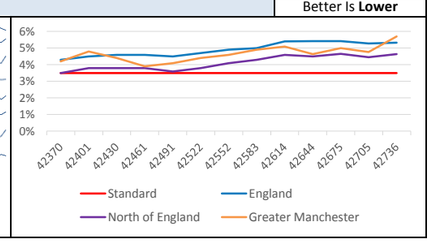


Improved Transition Of Care Across Health And Social Care

Delayed Transfers of Care - Bed Days

Better Is **Lower**

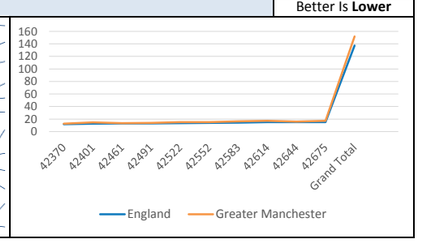
Bolton NHS	5.0%
Pennine Ac	2.0%
Salford Roy	11.9%
Stockport N	9.2%
Tameside N	9.6%
UHSM NHS	14.1%
WWL NHS	1.3%
CM NHS FT	3.3%



Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

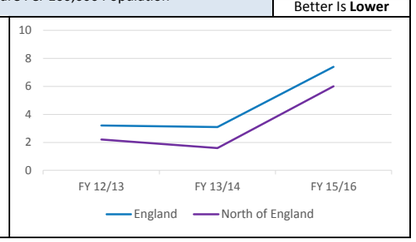
Bolton	16.1
Bury	11.3
Central	19.4
HMR	4.8
North	17.7
Oldham	8.4
Salford	12.2
South	16.7
Stockport	29.6
T&G	24.2
Trafford	37.7
Wigan	5.5



Delayed Transfers Of Care From Hospital, And Those Which Are Attributable To Adult Social Care Per 100,000 Population

Better Is **Lower**

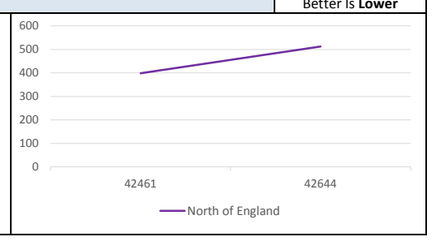
Bolton	4.4
Bury	5.5
Central	7.5
HMR	4.6
North	7.5
Oldham	2.3
Salford	4.2
South	7.5
Stockport	3.6
T&G	6.4
Trafford	14.5
Wigan	4.9



No Of Bed Days - Delayed Transfers Of Care Aged 18+ Per 100,000 Population

Better Is **Lower**

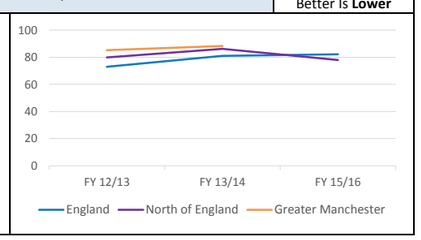
Bolton	496.0
Bury	297.0
Central	473.0
HMR	99.0
North	473.0
Oldham	214.0
Salford	175.0
South	473.0
Stockport	963.0
T&G	1065.0
Trafford	989.0
Wigan	178.0



Proportion Of People Using Social Care Who Receive Self-Directed Support, And Those Receiving Direct Payments

Better Is **Lower**

Bolton	97.2
Bury	85.9
Central	65.2
HMR	99.0
North	65.2
Oldham	96.0
Salford	77.7
South	65.2
Stockport	89.6
T&G	96.2
Trafford	49.1
Wigan	85.3



Long-Term Support Needs Met By Admission To Residential And Nursing Care Homes, Per 100,000 Population

Better Is **Lower**

Bolton	225.1
Bury	180.8
Central	70.8
HMR	170.6
North	70.8
Oldham	177.7
Salford	196.9
South	70.8
Stockport	193.0
T&G	123.8
Trafford	128.7
Wigan	190.8

Percentage Of People Aged 65+ Discharged Direct To Residential Care

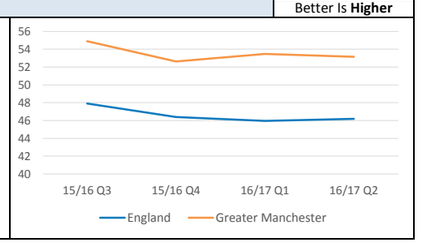
Better Is **Lower**

Bolton	1.9
Bury	1.6
Central	2.1
HMR	1.6
North	2.1
Oldham	2.9
Salford	3.6
South	2.1
Stockport	2.9
T&G	1.1
Trafford	1.8
Wigan	2.4

People Eligible For Standard NHS Continuing Healthcare

Better Is **Higher**

Bolton	59.3
Bury	27.4
Central	29.3
HMR	28.7
North	31.1
Oldham	23.3
Salford	121.8
South	72.9
Stockport	27.0
T&G	62.7
Trafford	56.9
Wigan	81.1

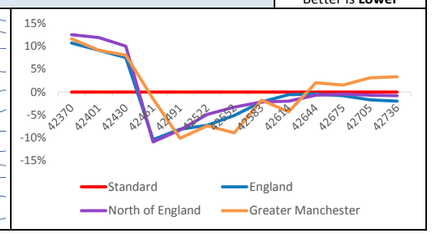


Placeholder TBC

C.Difficile (Ytd Var To Plan)

Better Is **Lower**

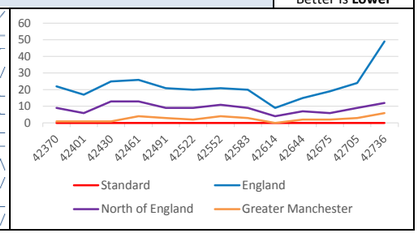
Trafford	-34.0%
Oldham	-26.0%
T&G	-17.1%
Bolton	-9.0%
Salford	-5.5%
South	7.7%
North	12.1%
HMR	17.1%
Bury	21.1%
Wigan	26.1%
Central	41.2%
Stockport	49.1%



MRSA

Better Is **Lower**

Bolton	2
Bury	0
Central	1
HMR	1
North	0
Oldham	0
Salford	0
South	0
Stockport	0
T&G	1
Trafford	0
Wigan	1



Achievement Of Milestones In The Delivery Of An Integrated Urgent Care Service

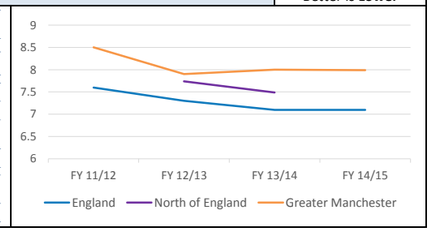
Better Is **Higher**

Bolton	4
Bury	4
Central	4
HMR	4
North	4
Oldham	4
Salford	4
South	4
Stockport	4
T&G	4
Trafford	4
Wigan	4

Neonatal Mortality And Stillbirths

Better Is **Lower**

Bolton	8.5
Bury	8.5
Central	9.3
HMR	7.3
North	10.3
Oldham	9.4
Salford	7.7
South	7.1
Stockport	6.8
T&G	7.8
Trafford	6.3
Wigan	7.1



Primary Care Workforce

Better Is **Higher**

Bolton	1.0
Bury	0.9
Central	0.8
HMR	0.9
North	0.8
Oldham	0.9
Salford	1.1
South	0.8
Stockport	0.9
T&G	1.0
Trafford	0.8
Wigan	0.9

Achievement Of Clinical Standards In The Delivery Of 7 Day Services (Placeholder)

Better Is **Higher**

Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

Choices In Maternity Services

Better Is **Higher**

Bolton	64.3%
Bury	69.7%
Central	63.0%
HMR	68.7%
North	68.7%
Oldham	65.3%
Salford	69.8%
South	67.8%
Stockport	65.0%
T&G	61.4%
Trafford	64.5%
Wigan	64.6%

People Offered Choice Of Provider And Team When Referred For A 1st Elective Appointment

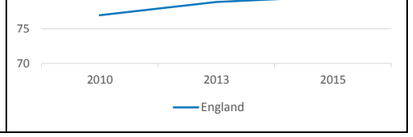
Better Is **Higher**

Bolton	99.1%
Bury	69.3%
Central	46.1%
HMR	60.3%
North	72.2%
Oldham	87.1%
Salford	97.7%
South	73.9%
Stockport	61.6%
T&G	10.4%
Trafford	66.3%
Wigan	56.8%

Women's Experience Of Maternity Services

Better Is **Higher**

Bolton	82.1
Bury	82.2
Central	74.3
HMR	77.6
North	82.3
Oldham	76.9
Salford	83.5
South	81.9
Stockport	82.5
T&G	77.6
Trafford	83.1
Wigan	80.5



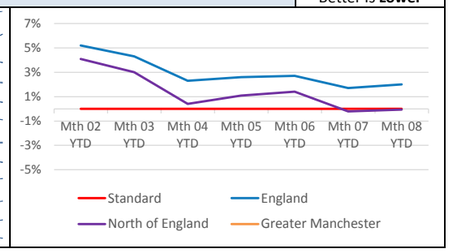
Sustainability

Reduced Demand for Reactive Health and Social Care Services and a Shift in Spend to Proactive Provision

Activity V Plan: Total Referrals (Specific Acute)

Better Is **Lower**

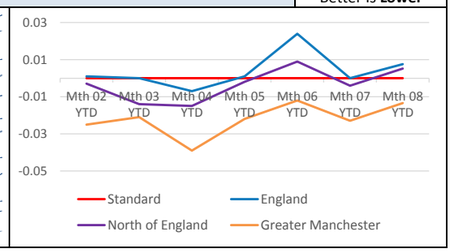
Bolton	14.1%
Bury	1.0%
Central	-6.4%
HMR	0.5%
North	-7.1%
Oldham	1.5%
Salford	-5.4%
South	-2.4%
Stockport	-3.0%
T&G	-5.4%
Trafford	-5.5%
Wigan	3.4%



Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

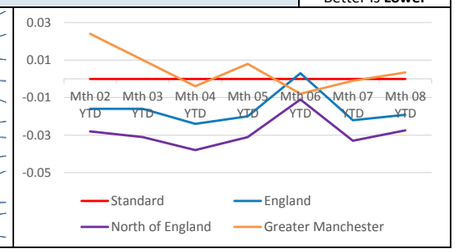
Bolton	3.5%
Bury	0.3%
Central	-4.0%
HMR	2.2%
North	1.0%
Oldham	-3.8%
Salford	3.2%
South	-5.2%
Stockport	-2.5%
T&G	-10.0%
Trafford	-5.9%
Wigan	6.8%



Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

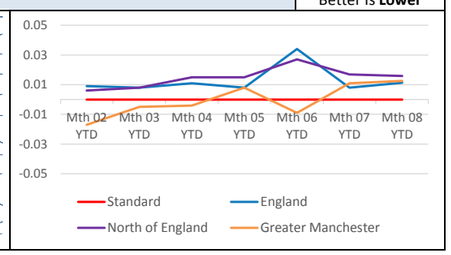
Bolton	6.1%
Bury	1.0%
Central	7.5%
HMR	-3.3%
North	-3.3%
Oldham	-5.1%
Salford	3.2%
South	1.6%
Stockport	5.8%
T&G	-13.1%
Trafford	3.2%
Wigan	2.0%



Activity V Plan: Non-Elective Spells Complete (Specific Acute)

Better Is **Lower**

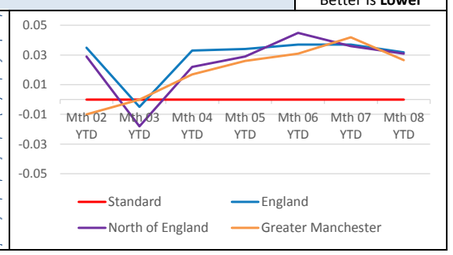
Bolton	1.9%
Bury	6.0%
Central	2.1%
HMR	4.3%
North	-1.5%
Oldham	-1.6%
Salford	3.3%
South	6.7%
Stockport	-2.6%
T&G	-5.5%
Trafford	-0.4%
Wigan	9.2%



Activity V Plan: Attendances At A&E (All Types)

Better Is **Lower**

Bolton	-1.8%
Bury	3.8%
Central	3.7%
HMR	0.7%
North	0.9%
Oldham	2.4%
Salford	3.8%
South	1.1%
Stockport	1.3%
T&G	1.5%
Trafford	3.0%
Wigan	-2.8%



Digital Interactions Between Primary And Secondary Care

Better Is **Higher**

Bolton	81.3%
Bury	70.0%
Central	56.0%
HMR	65.7%
North	67.7%
Oldham	71.5%
Salford	72.6%
South	69.1%
Stockport	66.0%
T&G	53.7%
Trafford	65.1%
Wigan	63.8%

Financial Plan 16/17

		In-Year Financial Performance 16/17 Q1	In-Year Financial Performance 16/17 Q2	-
				Better Is **Green**
Bolton	#REF!	Green	Green	◀▶
Bury	#REF!	Amber	Amber	◀▶
Central	#REF!	Green	Green	◀▶
HMR	#REF!	Green	Green	◀▶
North	#REF!	Green	Green	◀▶
Oldham	#REF!	Green	Green	◀▶
Salford	#REF!	Green	Green	◀▶
South	#REF!	Green	Green	◀▶
Stockport	#REF!	Red	Amber	▲
T&G	#REF!	Red	Amber	▲
Trafford	#REF!	Amber	Amber	◀▶
Wigan	#REF!	Amber	Amber	◀▶

Local Strategic Estates Plan (SEP) In Place

		-	-
		Better Is **Yes**	
Bolton	#REF!		
Bury	#REF!		
Central	#REF!		
HMR	#REF!		
North	#REF!		
Oldham	#REF!		
Salford	#REF!		
South	#REF!		
Stockport	#REF!		
T&G	#REF!		
Trafford	#REF!		
Wigan	#REF!		

Adoption Of New Models Of Care (Placeholder)

Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Local Digital Roadmap In Place (Placeholder)

Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Expenditure In Areas With Identified Score For Improvement (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Outcomes In Areas With Identified Scope For Improvement (Placeholder)

Better Is **Higher**

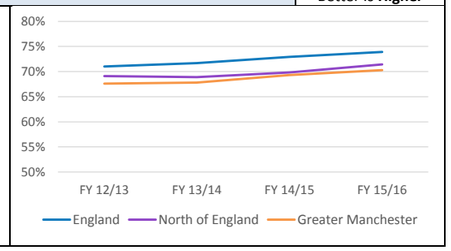
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

More People Will Be In Employment, With An Increasing Proportion In 'Good Work' And Able To Stay In Work For Longer

Employment Rate, Resident Population Aged 16-64

Better Is **Higher**

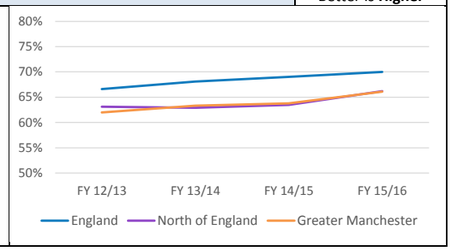
Bolton	70.0%
Bury	70.6%
Oldham	67.0%
Rochdale	63.0%
Salford	69.2%
Stockport	77.9%
Tameside	71.2%
Trafford	79.0%
Wigan	76.9%



Employment Rate, Resident Population Aged 50-64

Better Is **Higher**

Bolton	66.1%
Bury	61.3%
Oldham	67.7%
Rochdale	61.0%
Salford	64.0%
Stockport	73.8%
Tameside	65.5%
Trafford	68.8%
Wigan	71.6%



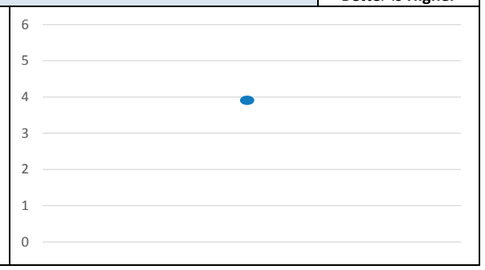
Well Led

Placeholder TBC

Staff Engagement Index

Better Is **Higher**

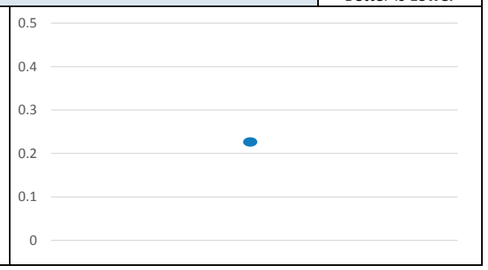
Bolton	3.9
Bury	3.7
Central	3.9
HMR	3.7
North	3.8
Oldham	3.7
Salford	3.8
South	3.8
Stockport	3.8
T&G	3.9
Trafford	3.8
Wigan	4.0



Progress Against Workforce Race Equality Standard

Better Is **Lower**

Bolton	0.5
Bury	0.3
Central	0.0
HMR	0.2
North	0.2
Oldham	0.2
Salford	0.2
South	0.1
Stockport	0.3
T&G	0.3
Trafford	0.1
Wigan	0.6



Effectiveness Of Working Relationships In The Local System

Better Is **Higher**

Bolton	74.4
Bury	67.1
Central	71.0
HMR	71.5
North	66.0
Oldham	74.3
Salford	74.2
South	69.8
Stockport	68.8
T&G	66.9
Trafford	69.9
Wigan	69.8

Quality Of CCG Leadership

Better Is G**reen Star**

Salford	Green Star
Bolton	Green
Bury	Green
Central	Green
HMR	Green
North	Green
Oldham	Green
South	Green
Stockport	Green
T&G	Green
Trafford	Green
Wigan	Green

Sustainability And Transformation Plan (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Probity And Corporate Governance (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Select a CCG

1. North ← Select a region
2. STP ← Select STP or DCO
3. ← Select an STP or DCO
4. ← Select a CCG
5. ← Select an indicator

Print Current CCG to PDF
(This will print rows 57 - 116 only)

NHS Tameside and Glossop CCG

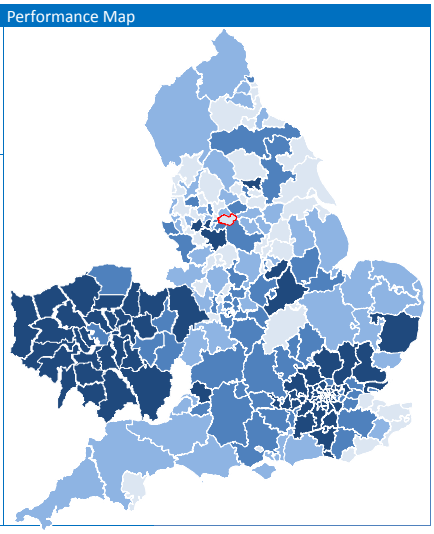
The 10 closest CCGs to NHS Tameside and Glossop CCG

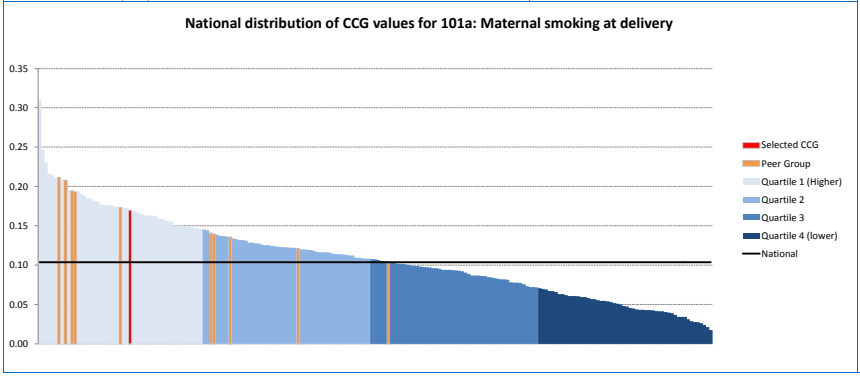
NHS Rotherham CCG (12.1%)
NHS Stoke on Trent CCG (19.4%)
NHS Bury CCG (10.5%)
NHS Wakefield CCG (20.8%)
NHS Hartlepool and Stockton-on-Tees CCG (14.1%)
NHS Barnsley CCG (14.0%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (17.3%)
NHS South Tees CCG (21.1%)
NHS Telford and Wrekin CCG (19.3%)

What you need to know...

- CCG and national values for each IAF indicator are presented in the table.
- Sparklines show the scores for each indicator over time.
- The spine chart shows how the CCG value compares other CCGs. A key is displayed over the chart to help with interpretation.

Performance Map

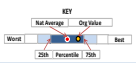




Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in **BLUE**, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A



	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▲	Maternal smoking at delivery	Q2 16/17	16.9%	10.4%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	34.1%	33.2%		L	
▼	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) fi	2014-15	46.8%	39.8%		H	
◀▶	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	0.0%	5.7%		H	
▲	Injuries from falls in people aged 65 and over	Jun-16	2,159	1,985		L	
▼	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Sep-16	10.4%	51.1%		H	
▲	Personal health budgets	Q2 16/17	7.3	18.7		H	
▼	Percentage of deaths which take place in hospital	Q1 16/17	49.8%	47.1%		<>	
▼	People with a long-term condition feeling supported to manage their condition(s)	2016	61.4%	64.3%		H	
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	1,475	929		L	
▲	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	3,144	2,168		L	
▼	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Sep-16	1.1	1.1		<>	
▼	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Sep-16	7.8%	9.1%		<>	
▲	Quality of life of carers	2016	0.78	0.80		H	
	Better Care						
◀▶	Provision of high quality care	Q3 16/17	55.0			H	
◀▶	Cancers diagnosed at early stage	2014	44.2%	50.7%		H	
▼	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q2 16/17	86.6%	82.3%		H	
▲	One-year survival from all cancers	2013	67.6%	70.2%		H	
◀▶	Cancer patient experience	2015	8.7			H	
▲	Improving Access to Psychological Therapies recovery rate	Sep-16	46.0%	48.4%		H	
▲	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Nov-16	89.5%	77.2%		H	
◀▶	Children and young people's mental health services transformation	Q2 16/17	DQ Issue			H	
◀▶	Crisis care and liaison mental health services transformation	Q2 16/17	80.0%			H	
◀▶	Out of area placements for acute mental health inpatient care - transformation	Q2 16/17	100.0%			H	
▲	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q2 16/17	63			L	
▲	Proportion of people with a learning disability on the GP register receiving an annual health check	2015/16	41.4%	37.1%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	7.8	7.1		L	
◀▶	Women's experience of maternity services	2015	77.6			H	
◀▶	Choices in maternity services	2015	61.4			H	
▼	Estimated diagnosis rate for people with dementia	Nov-16	74.4%	68.0%		H	
▲	Dementia care planning and post-diagnostic support	2015/16	80.6%			H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	3,269	2,359		L	
▲	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Nov-16	86.8%	88.4%		H	
▼	Delayed transfers of care per 100,000 population	Nov-16	24.2	15.0		L	
▼	Population use of hospital beds following emergency admission	Q1 16/17	1.2	1.0		L	
▼	Management of long term conditions	Q4 15/16	1,276	795		L	
▲	Patient experience of GP services	H1 2016	83.2%	85.2%		H	
◀▶	Primary care access	Q3 16/17	70.7%			H	
◀▶	Primary care workforce	H1 2016	1.0	1.0		H	
▲	Patients waiting 18 weeks or less from referral to hospital treatment	Nov-16	92.6%	90.6%		H	
▼	People eligible for standard NHS Continuing Healthcare	Q2 16/17	62.7	46.2		<>	
	Sustainability						
◀▶	Financial plan	2016	Amber			<>	
▲	In-year financial performance	Q2 16/17	Amber			<>	
◀▶	Outcomes in areas with identified scope for improvement	Q2 16/17	CCG not incl			H	
◀▶	Expenditure in areas with identified scope for improvement	Q2 16/17	Not included			H	
◀▶	Local digital roadmap in place	Q3 16/17	Yes			<>	
▲	Digital interactions between primary and secondary care	Q3 16/17	53.7%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes			<>	
	Well Led						
◀▶	Probity and corporate governance	Q2 16/17	Fully complia			H	
◀▶	Staff engagement index	2015	3.9	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.3	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	66.9			H	
◀▶	Quality of CCG leadership	Q2 16/17	Green			<>	

TAMESIDE AND GLOSSOP
Caretogether

Appendix

Improving Urgent Care

Tuesday 9th May 2017

NHS Tameside and Glossop Clinical Commissioning Group

Tameside Hospital NHS Foundation Trust

Tameside Metropolitan Borough

Current Performance Issues

- Expectation was that 90% would be achieved by end of March and through-out Q1.

- From March 27th onwards performance deteriorated significantly as implications of IR35 began to affect medical rotas.

- Impacted across specialties not just within ED department affecting flow across the hospital wards.

Current Performance Issues

- Trust has relatively small number of training posts at the registrar level.
- Difficulty in recruitment to middle grade level across Trust.
- Substantive workforce supported through long- term locum doctors working via personal service companies.
- Many stepped off rotas given their concerns regards IR35.
- Compounded by holiday period which had been covered but withdrawal of locums had additional impact.

Immediate Actions to Address

- Executive meetings with consultant and middle grade doctors.
- Agreed pay rates to support transition from agencies and PSC to hospital bank.
- Remained within pay-rates across GM.
- Providing from 8th May weekly pay to replicate arrangements with agencies.
- Already engaged an umbrella company to ensure compliance with IR35 and enable cascade to multiple framework agencies in line with NHSI guidance and commenced on 1st April.
- Transition from previous provider to new resulted in poor performance from both providers.
- Return to the 90s week commencing 8th May.

Back to the 90s Week Initiative

- Every patient, every ward to be reviewed and Executive team each assigned area to oversee.
- 3 Sitrep meetings per day with Executive input to support pull from ED and assessment areas.
- Aligned with on-going work around red & green days which NHSI will support review of this month as agreed at visit in February.

On-going "internal" actions

- **Action plan focused on:**

  Medical workforce planning

  Junior workforce planning

  Clinical Streaming – dependent on capital monies

  Patient Flow.

- Aiming to stabilise performance at 85% for the remainder of the Quarter.

- Return to 90% in Q2.

TAMESIDE AND GLOSSOP Caretogether

Economy Wide Schemes

NHS Tameside and Glossop Integrated Care ust

Care Together Transformational Schemes – 2017-18

Home First
Project Lead: Rachel Brown/ Grace Wall
Clinical Lead: Dr S Ahmed / Dr N Riyaz
£

Digital Health in Care Homes
Project Lead: Peter Grace/Grace Wall
Clinical Lead: Dr S Ahmed / Dr N Riyaz
£

E-Referrals
Project Lead: Zoe Maher/ Michelle Shiels
Clinical Lead: Dr A Lee / Dr A Ali

Advice & Guidance
Project Lead: Zoe Maher/ Michelle Shiels
Clinical Lead: Dr A Lee / Dr A Ali

Heart Disease
Project Lead: Ems O'Neill-Jones
Clinical Lead: Dr A Abraheem / Dr J Harvey / Dr T Jones

Diabetes
Project Lead: Ems O'Neill-Jones
Clinical lead: Dr E Jude / Dr T Jones

Community Bed Base
Project Lead: SCF
£

Home Care
Project Lead: Sandra Whitehead
£

GM Cancer Plan
Project Lead: Dr S Penney/Teresa Hopley
Clinical Lead: Dr S Penney / Dr A Lee / Dr R Jha

IV Therapies
Project Lead: Dawn Fletcher
Clinical Lead: Dr S Ahmed
£

Urgent Care Walk-in-Centre
Project Lead: Commissioners/ Trish Cavanagh
Clinical Lead: Dr S Ahmed / Dr N Riyaz

Urgent Care Streaming
Project Lead: Trish Cavanagh
Clinical Lead: Dr S Ahmed / Dr N Riyaz
£

Neighbourhood Community System
Project Lead: Colin Skoyles
£

Co-location of Neighbourhood Teams
Project Lead: Neighbourhood Managers / Angela Brierley

Single Point of Contact
Project Lead: John Schooling / Angela Brierley

Neighbourhood Workforce
Project Lead: Amanda Bromley
£

Extensive Care Service
Project Lead: Natalie Davies
Clinical Lead: Dr H Bain / Dr K Miller
£

Falls
Project Lead: Sandra Whitehead
Clinical Lead: Dr S Ahmed / Dr N Riyaz

Social Prescribing
Project Lead: Chris Easton
Clinical Lead: Dr J Harvey
£

System-wide Social Marketing
Project Lead: Chris Easton
£

System-wide Asset Based Approaches
Project Lead: Chris Easton
Clinical Lead: Dr J Harvey
£

System-wide Workforce Education
Project Lead: Chris Easton
Clinical Lead: Dr A Lee
£

System-wide Self Care & PAM
Project Lead: Chris Easton
Clinical Lead: Dr J Harvey
£

System-wide Self Care IT development
Project Lead: Chris Easton
Clinical Lead: Dr J Harvey
£

Community Mental Health
Project Lead: Giles Wilmore
Clinical Lead: Dr L Gutteridge
£

IN Paramedics
Project Lead: Sam Hogg (July 17)
Clinical Lead: Dr R Jha
£

IN Pharmacists
Project Lead: Tony Sivner
Clinical Lead: Dr A Ali
£

System-wide Pathway Redesign Projects

Sexual Health
Clinical Lead: Dr J Harvey

HPB/Liver Pathway
Clinical Lead: Dr V Patel & Dr A Lee

Gynaecology Pathways
Clinical Lead: Dr F New & DL Gutteridge

¶

Everyone Matters

Delivery of Transformation

Tameside and Glossop Integrated Care NHS Foundation Trust

- Majority of schemes aimed at reducing urgent care demand and managing that demand effectively.
- 6 schemes now become operational which will support admission avoidance/flow.
- Progress monitored through governance system in place.

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	25 May 2017
Reporting Member / Officer of Single Commissioning Board	Sandra Whitehead, Assistant Executive Director (Adults Services)
Subject:	**ADULT SOCIAL CARE TRANSFORMATION PROPOSALS**
Report Summary:	This report provides a set of high level proposals that will address some of the unmet social care need in the system, and will transform a number of existing services. Many of the proposals will offer improvements to the whole system and will increase options and improve outcomes to people who access services.
Recommendations:	That the Single Commissioning Board notes the content of the report and: • Supports in principle the further development of proposals contained within the report which are based on the level of detail available at this time. It should be acknowledged that these proposals are work in progress and are subject to further detailed project plans together with associated cost benefit analysis. • Approves the proposed approach to manage the programme of proposals which includes the Programme Management Office (PMO) Care Together oversight of the programme. • Approves the payment of non recurrent grant funding to Age UK of £ 0.127 million for one year only.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	£10.296m (covering the three year period 2017/2018 to 2019/2020 per the table in section 2.3)
CCG or TMBC Budget Allocation	TMBC
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75 (£3.396m) Aligned Budget (£0.760m) Based on draft proposals
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board (Section 75) Executive Cabinet (Aligned Budget)
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Savings deliverable, demand avoidance across the health and social care economy.

Additional Comments

The proposals outlined in this report can be grouped into 3 areas in terms of benefits realisation:

Addressing backlog to ensure compliance, addressing unmet need and transformation projects to deliver benefits across the wider health and social care system. All of the proposals meet the required grant conditions and will be closely monitored throughout to ensure that this remains the case.

The proposals require a combination of both recurrent and non-recurrent investment to support deliverability. Section 5.9 provides a summary of the recurrent and non-recurrent levels of proposed investment at this stage.

Each proposal will be subject to a detailed cost benefit analysis to ensure that the investment can deliver tangible benefits. It should be noted however that not all benefits may be cashable – some may provide social benefit for individuals and their families whereas others will ensure compliance with Care Act legislation.

Legal Implications:

(Authorised by the Borough Solicitor)

As part of the detailed scoping of projects, the legal implications will be considered on an individual project basis.

How do proposals align with Health & Wellbeing Strategy?

The proposals and strategic direction are consistent and aligned.

How do proposals align with Locality Plan?

The proposals and strategic direction are consistent and aligned.

The service is consistent with the following priority transformation programmes:

- Healthy Lives (early intervention and prevention);
- Enabling self-care;
- Locality-based services;
- Urgent Integrated Care Services;
- Planned care services.

The Programme will develop and enhance community assets, providing further choice for local people, with increased quality of provision. In this way it supports people to remain independent and as close to home as possible.

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

- Empowering citizens and communities;
- Commission for the 'whole person';
- Target commissioning resources effectively.

These proposed projects will focus on wider determinants of health, early intervention and prevention; encouraging healthy lifestyles, and support mental health in all that we do.

Recommendations / views of the Professional Reference Group:	The report was generally well received and the recommendations accepted by the Professional Reference Group with very few additions. Main points from discussion: 1. Asset based approach and organisational workforce developments need to closely align with other asset based approaches being implemented by the Integrated Care Foundation Trust including social prescribing. 2. Need to include more information with regards Derbyshire County Council's plans for spending the additional budget allocation. 3. The report needs to ensure acknowledgement of other transformational funding to Adult Social Care including the Greater Manchester money for help to live at home developments. 4. Ensure alignment with the Carers Strategy 5. Important to identify in subsequent business cases and benefits appraisals the return on investment for transformation projects. It was however acknowledged by Professional Reference Group that some spending won't have any return other than meeting statutory requirements (eg. Clearing reassessment/review backlog). It was recognised that the programme management would align itself to the Care Together programme via the Programme Management Office and appropriate metrics need to be identified in business cases to meet the needs of the Care Together transformation programme. 6. Ensure alignment of reablement with the developing Intermediate Care Strategy. Although it was accepted that Age UK need to be funded this year there was concern that a consistent approach to funding the third sector was needed particularly in light of potential reductions in third sector spending in the future.
Public and Patient Implications:	People will continue to receive services that meet their needs. Where there is a service redesign, or transformation, each project will ensure clear communication and engagement with service users and carers, using principles of co-design.
Quality Implications:	Through the delivery of this programme, and especially the proposal for a Quality Team to be formulated, it is anticipated that quality of service provision will increase, and support in meeting standards across the Health and Care economy.
How do the proposals help to reduce health inequalities?	The proposals are to continue to work on delivering outcomes for local people, meeting assessed needs, empowering people to manage their care where possible and supporting the creation of a proactive and holistic population health and care system.
What are the Equality and Diversity implications?	It is not anticipated that there are any equality and diversity issues with this proposal.
What are the safeguarding implications?	There are no anticipated safeguarding issues. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are

	raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	It is not anticipated that there are any Information Governance implications at present as the cohort of people are the same people that we currently deliver services to. As part of the detailed scoping of projects, the implications of Information Governance will be considered on an individual project basis.
Risk Management:	In line with best practice and Programme Management Office standards, robust risk registers will be developed, regularly maintained and reviewed.
Access to Information :	The background papers relating to this report can be inspected by contacting; Sandra Whitehead – Assistant Executive Director, Adults Telephone: 0161 342 3414 e-mail: sandra.whitehead@tameside.gov.uk Reyhana Khan – Progamme Manager Telephone 0161 342 4077 e-mail: Reyhana.Khan@tgh.nhs.uk

1. BACKGROUND

1.1 On 24 February 2017 the Greater Manchester Health and Social Care Partnership Board approved a report that confirmed the transformation priorities and delivery approach proposed by the Greater Manchester Health and Social Care Partnership for a Greater Manchester-wide transformation programme for adult social care. This reform is fundamental to the delivery of *Taking Charge our Health and Social Care in Greater Manchester.*

1.2 The programme will deliver the following transformational changes:

- A universal offer for carers around information, advice and support;
- A new model for Care at Home that is integrated across health and care and links to community assets;
- Enhanced primary care into residential and nursing homes;
- A Greater Manchester assurance framework and quality support to care homes;
- An employment model and a shared approach to family-based care for people with a learning disability;
- A single set of core processes around assessment, care planning and discharge;
- Workforce reform and the development of new skills, career pathways and new roles;
- A Greater Manchester market position statement and market management approaches;
- A single set of Greater Manchester quality standards and commissioning frameworks;
- A shared function to commission and secure high cost complex care across Greater Manchester;
- A joined up supported accommodation and care strategy, including prioritisation of new provision as part of the *One Public Estate* Programme.

1.3 The programme proposed in this report will complement the wider Greater Manchester programme and where appropriate, for example a single set of quality standards and commissioning frameworks, and specialist commissioning for high cost care Adult Services will fully engage with the Greater Manchester programme.

1.4 As a complement to the Greater Manchester Health and Social Care Partnership transformation programme Greater Manchester Association of Directors of Adult Social Services has agreed and is developing 4 key priorities:

- Care at Home;
- Residential & Nursing Care;
- Learning Disabilities; and
- Support for Carers.

1.5 A number of cross-cutting themes have also been identified:

- Develop proposals for approach to *Care Innovation Manchester;*
- Develop approach to deployment of Apprenticeship Levy, to help build Adult Social Care workforce pipeline;
- Developing approach to supported housing to meet Adult Social Care needs;
- Develop approach to asset-based working;
- Improving system-wide performance with Adult Social Care data.

1.6 A core programme team has been approved and established to support Leads to deliver against the programme. Our local programme will work with the Greater Manchester priorities where these support the delivery of the local priorities.

1.7 In October 2015 the Department of Health published its *High Impact Change Model - Managing Transfers of Care* which identified 8 High Impact Changes to ensure people do

not stay in hospital for longer than they need to. Maintaining patient flow, having access to responsive health and care services and supporting families were identified as being essential to support prompt, safe and effective discharge. The Impacts were identified as:

- Early Discharge Planning;
- Systems to Monitor Patient Flow;
- Multi-Disciplinary/Multi-Agency Discharge teams, including the voluntary and community sector;
- Home First/Discharge to Assess;
- Seven-Day Services;
- Trusted Assessors;
- Focus of Choice;
- Enhancing Health in Care Homes.

1.8 The Chancellor of the Exchequer presented his Spring Budget on 8 March 2017. The Budget included an additional £2.0bn of funding for Adult Social Care, to be made available to local authorities over the period 2017-18 to 2019-20. For Tameside this equates to a total of £10.296 million through to 2019-20.

1.9 This paper focuses on how Adult Services will invest the additional funding allocated by government to improve outcomes and quality across adult social care, looking to support the whole health and social care economy to function effectively, being mindful of the above priorities, across the programme of transformation.

1.10 At this stage detailed project plans have not yet been developed that provide significant information about the cost benefits of the proposed schemes. These will be prepared in the next few weeks. The report will, however, provide an overview of the benefits of the transformation schemes. This level of detail is not proposed where funding is purely to address backlog as a result of capacity pressures.

1.11 The report seeks approval for the proposed schemes – in principle for those that require more detail, and to progress the clearance of backlog proposals.

2. FINANCIAL POSITION

2.1 Adult Services has seen significant reductions in its budget since 2010-11 as a result of cuts to government funding. This has placed pressure on the Council to continue to deliver good outcomes for local people who access Adult Services, within the available finances.

2.2 In order to mitigate against the reductions in funding there have been a number of responses:

- Care Together programme – an extensive integration programme of health and social care systems to drive up healthy life expectancy locally through a place-based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable health and social care economy within 5 years.
- Review and transformation of a number of services to improve outcomes while reducing funding levels. Good examples of this has been our programme to return people with learning disabilities to borough into extra care housing schemes that improve their outcomes while costing significantly less than their residential placements.
- Significant reductions in management capacity and support function capacity to minimise the reduction in front line services.

2.3 The Chancellor of the Exchequer presented his Spring Budget on 8 March 2017. The Budget included an additional £2.0bn of funding for Adult Social Care, to be made available

to local authorities over the period 2017-18 to 2019-20. For Tameside this equates to a total of £10.296 million through to 2019-20. The table below provides the analysis of the funding profile over this three year period.

2017/2018 £ m	2018/2019 £ m	2019/2020 £ m	Total £ m
5.365	3.299	1.632	10.296

2.4 Furthermore, one-off additional grant funding has been allocated to Adult Services, to the value of £1.159 million for 2017-18. However, to pay for this the Government has reduced the amount paid to local authorities in New Homes Bonus (NHB). Tameside will lose £1.165 million in NHB and as a result is marginally worse off and therefore does not receive any benefit from this change.

2.5 When the grant settlement was announced in December 2016 the Secretary of State set out his guidelines on Council Tax. He announced it would be permissible for the adult social care precept to be increased above the 2016/17 level of 2% (of the Council's tax level) as follows:

2017/18: maximum increase of 3%;
2018/19: maximum increase of 3%;
2019/20: maximum increase of 2%.

Over the three year period the maximum combined increase is 6%. This will equate to maximum income generation of £5.1 million – it should be noted that this funding is not additional to the budget as it funds existing Adult social care services and will mean that other parts of the Council will not have to subsidise Adult social care as they have done in previous years by making additional savings.

2.6 Indicative Better Care Fund allocations are as follows;

	£'000		
	2017-18	**2018-19**	**2019-20**
Better Care Fund	15,598	15,895	15,895
Improved Better Care Fund	983	4,500	9,200
Disabled Facilities Grant	2,153	tbc	tbc

2.7 At this stage a number of the proposals have not been fully costed.

- Where the proposals are funding existing capacity to address backlogs and waiting lists, costs have already been established and are time-limited, non-recurrent costs. Where clearing the backlog will result in additional demand on services i.e. an increase in a care package following re-assessment, this will be funded from Adults 2017-18 budget.

- Where schemes are to provide additional capacity to enhance business as usual, for example additional capacity in the Employment Service, the additional capacity can be clearly costed. Decisions will need to be made with regards this being recurrent funding following cost/benefit analysis.

- The enabling capacity to transform the identified services and/or functions can be costed, but the funding required recurrently for the new service models will be subject to the Programme Management Office Gateway process.

2.8 Work will be undertaken in the next few weeks to identify the benefits of the relevant schemes and to put them through the Programme Management Office process to understand the detail of how they will benefit the whole system.

2.9 **Appendix 1** details initial expectations with regards to whether the funding identified is recurrent or non-recurrent. In some instances there will be an element of non-recurrent funding, to support the implementation of the project, with recurrent funding required once the scheme has been implemented. It is important that the benefits of these schemes are articulated and demonstrated to maximise the benefits to the whole economy.

3. PROPOSALS

3.1 The new funding, albeit non-recurrent is very welcome, and will enable the service to develop and implement a number of programmes to transform services to inform quality and outcomes over the next few years. These plans will complement and enhance the existing Care Together transformation programme funded via Greater Manchester Transformation funds.

3.2 There are three broad themes locally that will be the focus of our programme to impact on service quality and outcomes:

- Quality assurance across community based services, particularly care homes and home care services;
- Transformation of services that Help people to Live at Home, including home care, Reablement, Community Response Service (Telecare, Telehealth);
- Asset Based Work – as well as working within communities, to ensure a focus on Carers, Shared Lives and dementia.

3.3 Each of the themes will be underpinned with an Organisational Development programme that will embed the transformation, ensuring mainstreaming beyond the funding timescale.

Quality Assurance

3.4 There is a particular need to focus on care home and home care provider quality, though the expectation would be that the resource would have capacity to work across all commissioned services. To enable a function to review and impact on quality additional resource is required to support the Commissioning Team – whether this resource sits within or out with the team is to be determined. At this stage would anticipate a Team Manager/Project Manager (Grade J) and 6 officers (grade to be determined) would form a team to deliver the assurance programme.

3.5 If this programme is to impact not only on the quality of services locally as determined by us as commissioners, but also on the results of Care Quality Commission (CQC) inspections, it is important that Adult Services links closely with wider Greater Manchester work with CQC to agree synergy across their inspection regime and the Locality assurance frameworks.

Care Homes

3.6 The development of an outcomes framework, working with Greater Manchester and Care Quality Commission, will be implemented across the local care home sector by the Quality Assurance Team, working with providers to improve quality. This will be supported by the team identified in 3.4 and will work with care homes individually as well as through a peer support programme.

3.7 An Organisational Development programme will be developed with a focus on skills development for working with people with complex needs, dementia, end of life etc.

3.8 Extension of the Digital Health programme to include primary care and Integrated neighbourhood capacity. The programme funded via the Care Together transformation programme does not include the wider development. This project will be included in the wider Community Response Service (CRS) review detailed later in the report.

3.9 To really impact on the quality of provision in care homes, and to reduce Accident & Emergency attendances a review of the community offer is necessary – this will consider the priorities that care homes have raised as key issues for them – access to General Practitioners, falls prevention programme and access to community Intra-Venous anti-biotics. There is a general feeling that people living in care homes do not receive the same community offer as those living in their own homes – the offer from community services needs to be revised.

3.10 The programme needs to understand how the Enhanced Care Worker programme, developed by HC One and accredited by the Royal College of Nursing and develop a plan to consider how it can support the implementation locally. Some local nursing homes may require support to understand how this model can improve their offer and create a career path for care home workers, improving retention and qualified staffing issues.

Home Care

3.11 It is widely acknowledged that the current delivery model for home care is unsustainable. Transformation plans have been funded through the Care Together programme, and implementation plans are being developed now the new contract providers have been established. The Quality Assurance project will work with the 'Help to Live at Home' programme to ensure there is no duplication or counter-intuitive developments. This programme will take a wider view of quality assurance and will support the project that is working with home care providers to implement the new model.

3.12 The local 'Help to Live at Home' model requires an Organisational Development programme for home care provider staff, for assessment and care management staff and real engagement with current and new service users and their families. This programme will supplement the existing programme to deliver real change.

3.13 It is anticipated that Adult Services will make a contribution to a wider Greater Manchester quality and assurance programme, though the value of the contribution is yet to be confirmed.

3.14 It is anticipated that the team of 7, with project management support, will be sufficient to deliver the majority of the programme. In addition funding will be required to support the Organisational Development programme that will be developed and to work with INs to develop a community offer for care homes – 1 Whole Time Equivalent post to undertake this project.

Support to Live at Home

3.15 The local Help to Live at Home model adopts an outcome based approach to home care commissioning, incentivising providers to deliver against outcomes, shifting away from a time-task culture and focusing on quality rather than costs. This is a significant culture change and will require genuine transformation of the current home care model locally and nationally. As described above a team is currently being recruited to deliver the new model – it is proposed that a wider infrastructure will be established to offer much more comprehensive project management oversight.

3.16 While home care (*Help to Live at Home*) as described in 3.11 is a fundamental feature of enabling people to remain at home, living independently, there are a range of other services that will enable people to remain at home that will form part of this programme. These will be referred to collectively as 'Support to Live at Home' schemes and will deliver a wider transformation programme that will offer a range of options to enable as many

people as possible to remain at home. In the main this will be the review and transformation of existing schemes.

Community Response Service System

3.17 The current Community Response Service system has served the people registered on it well over recent years, but the system and service is in need of review and significant reform. The current service is a standalone system, not linking with IAS (the Adult Service Information Technology (IT) system) and is essentially paper-based. A new system that links with EMIS Community (the community health IT system) and IAS is required. There are extensive opportunities to develop the service to significantly extend the telehealth offer locally and to link with General Practitioner practices to ensure proactive responses to call outs (at this time there is no interaction between services).

3.18 One Whole Time Equivalent project officer is required to lead this project. Information Technology expertise will also be required to support the project.

3.19 As well as linking with the Asset Based Organisational Development programme described later in the paper, a skills training programme will be developed and rolled out across the Community Response Service workforce to ensure the impact of this resource is maximised to support people outside of the formal care system.

Reablement Service

3.20 While the current Reablement Service has delivered good performance and has contributed significantly to maximising independence, while reducing potential service costs, a review and refresh of the service Is appropriate.

3.21 Asset based training will be rolled out; this will be supplemented with a more specific and bespoke training programme that will ensure staff are practicing in a way that maximises an individual's independence and does not simply offer an enhanced home care service.

3.22 The current system is paper-based and reliant on a team of staff. An electronic/web-based solution is required. This is currently being scoped and will be developed over 2017-18 with implementation during 2018-19 at the latest. Project officer capacity will be required to deliver this project.

3.23 Reablement will sit within the Intermediate Tier of the wider Care Together model of care so further conversations will be required with the Integrated Care Foundation Trust to ensure that the proposed service model will form part of the underpinning offer that will strengthen plans for people to remain at home safely and independently.

Shared Lives

3.24 There is significant scope to transform and really exploit our Shared Lives service to offer more opportunities for people to live within a family environment. There service currently offers long term support, in the main to people with Learning Disabilities, respite care and day services. There are real opportunities to widen the model to support people at end of life, to work with young adults who have previously been in the care system as Looked After Children to be mentors to current children who are looked after in a Shared Lives setting and to generally be a more proactive and responsive, flexible service.

3.25 To understand this it is proposed that Shared Lives Plus (UK Shared Lives Network) is commissioned to review the current service and to work with the service and project team to redesign our offer. Following this will be a recruitment and Organisational Development programme and an advertisement, recruitment and training campaign for new carers.

Assessment and Care Management

3.26 While this funding is non-recurrent, consideration will also be given to capacity to support the assessment and care management function in neighbourhoods to address the backlog we have in undertaking re-assessments. This would be a fixed term resource as capacity issues should be addressed as the new integrated neighbourhood model is embedded and transformed.

Employment Services for People with Learning Disabilities

3.27 Current performance is poor due to the resource dedicated to supporting people into employment. The function has been moved into the Employment and Skills Service to provide a better focus and wider network. In order to improve performance, additional resource is required to increase capacity. Additional resource will be supported, following the impending service review.

Alternative Housing Options

3.28 Conversations are taking place with several housing providers to develop additional housing capacity to meet increased demand in order to support people to remain at home. While funding via grants is available to support to development of the schemes, care and support costs need to be found. Where invest to save proposals can evidence that funding these schemes will reduce spend elsewhere in the system, then funding will be released to establish the schemes – these will be extra care type models for younger adults and older people to continue our programme of returning people to borough, and maintaining people in their own homes.

Approved Mental Health Practitioners (AMHPs) and Court of Protection (CoP)

3.29 When applying national formula the Council is under-resourced in the number of Approved Mental Health Practitioners it employs, which places significant pressure on those in post. Consideration will be given to increasing this function.

3.30 The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection (CoP) can authorise a deprivation of liberty. While we are managing demand and capacity to assess people in hospital or in a care home, we do not have the expertise or capacity to address the number of CoPs we need to. It is proposed that additional social work capacity is commissioned until current social work complement is trained to undertake CoP assessments.

Through the Night Service

3.31 Over the winter period an identified pressure on Delayed Transfers of Care was the lack of capacity on the Through the Night Service. In response to this an additional round was funded from Winter Pressures funding. This funding was non-recurrent and there is now a full round so funding must be sourced for this service. Ceasing the service would put pressure into the system and could result in people who are currently being managed in the community needing to access 24 hour care.

Direct Payment Capacity

3.32 The number of people choosing to access their support via a Direct Payment is lower than the Greater Manchester and national average in Tameside. In order to promote and actively generate interest in Direct Payments will require additional resources. It is proposed that additional capacity is funded to undertake this work. It is proposed that additional capacity is funded in the Neighbourhoods over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments.

Day Service Options for People with Learning Disabilities

3.33 While there has been considerable change to the day service options offered to many people with Learning Disabilities, there is a need to further review the offer to people. It is known that 59 people are due to transition through from Children's Services in the next 5

years who will require day service provision. Plans are currently being developed and approved to implement a new service, through Active Tameside and other local providers to improve the offer to people, with education, pre-employment training and skills teaching. This scheme proposes improved outcomes for people the opportunity of employment and services within the borough, not in out of borough residential placements. Costings are currently being developed for the funding of the revised service – this will ensure we can meet the increasing demand for service, offer a more meaning service, and mitigate against significant cost pressures.

Sensory Services

3.34 Over previous years considerable funding has been reduced from the Sensory Service. It is proposed that additional capacity is funded in the team to work with individuals known to the service to promote self-management and to develop resilience to reduce demand and reliance on formal services.

Asset Based Work

3.35 A key pillar of the Care Together programme is the integration of community resources and assets into the health and social care offer and solution to the model of care. Extensive work is underway with this programme that is funded via the transformation funding, led by the team in the Integrated Care Foundation Trust on behalf of the economy, but there is a significant piece of work and impact that Adult Services can contribute to this.

3.36 A service wide Organisational Development programme is currently being designed, with learning from the Wigan Deal and other models that will be rolled out across all staff in the service, ensuring they are aware of, and consider all community assets in the local neighbourhood to meet an individual's' needs and enhance their quality of life. Sessions will be held in early summer, and all staff will attend. More bespoke programmes will be delivered to Social Workers and other assessment staff to ensure their practice is 'asset based' and appreciative, not deficit based with solutions being sought through formal services as a starting point. While designed internally, facilitation of the programme will be commissioned.

Carers

3.37 Carers add significant value to the lives of the people they care for and reduce significant demand on social care and health services. In order to enable carers to continue in this role, in good health themselves, it is critical that the Council offers the appropriate support mechanisms. The Carers Strategy is currently being refreshed, and following a recent consultation exercise with over 130 carers we are developing our action plan. Funding will be used to develop our offer to carers. Additional capacity will be sourced to implement the plan.

3.38 One of the key challenges set by carers was engagement of General Practitioners with the carer's agenda so a focus will be placed on this in the coming year, supported by this funding. This will not only be to raise awareness of the carers agenda locally, but for General Practitioners to identify and flag carers and to signpost them to carers services. Some resource will be required to develop this.

Dementia

3.39 Dementia is a significant cost in the local economy and impacts not only on individuals but their families and friends, recent conversations with the Alzheimer's Society will be pursued to help shape a local offer to people with dementia and their families. Resource will be required to support the project and to match fund the schemes developed locally. Further mapping is required to specify the resource required to develop this programme.

Autism

3.40 One of the key themes in the Greater Manchester Learning Disability priority work stream is Autism. The Tameside joint Autism Strategy is currently being finalised, and it is proposed that a project is undertaken over the next 12 months to complete and roll out the Strategy, ensuring that the key themes and priorities in the action plan are implemented. A project group will also identify any schemes or activities that would improve the offer to local people with autism if there was funding to pump prime them.

Mental Health Recovery

3.41 There is currently a gap in step down services for people with chronic and relapsing mental health conditions within the community. This means that secondary care Community Mental Health Teams (CMHTS) within tier 4 are holding clients longer in a monitoring role, as there is nowhere to signpost them to on discharge, other than General Practitioner only care. As such clients are stepping down from tier 4 to tier 1. This proposal suggests that there should be an intermediate tier with a recovery focus once a client is stabilised at tier 4 but requires less intense monitoring due to a chronic and relapsing condition. The proposal is to develop a 'Well Connected' service, in partnership with Tameside Oldham and Glossop Mind that focuses on people staying well and connected within families and the community, following discharge from CMHT services to prevent re-referral and relapse. Working with people outside of traditional CMHT services can prevent institutionalisation and dependency. The Well Connected service will identify and build pathways to existing community services and groups that can support people to maintain their wellness. The provision will work proactively and in partnership with individuals and families/care givers within an asset based approach, developing bespoke techniques to support the person to stay well and build resilience. The aim is to run the project over an initial 2-year period, to allow time to evaluate its effectiveness in terms of outcomes for people, savings/cost avoidance.

Voluntary Sector Capacity

3.42 A key theme of the Care Together programme is the asset based approach to enabling individuals to support themselves and thrive and there is currently significant pressure on funding for voluntary sector capacity

'Grafton Model' Roll Out

3.43 Non-recurrent funding is proposed to replicate the Grafton Centre model across other neighbourhoods. This includes support to local community groups to develop their local community asset that offers activities and opportunities to local people to reduce isolation, improve independence, skills and engagement. The Grafton centre has been a huge success, increasing attendance from approximately 12 per day to a membership of over 500 people. The scheme became self-sustaining within 3 years.

Care Home Contract Development

3.44 The current care home contracts expire in December 2017. Some support is required to build in capacity to design and implement a new contract, jointly produced and with the engagement of stakeholders to support the entire economy and our collective integration objectives.

4. APPROACH

4.1 The extensive proposals described in section 3 will be delivered within the next three years, and will require additional resources to manage delivery. A Programme Manager and several Project Co-ordinators will be required to form a small Programme Management Office (PMO), and where relevant, will work with the Care Together Programme Management Office to ensure economy wide processes are met.

4.2 It is anticipated that the resources outlined above will be sourced internally. This Programme resource will be managed by Adult Services, working to the Executive Director and Assistant Executive Director as Senior Responsible Officers.

4.3 The timescales for delivery of programme benefits are extremely challenging, and some external resources to support the cost benefit analysis process are being investigated with New Economy.

4.4 At the Local Executive Group meeting on 19 April 2017 a draft outline report was presented to consider the service areas which needed support to maintain high quality standards, enhance opportunities in the community, and help people to stay independent at home where appropriate to do so.

4.5 These themes formed the basis for generating ideas for new projects which were presented for discussion. These projects were prioritised for areas of unmet need described on the allocation of the funding. Since then, further engagement has taken place with the Integrated Care Foundation Trust to go through in more detail in order to gather views for a collective approach, understand what is being proposed, how it supports the Care Together integration objectives and how best to work with partners to deliver positive outcomes for local people.

4.6 Early conversations have also taken place with the Care Together Programme Management Office to consider how the Gateway process can be utilised for necessary oversight of the Programme economy wide.

4.7 The governance arrangements are still to be mapped out, aligned and agreed for this Programme. For example, where procurement is a requirement, compliance with Procurement Service Orders and internal governance will be adhered to. However, where a new project is initiated through economy wide processes, this may take a different governance route.

4.8 Furthermore, it is likely there will be a quarterly external process for providing assurance on the plans and use of these monies. Due regard for the internal process to sign off, prior to any external submission will need to be considered. Once the transformation/service redesign projects have been agreed, the individual projects will be initiated with appropriate documentation.

4.9 The Adults Management Team will act as the conduit for Adult Social Care Transformation, acting as a Steering Group to provide the necessary support and challenge through the implementation of a Transformation Programme Board (TPB), a method that has been effective in managing previous transformation and savings projects.

5. COSTS IDENTIFIED

5.1 **Appendix 1** outlines anticipated costs that have already been identified against the additional funding. Total funding over the 3 year period is £10,296 million, with £4.156 million provisionally allocated to date.

5.2 At this point only funding that has been clearly identified and costed has been included. In the main this is staffing resource and where non-recurrent funding has been identified for projects.

5.3 Until the transformation projects have undertaken detailed scoping and review, it is not possible to understand the detailed costs required to deliver system outcomes. This work will be undertaken with the support of the Care Together PMO over the next few weeks. On completion of this, a full analysis breakdown of the expenditure will be shared.

5.4 **£0.813 million** has been identified to fund additional capacity to clear waiting lists and backlogs across a number of individual services:

	£'000		
	Recurrent	Non-recurrent	Total
Increase Assessment and Care Management Capacity		85	85
Approved Mental Health Practitioner		414	414
Court of Protection - clear backlog		246	246
Additional Occupational Therapists		68	68
Total		813	813

5.5 **£0.430 million** has been identified to fund additional capacity across teams where unmet need has been identified:

	£'000		
	Recurrent	Non-recurrent	Total
LD Employment Services	87		87
Direct Payment Capacity		108	108
Through the Night Service	112		112
Sensory Services	123		123
Total	322	108	430

5.6 **£1.485 million** has been identified to support business as usual. Included in this is funding identified to cover contract uplifts and demographic pressures for the 3 years of the funding and support to local third sector organisations to ensure their ongoing viability.

	£'000		
	Recurrent	Non-recurrent	Total
Grafton Model rollout		150	150
Care Home Contracts		46	46
Contract uplifts / demographic pressures	1,152		1,152
Third Sector capacity		137	137
Total	1,152	333	1,485

5.7 At this stage, only project support costs have been identified against transformation schemes, with the exception of the Quality Assurance Team which has indicative costs included for the full function. These may change on completion of the detailed project plan.

	£'000		
	Recurrent	Non-recurrent	Total
PMO		202	202
Quality Assurance Team	900		900
CRS Project Lead		41	41
Reablement ATM		21	21
Shared Lives Project Lead		41	41
Carers Project Lead		41	41
Mental Health Recovery Service	100		100
Autism Co-ordinator	82		82
Total	1,082	346	1,428

5.8 **Appendix 1** also identifies which of the above projects require non-recurrent or recurrent funding. Where recurrent funding is required beyond the 3 year funding period, review and evaluation will take place during the life of the project to ensure that plans are made to identify how this recurrent funding will be resourced following the additional funding.

5.9 In summary the estimated required investment for all of the proposals detailed above is as follows;

	£'000		
	Recurrent	Non-recurrent	Total
Section 75	2,456	940	3,396
Aligned	100	660	760
Total	2,556	1,600	4,156

6. ANTICIPATED BENEFITS

6.1 While the proposed schemes have been grouped in the 3 themes that have been identified – quality assurance, support to live at home and asset based approaches, it is helpful to look at the benefits of the schemes using a slightly different configuration:

- Addressing backlog to ensure compliance;
- Unmet need;
- Business as usual;
- Transformation projects.

Addressing the Backlog

6.2 As identified in **Appendix 2** there are a small number of schemes that involve the funding of additional capacity to ensure Adult Services are compliant with their statutory duty to re-assess individuals in receipt of services. At this time there is a backlog of approximately 680 outstanding re-assessments. Undertaking these re-assessments may not have a direct benefit on the system, but are essential. It is not possible to anticipate the impact of service demand as a result of the reassessments, though should there be an increase in the level of service required to meet identified need for individuals this will be met from within the Adults 2017-18 budget.

6.3 Without identifying and undertaking the reassessments it is not possible to speculate if any of these individuals have been placing unplanned demand on services because they are not receiving the correct level of support.

6.4 These reassessments will offer the opportunity to review if an individual could be encouraged and enabled to use community assets and social prescribing to meet their identified needs, thus reducing the demand on formal services. Data will be collected to understand the level of this achievement. It may be that the neighbourhood offer is not developed sufficiently to really impact on this during this exercise, though will do in the future.

6.5 This is non-recurrent funding – once the outstanding assessments have been undertaken the additional capacity will cease. It is important for the system to ensure that a similar outstanding list does not occur again, and consider future requirements. It is not proposed that these schemes are subject to detailed project plans – targets will be set and monitored through the Transformation Project Board and will be reported through the agreed governance process.

Unmet Need / Business as Usual

6.6 A number of schemes, as identified in **Appendix 1**, have been identified as requiring additional capacity to meet current demand and impact positively for individuals. An example of this is the proposal to increase capacity in the Employment Service, Routes to Work. The impact and success of this service in supporting people with learning disabilities and mental health issues into employment has been limited due to the small resource in the function. There is an expectation that more individuals will be supported into, and to remain in paid employment or voluntary work, as a result of increased capacity. Research shows that being in paid employment improves mental health and wellbeing and results in better health and self-esteem. The benefits of supporting more people in paid employment should see a reduction in demand on other services in the whole system. While the numbers may not be significant, supporting people into paid employment are key indicators for Adult Services and are identified in the Care Act.

6.7 While it is not proposed that detailed project plans are submitted for these schemes, it is expected that performance targets are identified and monitored by the Transformation Project Board to ensure that the investment is improving performance and to understand the impact for individuals using these services. On-going review and evaluation will be undertaken by the Transformation Project Board to ensure that this additional funding is making the expected impacts on service delivery and outcomes for individuals and for the wider system.

Transformation Projects

6.8 Full project plans and cost benefit analyses will be carried out for all the transformation projects in the coming weeks. This will be supported by the Programme Management Office for the Care Together Programme to ensure a consistent approach across the economy and to ensure that the benefits for the range of projects are not double counted, resulting in under-achievement across the whole economy.

6.9 While not costed out at this stage, it is anticipated that a range of benefits will be seen across the whole system, as well as improved outcomes for individuals impacted upon by the transformation plans. Each of the transformation projects will involve a review and potential re-design of the service to improve the offer with the intention of having a positive impact on the whole system, as well as for individuals accessing the services. A number of benefits can be expected:

- Improved outcomes for individuals as services will offer more person-centred, co-produced approaches that will result in people having more control over their lives.

- Cost avoidance – maximising the use of community assets to meet individuals' needs and to increase self-management and resilience.
- Support to carers to enable prolonged capacity and ability to support the cared for at home with minimal long term, formal service inputs.
- Improved quality, choice and control for individuals.
- Improved economy performance – improvement in service provision will see more people supported to remain at home with step up and step down support, for example in Reablement.
- Support to enable people to remain at home thus reducing the pressure on acute services, including hospital attendances and admissions.
- Prevention and self-management – examples of this in the dementia and autism schemes.
- Increased community options such as Shared Lives and extra care housing schemes that will reduce costs and avoid costs by supporting people to live in the community rather than residential care.

6.10 The benefits of the individual schemes will be determined as the detailed work is undertaken, though it is anticipated that a combination of the above will be seen for each of the schemes.

6.11 The results from the cost benefit analysis will be reported back into Local Executive Group and Single Commissioning Board on a regular basis to provide assurance that the programme is delivering benefits to the system as well as to individuals.

7. INTERDEPENDENCIES

7.1 It is not anticipated that this programme will duplicate the work currently being implemented through the GM funded transformation schemes. Engagement with the Greater Manchester transformation programme will continue to ensure that our plans complement Greater Manchester plans and where appropriate for local people, will work collaboratively to deliver change and improved outcomes.

7.2 The Adult Social Care Programme Management Office will work closely with the Programme Management Office at the Integrated Care Foundation Trust to ensure that programmes are complementary, enhanced, and that collective views are gathered to support delivery, and future design of holistic services.

7.3 The primary focus of this programme is identified as meeting unmet adult social care need by the Department of Health. However, the programme will identify cashable and non-cashable benefits to the whole social care and health economy in delivering these projects.

7.4 These benefits will be useful to feed into the Outline Business Case, for the economy wide transaction of services, staff and contracts into in the Integrated Care Foundation Trust.

8. GLOSSOPDALE PROPOSALS

8.1 Details of Derbyshire County Council plans for Adult Social Care spend in Glossopdale have not yet been confirmed. There have been initial conversations with the Head of Service for Adults in Derbyshire in a meeting with Tameside colleagues to look to align schemes and investments.

8.2 Where there are plans for spend that will include health service provision for example the Quality Assurance Team, arrangements for how the practical business will be carried out will be discussed as those plans are developed.

9. FUNDING FOR VOLUNTARY SECTOR – AGE UK

9.1 Specific funding has been identified for voluntary sector organisations to support them at a time where funding has been seriously challenged, at the same time that the development of the community offer is a mainstay of the Care Together programme. Many organisations are reporting that they are facing significant financial challenges, among them Age UK, who have reported that they have had to review, redefine and significantly reduce their offer locally in order to stabilise the business.

9.2 One of the proposals in the programme is to grant fund £127,000 to Age UK for one year only, to stabilise the business and give them some capacity to re-structure and embed their new local offer. Age UK do receive funding from Adult Services to core fund the service, but due to other reductions in funding, they are re-structuring and re-scoping their business model to ensure their continued presence in the market.

9.3 Any risks to the ongoing functioning of Age UK would place significant pressure on the local economy and potentially on the local health and social care economy. Many individuals and families use the services provided by Age UK to support them to remain living independently without the intervention of formal services. Age UK also offer information and advice to support income maximisation and on local services and opportunities to support individuals, their carers and families to maintain independence.

9.4 This report seeks permission to grant fund for one year to the value of £127,000 to ensure the viability of the business. Age UK are a very well recognised and well-established voluntary sector organisation, the failure of which and withdrawal from the local community would be a great concern and would question the economy's commitment to a thriving voluntary sector as described in the Care Together programme.

9.5 While grant funding is proposed to underpin the business for a transition year, Age UK have provided clear plans on how they will invest the funding to maximise the impact of the funding on their new offer.

10. EQUALITIES

10.1 As additional funds are being committed to existing services and to transform services, it is not anticipated that there will be an adverse impact on any of the groups with protected characteristics. In order to ensure that no groups are disadvantaged impact assessments will be carried out on the individual transformation projects.

11. RISK MANAGEMENT

11.1 A number of key risks have been identified.

Risk	Consequence	Impact	Likelihood	Action to mitigate against risk
Failure to deliver the projects	Failure to deliver against the identified benefits; reputational damage for the economy	4	2	Programme Manager employed and Transformation programme Board established to monitor and manage the programme
Failure to identify recurrent funding for identified schemes	Failure to meet intended outcomes for local people.	4	2	Ongoing dialogue with all parties to ensure resources are identified

	Future build-up of backlog and unmet need.			and committed.
Inability to recruit to identified project lead posts	Lack of capacity to deliver the projects	2	2	Engaging recruitment campaign and support to take on role where skills deficit identified
Inability to backfill following internal recruitment	Lack of capacity to deliver business as usual	3	4	Consider external recruitment; use of apprentices
Failure to deliver the identified objectives on time and within the budget	Failure to deliver the wider programme.	4	2	Robust performance management and corrective action to address poor performance

12. CONCLUSION

12.1 In his March 2017 budget the Chancellor announced an additional £2.0bn of funding for Adult Social Care to be made available to local authorities over the period 2017-18 to 2019-20. For Tameside this equates to a total of £10.296 million through to 2019-20.

12.2 This report provides an overview of the schemes that are proposed to contribute to the 3 key priorities that have been defined as key to improving system efficiency and will improve outcomes for people accessing services.

12.3 The proposals are intended to meet unmet need, to tackle a backlog of work, and also to transform services to improve outcomes for individuals, to benefit the wider economy by promoting resilience, self-management and supporting people to remain independently at home. Additional benefits are also expected with regards to step up and step down community capacity to reduce Accident & Emergency attendances and hospital admissions.

12.4 The programme will be managed through a Transformation Projects Board, will report through the Care Together Programme Management Office programme and will provide regular updates on progress through Local Executive Group and the Single Commissioning Board.

12.5 Specific permission is requested to provide grant funding of £127,000 to Age UK to support the re-scoping and embedding of the re-defined local offer for one year only..

13 RECOMMENDATIONS

13.1 As stated on the front of the report.

APPENDIX 1

	Proposal	Staffing / Resource Required	Grade	Number Of Posts	Months Funding Required	Total Estimate	Recurrent Beyond 3 Years Y/N/Both
				FTE		£'000	
	GM Pooled Initiatives/Contribution						N
	Contract Uplift/demographic pressures					1,152	Y
	Programme Manager	Programme Manager	Grade 8b (health)	1	24	120	N
		Project Analyst	Grade H	1	24	82	N
	QUALITY ASSURANCE						
1	Quality Assurance Team	Team Manager	Grade I	1	36	138	Y
		Social Worker	Grade H	2	36	246	
		Nurse		2	36	195	
		Medicines Technician		1	36	99	
		Vacant		1	36	123	
		Sessional Resources				100	
	SUPPORT TO REMAIN AT HOME						
2	CRS System	Project Lead	Grade H	1	12	41	Both
3	Reablement Service	Assistant Team Manager	Grade H	0.5	12	21	Both
4	Shared Lives	Project Lead	Grade H	1	12	41	Both
5	LD Employment Services	Employment Officer	Grade F	1	36	87	Y
6	Assessment and Care Management capacity	Social Worker	Grade H	5	5	85	N
7	Direct Payment Capacity	Project Lead	Grade H	0.5	12	21	N
		DP Officer	Grade F	1	36	87	
8	AMHP & CoP Capacity	AMPHs	Grade I	3	36	414	N
		Social Worker BIAs	Grade H	2	36	246	
9	Alternative Housing Options						Y
10	Day Service options for people with LD						Y
11	OT Capacity	Occupational Therapists	Grade H	5	4	68	N
12	Through the Night Service					112	Y
13	Sensory Services	Sensory Therapist	Grade H	1	36	123	Y
	ASSET BASED APPROACHES						
14	OD programme for whole workforce						N
15	Dementia						Y
16	Carers	Project Lead	Grade H	1	12	41	Both
17	Mental Health Recovery Service					100	Y
18	Third Sector Capacity/Investment	Funding to Age UK				127	N
		Funding to Tameside Sight				10	
19	Autism	Autism Co-ordinator	Grade H	1	24	82	Y
20	Grafton Model' Roll Out	4C				150	N
	ADDITONAL PROPOSALS						
21	Care Home Contract	Project Lead	Grade H	1	6	21	N
		Accountancy Support	Grade K	1	4	25	
					Total	**4,156**	

APPENDIX 2 - PROPOSED PROJECT INITIATION

PROPOSAL	MANAGER/OWNER	CLASSIFICATION OF PROJECT: BACKLOG / UNMET NEED / TRANSFORMATION / ENABLER / BaU
GM Pooled Initiatives/Contribution	Stephanie Butterworth	ENABLER
Programme Manager	Sandra Whitehead	ENABLER
Project Officer/Analyst	Reyhana Khan	ENABLER
QUALITY ASSURANCE		
Quality Assurance Team	Gill Gibson	TRANSFORMATION
SUPPORT TO REMAIN AT HOME		
CRS System	Mark Whitehead	TRANSFORMATION
Reablement Service	Paul Dulson	TRANSFORMATION
Shared Lives	Mark Whitehead	TRANSFORMATION
LD Employment Services	Mark Whitehead	UNMET NEED
Assessment and Care Management capacity	Paul Dulson	BACKLOG
Direct Payment Capacity	Paul Dulson	UNMET NEED
AMHP & CoP Capacity	Mark Whitehead	BACKLOG
Alternative Housing Options	Clare Watson	TRANSFORMATION
Day Service options for people with LD	Mark Whitehead	TRANSFORMATION
OT Capacity	Paul Dulson	BACKLOG
Through the Night Service	Mark Whitehead	UNMET NEED
Sensory Services	Mark Whitehead	UNMET NEED
ASSET BASED APPROACHES		
OD programme for whole workforce	Sandra Whitehead	TRANSFORMATION
Dementia	Clare Watson	TRANSFORMATION
Carers	Sandra Whitehead	TRANSFORMATION
Mental Health recovery	Clare Watson	TRANSFORMATION
Third Sector Capacity/Investment	Sandra Whitehead	BUSINESS AS USUAL
Autism	Mark Whitehead	TRANSFORMATION
Grafton Model Roll Out	Clare Watson	BUSINESS AS USUAL
Care Home Contract	Clare Watson	BUSINESS AS USUAL

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Report to: **SINGLE COMMISSIONING BOARD**

Date: 25 May 2017

Officer of Single Commissioning Board Anna Moloney, Consultant Public Health

Subject: **CONTRACT FOR THE PROVISION OF A YOUNG PEOPLES EMOTIONAL WELLBEING SERVICE**

Report Summary:

To present a report seeking authorisation under Procurement Standing Order F1.3 to extend for a period of twenty four months where there is provision to do so in the contract.

The current contract price for the financial year 2016/17 is £91,500. This was a reduction the previous annual sum of £106,785 for the financial year of 2014/15 as part of Council's Budget Strategy. In addition, at the time of the national in year Public Health grant saving (October 2015) this contract was further reviewed. It was considered that this service could not sustain an additional saving without a significant detrimental impact on children and young people Tier 1 and Tier 2 mental health interventions. This would have implications for the whole system approach in transformation for young people's mental health services as set out in the Children and Young people Emotional Wellbeing and Mental Local Transformation Plan.

This contractual service provision offer is a significant part of Tameside's ambition to provide high quality, seamless services to children, young people and their families and reduce demand on high-cost reactive services. The offer is integral to the system integration outlined in the Local Transformation Plan for children and young people's mental wellbeing.

Recommendations:

That the contract is extended for a period of twenty four months from 1 October 2017 to 30 September 2019.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

17/18 Budget Allocation (if Investment Decision)	£ 91,500
CCG or TMBC Budget Allocation	TMBC
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Expenditure and demand avoidance. Comparable benchmark data not available as a bespoke service contract (section 3.6 refers)

Additional Comments

The report requests a two year contract extension for the period 1 October 2017 to 30 September 2019 which is permissible within the terms of the existing contract.

Section 3.13 explains that it has been agreed that this contract is excluded from the wider commissioning review of existing grants and contracts.

The report also explains that the existing contract is performing well and is subject to quarterly monitoring reviews with the provider (please refer to tables in section 4.2). The service delivered also ensures greater demand related costs are avoided within the health and social care economy.

It is essential robust quarterly contract monitoring remains in place should the 2 year contract extension be approved. It is also essential that appropriate contract break clauses are also included within the extension period.

Economies of scale should continue to be monitored and evaluated as service provision within the economy is transformed over the medium term.

Legal Implications: **(Authorised by the Borough Solicitor)**	There is no reason to believe that this contract has not been properly procured therefore it would not be unlawful to extend the contract as described.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action.
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group advises that SCB endorse the recommendation that the Emotional Wellbeing Service contract is extended for a further 2 years from 1 October 2017 to 30th September 2019. The contract should continue to be part of our Children and Young People's Mental Health Transformation pathway.
Public and Patient Implications:	There may be implications for some Young People who without this preventive/early intervention service may then be admitted to hospital via Accident and Emergency Services either as an out-patient or an in-patient. The young person's family may also be impacted as they seek help for support and advice.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.

How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding is central to this service.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	There are no anticipated financial risks given the relatively low value of the contract. The service will work closely with the provider to manage and minimise any risk of provider failure consistent with the provider's contingency plan.
Access to Information :	The background papers relating to this report can be inspected by contacting Anna Moloney, Consultant Public Health Telephone: 0161 342 2189 e-mail: anna.moloney@tameside.gov.uk

1. INTRODUCTION AND SCOPE

1.1 Commissioners are working to deliver the requirements in the Tameside Health and Wellbeing Strategy to achieve better outcomes for young people aged up to 25 years of age with respect to emotional wellbeing and mental health from prevention through to specialist services. The Emotional Wellbeing Service is an integral part of this delivery. It has complemented services provided by specialist mental health services and can be classified as targeted and universal tier 2 mental health services although delivery and referral, including self-referral, may often be via Tier 1 services.

1.2 **Tier 1:** Primary care services including those offered by GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services.

1.3 **Tier 2:** Child and adolescent mental health services relating to workers in primary care. It includes: clinical child psychologists, paediatricians with specialist training in mental health, educational psychologists, child and adolescent psychiatrists, child and adolescent psychotherapists, counsellors, community nurses/nurse specialists and family therapists.

1.4 **Universal approach:** Universal approaches are curriculum-based programmes and other activities aimed at developing the social and emotional competence of all student

2. SERVICE VISION

2.1 In response to this challenge, the vision for this Service is as follows:

2.2 "Improve the emotional wellbeing of young people aged 10 - 25 who live in Tameside. This will be done by working with, supporting and actively engaging with children, young people, parents, policymakers and professionals." The Emotional Wellbeing service is a bespoke service tailored to cater for the mental health needs of our young people and is a pivotal part of the early intervention and prevention pathway.

2.3 Young people that meet the criteria for specialist mental health services, such as the child and adolescent mental health service (CAMHS) or adult mental health services should be referred for assessment and intervention.

2.4 The Emotional Wellbeing Service is 'person centred' and evidence based, which means that it has been delivered in conjunction with young people to support them to work through their issues, at their pace, in their own ways. Any identified safeguarding issues are addressed via the appropriate channels and dealt with in a safe, timely and professional manner in line with the Tameside Local Safeguarding Children's Board requirements.

2.5 The individual benefits/outcomes of emotional wellbeing support are described as:

- Better understanding of problems or issues
- Improved coping strategies for the presenting problem(s)
- Coping strategies that can be used and re-used for future problems
- Improved health and well being
- Reduced sickness absence from school/college/work
- Prevention of further risk(s)
- Improved life chances
- Improved social skills
- Individuals feel valued
- Improved chances of returning to work/gaining employment

- Less need for medication
- Prevention of problems or issues escalating

3. CURRENT SITUATION

3.1 Promoting social and emotional wellbeing of young people will help local authorities and their local partners meet objectives outlined in the Public Health Outcomes Framework for England, 2013–2016 and 2017 refresh.

3.2 As outlined above the wider family and community influence the emotional wellbeing of young people, and the following information demonstrates the high level of risk for Tameside's young people:

- Children exposed to domestic abuse at an early age have on average lower mental development than those not exposed, (on average an IQ score 7.25 points lower). In 2012/13 there were 27.7/1000 incidents of domestic abuse in Tameside compared to the England average of 18.8/1000.
- The number of parents in Tameside who are attending treatment for substance misuse who live with their child/children in 2011/12 was 189.7/100,000 compared to 110.4/100,000 nationally.

3.3 Locally the percentage of children living in poverty in 2014 was 24% compared to the England average of 21%

- The rate of alcohol harm amongst young people in Tameside is significant with Tameside having the second highest proportion of young people aged 14-17 years who reported binge drinking across Greater Manchester. Alcohol related hospital admissions 2012/2013 for under 18 years is significantly higher than the England Average at 67.9/100,000 compared to 36.6/100,000

- The rate of Tameside young people aged 10 to 24 years who are admitted to hospital as a result of self-harm in 2014/2015 period was significantly higher than the England average at 572.1/100,000 compared to 398.8/100,000.

- The local rate of children and young people aged 0-17 years admitted to hospital as a result of a mental health condition in 2014/2015 was higher than the England average at 180.5/100,000 compared to 87.4/100,000.

3.4 The contract commenced on the 1 October 2015 for an initial two years and with provision to extend for up to an additional two years.

3.5 The current contract price for the financial year 2016/17 is £91,500. This was a reduction the previous annual sum of £106,785 for the financial year of 2014/15 when the contract underwent a robust procurement exercise assessing population health need, evidence based practice, return on social value and value for money. Off the Record were granted the contract after a competitive process.

3.6 In addition, at the time of the national in year Public Health grant saving (October 2015) this contract was further reviewed. It was considered that this service could not sustain an additional saving without a significant detrimental impact on children and young people Tier and Tier 2 mental health interventions. The assessment at the time showed demand for Off the Record service was at an all-time high which remains to date. This would have implications for the whole system approach in transformation for young people's mental health services. The service delivery is unique and bespoke to Tameside and is a critical part of our young person mental health pathway. The service provider has been a key

partner on the CAMHS transformation workstream so we have seamless service provision. Therefore it is difficult to assign comparative benchmarking data with other localities. The assessed impact on service delivery for a 7% reduction would mean the provider would have to renegotiate with commissioners the online service provision which is intended to reach out to our most vulnerable children who may not have the support of a parent/carer advocate. At a 10% reduction the overall level service provision would be reduced and the vision for the children and young people's mental wellbeing system scaled back. This would have a negative impact on the demand for GP services and Healthy Young Minds and further implications for outreach work into schools. A 15% reduction would necessitate implementing emergency measures to ensure the offer remained viable and safe.

3.7 This contract helps to provide the infrastructure, which enables OTR to provide other separately funded activities and projects such as the Time -2- Talk Project, which is funded by Comic Relief. In addition, all grant providers now scrutinise charitable organisations accounts to test their financial stability and sustainability. Any threats to long term funding make it much harder for organisations like OTR to raise much needed funding from The Big Lottery, Comic Relief, Children in Need etc.

3.8 The service is subject to three monthly performance management meetings which includes a review of performance data and case studies. It is also subject to an annual validation.

3.9 The Performance Officer has seen evidence from the young people who use the service that they clearly value the staff and the service that they receive feedback from young people is extremely positive regarding outcomes and quality of service received. They speak highly of all the staff and have stated that they feel that their lives benefit from using the service.

3.10 The service is performing as required under the contract and there are no contractual compliance issues, and overall the service has developed well with joint working across stakeholders.

3.11 Routine Outcome Measures data regarding the service is sent 6 monthly to the Child Outcome Reach Consortium (CORC). This is used as a national bench mark measure. Activity data is collated monthly in order for the data to be submitted in time. In addition Patient Stories are required quarterly and Annual Voice of the Child Audit findings to the Single Commission Service. Review meetings are held every 3 months with the provider and Single Commission.

3.12 The total cost for the twenty four month extension period will be £183,000 (£ 91,500 per annum).

3.13 It should be noted that this service contract is excluded from the wider commissioning review of grants and contracts as the service model and funding has been reviewed twice by commissioners during the last two years. To reduce the current contract price would seriously jeopardise the service efficacy as described above.

4. GROUNDS UPON WHICH AUTHORISATION TO PROCEED SOUGHT

4.1 Authorisation under Procurement Standing Order F1.3 where there is provision within the contract to extend for a period of up to twenty four months from 1 October 2017.

4.2 Robust contract monitoring has been undertaken throughout the length of the contract. The report's author is satisfied that the service is being delivered to an excellent standard.

Performance data received each quarter provides good evidence the service is meeting Children's Services objectives. Key performance measures are provided in table 1 below:

Table 1

	Oct 2015 to Dec 2015	Jan 2016 to Mar 2016	Apr 2016 to Jun 2016	Jul 2016 to Sept 2016	Oct 2016 to Dec 2016
Counselling - One to One Sessions					
Number of young people seen	120	126	137	133	111
Number of new young people seen	67	98	105	91	80
Number of sessions delivered	492	579	530	513	476
Average number of sessions delivered to each young person that attends - **National average is 4.6 sessions**.	4.1	4.6	3.8	3.9	4.3
Number of new referrals received	84	64	40	32	67
Number of young people discharged	46	40	39	53	44
Drop in Sessions					
Number of service users seen	50	64	40	32	38
Number of sessions attended by young people	50	38	32	48	57
Number of repeat visits by young people	23	26	17	16	19
Waiting Lists					
Number of young people on waiting list (All young people on the waiting are informed about the Drop-In, some attend)	207	267	127	113	149
Average number of weeks young people have been on a waiting list	20	22	18	14	13

Table 2 provides details of the referring partner / agency for new referrals :

Table 2

Partner / Agency	Oct 2015 to Dec 2015 %	Jan 2016 to Mar 2016 %	Apr 2016 to Jun 2016 %	Jul 2016 to Sept 2016 %	Oct 2016 to Dec 2016 %
GP	34	30	35	38	48
Friend/Family	9	13	15	16	13
School	20	34	18	10	7
CAMHS	8	5	9	10	5
Inspire Team	1			1	
College	4	1	2	1	1
The HUB/Social Services	4	3	6	8	6
Family First			1		1
Early Help	1	1	2	1	3
42nd Street	2				
Branching Out	2				
Hospital		1		3	2

Ex client		9	12	12	11
Carer		1			
MIND		1			1
School Nurse		1		1	1
CAF				3	
Health visitor				1	
Leaving care				1	1
The Police				5	
A Poster					1

4.3 The service is essential to ensure there is; intervention at an earlier stage with young people who maybe or are experiencing mental and emotional health needs.

4.4 The current service provider has shown a commitment to continually improving systems and service delivery to meet the needs of its service users:

4.5 The following options have been considered and discounted for the reasons stated below:-

- **End contract and amalgamate the service with other services/contracts.** Due to the specific nature of this service, it would be extremely difficult to undertake any form of amalgamation with other services/contracts as it was felt that the elements of the service could easily be consumed and the success of the service suffer as a result. It would be difficult to purchase the individual elements of the service for the financial commitment that is already provided by each area, as outlined above.

- **End contract and re-tender**; there is no guarantee that we would be able to find a successful tenderer to provide this service at the price that we currently invest. This had been reviewed at the time of procurement; the impact of a further reduction would make the delivery of the specification untenable. This course of action would not provide any added benefits to the organisation, the service provider or the service users and may create a break in service provision for young people.

- **Extend contract on renegotiated terms**; the current contract price is very low in terms of the significance of this work and reflects value for money. To reduce the current contract price would seriously jeopardise the service as the supplier would find it difficult to deliver the same levels of support. The purchaser and supplier agree that the current funding levels meet the required demand.

- **Extend contract on current terms;** based on the positive performance during this contract to date. This is the preferred option.

5. REASON WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED:

5.1 The Procurement Standing Orders are being complied with. Under Procurement Standing Order F1.3 permission must be sought to extend a contract even when the provision to extend is included within the contract.

6. RECOMMENDATION

6.1 As set out on the front of the report.

Report to: **SINGLE COMMISSIONING BOARD**

Date: 25 May 2017

Officer of Single Commissioning Board Angela Hardman, Executive Director - Public Health, Business Intelligence and Performance

Subject: **DRUG & ALCOHOL RECOVERY SERVICE**

Report Summary: Lifeline Project Ltd will transfer their business and assets to CGL (Change, Grow, Live) on 31 May 2017 and a novation of the current contract would be required to continue with current service provision.

Recommendations: That approval is given under Council Procurement Standing Order F1.5 to vary the contract for the above service by the novation of the contract to a new provider who takes on the obligations of the original contractor.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Budget Allocation (if Investment Decision)	2017/2018 - £ 3.469 million
CCG or TMBC Budget Allocation	TMBC – Public Health
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	Single Commissioning Board
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Avoidance of health service demand related expenditure

Additional Comments

Single Commissioning Board members should be satisfied that the novation of the contract to the new provider on 31 May 2017 will ensure continuity of an essential service to the health and social care economy.

It is important to note that the new organisation is currently considered to be financially stable based on the details provided within the organisation questionnaire referenced in **Appendix 1**.

However, it is critical that continual and regular reviews of the organisation's financial stability should be implemented within the ongoing contract monitoring arrangements to ensure there is a sufficient period available for alternative arrangements to be implemented in the eventuality of organisational failure in the future.

Legal Implications: **(Authorised by the Borough Solicitor)**	The need for the novation of the contract arises from the financial position of the contracted provider (Lifeline Project Limited) who intends to transfer the business to CGL Plc with effect from 1 June at the latest. Regulation 72(1)(d) of the Public Contracts Regulations 2015 allows the modification of a contract without a new procurement procedure where as a consequence of universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger, acquisition or insolvency, of another economic operator that fulfils the criteria for qualitative selection initially established, provided that this does not entail other substantial modifications to the contract and is not aimed at circumventing the application of the regulations. Officers have evaluated the Organisational Questionnaire submitted by CGL Plc and are satisfied that it meets the criteria for qualitative selection initially established during the original procurement. CGL Plc have confirmed during due diligence discussions that they propose to operate the contract as is with no modification and therefore it would not be unlawful for the Council to rely on Regulations 72(1)(d) and approve the recommendation.
How do proposals align with Health & Wellbeing Strategy?	Reducing harmful drug and alcohol use is identified as a priority within the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	Reducing harmful drug and alcohol use is important to reduce premature mortality, hospital admissions and long term conditions, and contribute to our ambition to increase healthy life expectancy.
How do proposals align with the Commissioning Strategy?	Reducing harmful drug and alcohol use will contribute to reducing premature mortality, hospital admissions and long term conditions.
Recommendations / views of the Professional Reference Group:	The report has not been submitted to the Professional Reference Group due to the urgency of events leading to this report.
Public and Patient Implications:	Novation of the contract will ensure continuity of service provision. The new service has attracted new clients, particularly alcohol users and young people.
Quality Implications:	The results of the Organisational Questionnaire are included in the waiver report. CGL passed all sections of the document which includes elements on organisational information, financial details, insurance, equal opportunities, health & safety, clinical safety and governance, business contingency and safeguarding. Each area has been evaluated by a lead officer.
How do the proposals help to reduce health inequalities?	Harmful drug and alcohol use is associated with social deprivation. The service aims to support recovery enable independence, and stability of housing, relationships and employment.
What are the Equality and Diversity implications?	The service is available to self referral from anyone with a concern about their use of drugs or alcohol.

What are the safeguarding implications?	Service users and their families may be vulnerable as result of harmful drug use. The current service was reviewed by CQC in December 2106, and no concerns about safeguarding were identified. Safeguarding was included in the Organisational Questionnaire for CGL, and some policy issues for follow up were identified.
What are the Information Governance implications?	Information Governance was included in the Organisational Questionnaire and considered satisfactory.
Has a privacy impact assessment been conducted?	This was concluded within the tender in 2015.
Risk Management:	Information Governance was included in the Organisational Questionnaire and considered satisfactory.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant Public Health  Telephone: 07989 991041  e-mail: e-mail: gideon.smith@tameside.gov.uk

1 BACKGROUND

1.1 A Key Decision was taken on 22 October 2014 whereby the Council agreed the following:-

- Decommission all current Drug & Alcohol services and commission a single prime provider to develop and deliver a whole system approach.
- Undertake a procurement exercise using the open procedure to let a 10 year contract with safeguards as highlighted in 6.6 of the Key Decision.
- Delegate to the Director of Public Health in consultation with the Executive Director – Governance (Borough Solicitor) and Executive Director Finance authority to approve the evaluation criteria and the procurement documentation needed.

1.2 Public Health is the commissioner of this service and were supported by the Joint Commissioning and Performance Management Team.

1.3 An open tendering exercise commenced on 6 November 2014 and closed on 12 January 2015. This was completed in accordance with Tameside Metropolitan Borough Council Procurement Standing Orders. Tenders were invited via OJEU (the EU Official Journal) and other related on-line sites and journals via Delta Electronic Tendering Service who facilitate access to OJEU).

1.4 A full financial check was undertaken on all tendering organisations by the Treasury Management Department at Tameside Council. All providers were considered to be financially viable to provide this contract, met the requirements of the Health and Safety checks completed and indicated they had or were willing to take out relevant insurance on contract award.

1.5 Following receipt of a full summary of the evaluation scores, Lifeline Project Ltd were awarded the contract.

2. PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

2.1 Authorisation required under Procurement Standing Orders F1.5 to vary a contract by novation of the contract to a new provider who takes on the obligations of the original contractor.

3 VALUE OF CONTRACT

3.1 The total contract value at commencement was £32,920,000. The contract began on 1 August 2015, with contractual planned end date of 31 July 2025.

3.2 The term currently remaining is 8 years and 2 months with a maximum value of £26,380,166 (including Payment for change element).

4. GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

4.1 Lifeline Project Ltd recently advised of their intention to transfer the business and assets of Lifeline to another organisation, Change, Grow, Live (CGL Plc). Lifeline Project Ltd proposed the change due to their current financial position following advice from financial advisors FRP Advisory. Lifeline have developed a close relationship with CGL in order to secure the continuity of its services to the community. The financial prospects of Lifeline is currently uncertain.

4.2 Lifeline and CGL have progressed their transfer to the stage of legal, contractual and workforce transference that is necessary for the handover from Lifeline to CGL to occur. This is planned to take effect at the end of May 2017.

4.3 In order to take all necessary steps to continue to protect the care of service users and employees it is proposed to novate the current contract held between Tameside MBC and Lifeline Project Ltd to a contract to be held between Tameside MBC and CGL Plc (Charity No: 1079327) (Company No: 03861209).

4.4 The novated contract would be completed on the existing contractual terms agreed for the remainder of the contractual term, which includes the necessary protection of staff in all areas of the contract, the value of which is provided within section 3.

4.5 In order to be assured of the capability and competence of CGL as an organisation and their ability to achieve and deliver the contractual obligations, a full organisational questionnaire was submitted by CGL, identical to the document provided by tendering organisations during the original service tender.

4.6 The results of the organisational questionnaire are provided in Appendix 1. CGL passed all sections of the document which includes elements on organisational information, financial details, insurance, equal opportunities, health & safety, clinical safety and governance, business contingency and safeguarding. Each section has been evaluated by lead officers.

5. REASONS WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED

5.1 Regulation 72(1)(d) of the Public Contracts Regulations 2015 allows the modification of a contract without a new procurement procedure where as a consequence of universal or partial succession into the position of the initial contractor, following corporate restructuring, including takeover, merger, acquisition or insolvency, of another economic operator that fulfils the criteria for qualitative selection initially established, provided that this does not entail other substantial modifications to the contract and is not aimed at circumventing the application of the regulations.

5.2 In order to ensure compliance with Regulation 72(1)(d) and to be assured of the capability and competence of CGL as an organisation and their ability to achieve and deliver the contractual obligations, a full organisational questionnaire was submitted by CGL identical to the document provided by tendering organisations during the original service tender.

5.3 The results of the organisational questionnaire are attached. CGL passed all sections of the document which includes elements on organisational information, financial details, insurance, equal opportunities, health & safety, clinical safety and governance, business contingency and safeguarding. Each section has been evaluated by lead officers.

5.4 The novation would require a new agreement on the same terms as the original agreement, with the original agreement between Tameside MBC and Lifeline Ltd being discharged. Once transferred, the original contract terms remain and the assignor (CGL) will remain bound by any prospective obligations and liabilities under it

6. RECOMMENDATION

6.1 As stated on the report cover

Appendix 1

	Organisational Questions & Scores	
Provider Name: CGL - May.17		
Q. Number	**Questions**	**Score**
1.10a	Bankruptcy proceedings or been involved in an organisation that has been subject to liquidation proceedings or had receivers appointed	Pass
1.10b	Convicted of any criminal offence, apart from minor traffic offences	Pass
1.10c	Committed a criminal offence relating to the conduct of your business or profession	Pass
1.10d	Any legal proceedings (including Arbitration) with any other organisations including local authorities	Pass
1.13	Compliant with Data Protection Act	Pass
2.1	Financial Details	Pass
3.1	Insurance Levels	Pass
4.1	Equal Opportunities Policy compliant with Equality Act 2010	Pass
4.3	Response to any finding of any unlawful discrimination	Pass
5.1	Is the Provider CHAS (or equivalent) registered?	Yes
5.2	If not CHAS or equivalent registered, is Health & Safety Policy compliant with legislation	Pass
6.1	Clinical Questions	Pass
6.2	Clinical Questions	Pass
6.3	Clinical Questions	Pass
6.4	Clinical Questions	Pass
6.5	Clinical Questions	Pass
6.6	Clinical Questions	Pass
6.7	Clinical Questions	Pass
6.8	Clinical Questions	Pass
6.9	Clinical Questions	Pass
6.10	Clinical Questions	Pass
6.11	Clinical Questions	Pass
7.1	Business contingency	Pass
7.2	Business contingency	Pass
8.1	Safeguarding	Pass
8.2	Safeguarding	Pass

Report to: **SINGLE COMMISSIONING BOARD**

Date: 25 May 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **2017-18 COMMISSIONING IMPROVEMENT SCHEME**

Report Summary:

This paper outlines a proposal for a Commissioning Improvement Scheme (CIS) for 2017/18 based on the learning from the 2016/17 scheme and preparatory discussions at Finance & Quality, Innovation, Productivity and Prevention Programme Group. Achievement under the parameters of the 2016/17 Commissioning Improvement Scheme have been calculated and the engagement and innovative thinking of practices and neighbourhoods acknowledged. There is however also learning from the framework of that scheme which needs to be reflected whilst maintaining the spirit in which the initial outline was drafted and the positive engagement and creative thinking the scheme has supported.

Recommendations:

The Single Commissioning Board is asked to support the 2017/18 Commissioning Improvement Scheme proposal, noting the recommendations made by the Professional Reference Group in relation to the following issues:

1. The continuation of the high cost patients risk pool, however with the change for 2017/18 to apply 50% of each high cost episode to the pool.
2. The adjustment to the achievement scenarios in relation to underspends and/or improvements made by practices the percentages to be applied and the inclusion of the neighbourhood element.

Financial Implications:

(Authorised by the statutory Section 151 Officer & Chief Finance Officer)

17/18 Budget Allocation (if Investment Decision)	£0 in 2017/18 – any payments due would be made in 2018/19 and 2019/20
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB decision
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoided, Benchmark Comparisons	Deliverable savings & Expenditure avoided.

Additional Comments

A commissioning improvement scheme was in place during 2016/17. During this period GP referrals reduced by 6% relative to the prior year, demonstrating the potential value the scheme has in challenging poor referral practice and contributing to the long term financial gap.

Payments in relation to the 2017/18 Commissioning Improvement Scheme will be made out of budgets in 2018/19 and 2019/20. An indicative budget of £1.5m has been created in 2018/19. From this we will need to make a final payment in relation to the 2016/17 scheme. Value of this is unknown at present, but estimated at around £0.5m. Leaving around £1m available in 2018/19 to fund the 2017/18 scheme.

It is important to note that the schemes proposed in this paper are not capped, which presents a risk to our financial position in 2018/19 and beyond. Payments due under Commissioning Improvement Scheme could be significantly higher than currently allowed for in budget if practice performance continues to improve. While sustained long term reductions in practice expenditure are clearly beneficial to the overall financial position, it is important to appreciate that in the short term the Commissioning Improvement Scheme would not be self-funding because of 'block' contracting arrangements.

Legal Implications: **(Authorised by the Borough Solicitor)**	Without an understanding of the financial implications not yet provided of the proposed Commissioning Improvement Scheme (CIS) it is not possible to assess whether it fulfils the public law test of value for money. Clearly the CIS should support and provide outcomes in line with the Strategies outlined below and within this paper.
How do proposals align with Health & Wellbeing Strategy?	The paper describes a mechanism for continued practice and neighbourhood engagement and delivery of all elements of the Health & Wellbeing Strategy.
How do proposals align with Locality Plan?	The paper describes a mechanism for continued practice and neighbourhood engagement and all elements of the Locality Plan, with primary care being a key link in its delivery.
How do proposals align with the Commissioning Strategy?	The Commissioning Improvement Scheme proposal fully supports the Commissioning Strategy with member practices a key link between our strategy and patient need.
Recommendations / views of the Professional Reference Group:	PRG recommended support of the Commissioning Improvement Scheme in principle and this version of the report reflects the discussion and views of PRG and the subsequent discussion recommended by PRG to be had at Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group on 17 May 2017.
Public and Patient Implications:	The CIS will not impact on service provision and therefore not impact directly on patients however may highlight areas for consideration through Commissioning Strategy for service redesign. As such any changes considered would be taken through appropriate governance and consultation as required.

Quality Implications:	The principles of the Commissioning Improvement Scheme are to recognise the performance of practices against their devolved unified commissioning budget in comparison to the prior year and therefore maintain and further develop engagement in delivering QIPP (Quality, Innovation, Productivity and Prevention) and securing best use of resources across the economy.
How do the proposals help to reduce health inequalities?	The engagement in the Commissioning Improvement Scheme by each practice will review the activity data and requirements for patients and therefore will address health inequalities within each practice population.
What are the Equality and Diversity implications?	This proposal addresses total practice population.
What are the safeguarding implications?	There are no safeguarding implications; the scheme provides a mechanism for each practice to review the data for their practice against its unified budget. Direct patient care will continue to be delivered through practices contracted route and therefore any safeguarding issues/implications be addressed under that process.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no IG implications; the data provided to practices is pseudonymised. Practices review their own data in line with their own IG protocols.
Risk Management:	Any risks identified will be managed through the neighbourhood support arrangements of Commissioning Business Managers and Neighbourhood Finance Leads.
Access to Information :	The background papers relating to this report can be inspected by contacting Tori O'Hare Telephone: 07920 086397 e-mail: tori.ohare@nhs.net

1. INTRODUCTION

1.1 This paper outlines a proposal for a Commissioning Improvement Scheme (CIS) for 2017/18 based on the learning from the 2016/17 scheme and preparatory discussions at Finance & Quality, Innovation, Productivity and Prevention Programme Group. Achievement under the parameters of the 2016/17 Commissioning Improvement Scheme have been calculated and the engagement and innovative thinking of practices and neighbourhoods acknowledged. There is however also learning from the framework of that scheme which needs to be reflected whilst maintaining the spirit in which the initial outline was drafted and the positive engagement and creative thinking the scheme has supported.

1.2 The principles of the Commissioning Improvement Scheme are to remain, that is to recognise the performance of practices against their devolved unified commissioning budget in comparison to the prior year and therefore maintain and further develop engagement in delivering QIPP (Quality, Innovation, Productivity and Prevention) and securing best use of resources across the economy.

1.3 This version of the scheme proposal reflects the discussion at the Professional Reference Group on 10 May 2017 and the discussion at Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group on the 17 May 2017.

2. LEARNING FROM 2016/17

2.1
- Budget Setting Methodology;
- Achievement – improvement v underspend;
- Forecasting of achievement payments;
- Parameters for utilisation of achievement payments.

2.2 The 2017/18 proposal recognises these issues and adapts the model to address the concerns raised.

3. BUDGET SETTING

3.1 Practice budgets are calculated annually to devolve to each practice their share of the Clinical Commissioning Group healthcare budgets. In 2016/17 and 2017/18 this includes devolving QIPP across practices. This principle is proposed to remain the same. The scope and mechanism for devolving budgets is for local determination though a national toolkit for calculating fair shares is available. After a comprehensive review of potential budget setting options Finance and QIPP Group have agreed a budget setting methodology for 2017/18 based directly on the national toolkit and utilises its full potential to set budgets at practice level with the exception of the four practices which opened during the source data period of the toolkit and consequently for whom the toolkit is not reliable and therefore a weighted capitation share is to be used as a proxy.

3.2 Opening practice budgets for 2017/18 are being calculated using this methodology. In line with previous years, they will change through the year for the quarterly list size refresh and for changes in Clinical Commissioning Group allocation.

3.3 The 2016/17 practice budgets will also be restated for this change to the methodology for the purpose of accurate prior year comparator. Practices' restated 2016/17 budget will be distributed for information as soon as possible.

3.4 The high cost patients risk pool included in the budget setting methodology for 2016/17 was to hold a £1.5m risk pool topslice and the highest cost episodes of patient level expenditure mapped against this rather than practice budgets. This approach to managing a risk pool will be replicated in 2017/18 however with an adjustment to allocate 50% of the cost of the high cost episode to the risk pool. This approach is felt to allow the resource to be distributed further and therefore support a greater number of practices to benefit from the risk pool.

3.5 The potential for variation in those episodes attributed to the risk pool will be reiterated in the presentation of the data to practices to support practices in the management of their budget.

4. ACHIEVEMENT FRAMEWORK/GRID

4.1 The proposal for achievement under the Commissioning Improvement Scheme in 2017/18 is proposed to follow the same principles as 2016/17 of recognising underspends against budget in year and recognising improvements against 2016/17 when comparing the variance position of each year.

4.2 A point of learning acknowledged from 2016/17 is that the potential for a significant improvement by a practice which resulted in a change from an overspent position to an underspend position was not clearly recognised. This has been addressed in the achievement framework proposed for 2017/18.

4.3 The Commissioning Improvement Scheme proposal for 2017/18 will see practices achieving one of four outcomes:

	Budget Outcome	Achievement Proposal
A	Practice achieves an underspend against their 2017/18 budget and achieved an underspend against their 2016/17 budget	Practice receives an underspend payment of 50% of the value of the 2017/18 underspend.
B	Practice achieves an underspend against their 2017/18 budget and this is an improvement from an overspent year end variance in 2016/17.	Practice receives an underspend payment of 50% of the value of the underspend. Practice receives 15% of the improvement made, the value of the overspend to breakeven position.
C	Practice overspends against their 2017/18 budget however that this is an improvement in comparison to the year end variance in 2016/17.	Practice receives 15% of the improvement value.
D	Practice overspends against their 2017/18 budget and this is not an improvement in comparison to the year end variance in 2016/17.	Practice does not qualify for an achievement payment.

Notes:
- comparison to the 2016/17 variance is the variance restated for the change in budget setting methodology.

4.4 Based on the above percentages a number of worked examples of the achievement proposal are illustrated below:

Practice	16/17 Variance	17/18 Variance	Outcome	Under-spend Payment	Improvement Payment	Total Achievement
A	(£299,958)	£19,407	B	9,704	44,994	54,697
B	£321,430	£60,743	A	30,371	-	30,371
C	(£810,464)	(£578,966)	C	-	34,725	34,725
D	£133,876	(£39,765)	D	-	-	-
E	£251,924	£287,444	A	143,722	-	143,722
F	£687,451	£176,183	A	88,092	-	88,092

5. COST

5.1 The affordability of achievement payments needs to be considered, this would be a commitment in budget setting for 2018/19 as the nature of a Commissioning Improvement Scheme requires achievement payments to be made in the following financial year.

5.2 Sensitivity analysis, varying the rate for each achievement component, was undertaken through the Professional Reference Group and Finance & Quality, Innovation, Productivity and Prevention Programme Assurance Group discussions before agreeing on the above percentages.

5.3 In addition to the above, a neighbourhood payment was supported for inclusion by the Professional Reference Group. This would see a further payment, proposed on the basis of a rate per weighted head of population at 1 January 2018, made to each practice if a neighbourhood underspend is achieved. This is proposed as being payable to all practices in the neighbourhood, if the neighbourhood achieves an underspend, and is not linked to individual practice achievement against the outcome grid. This, based on £2 per weighted head of population, would equate to a maximum further payment of circa £517k. This figure is illustrative based on 1 January 2017 list sizes however would be calculated based on list size information at 1 January 2018.

5.4 The inclusion of a neighbourhood element to the Commissioning Improvement Scheme would support continued sharing of best practice around processes and protocols, peer review and support in each of our five neighbourhoods and would strengthen the commissioning focus within neighbourhood discussions. This would also retain the neighbourhood element of the 2016/17 scheme without increasing the complexity of criteria for improvement payments.

6. ACHIEVEMENT CALCULATIONS TIMESCALES & PAYMENT TIMESCALES

6.1 One of the challenges in year relating to the 2016/17 scheme was the request from practices and neighbourhoods for achievement forecasts. The risk of forecasting a year end position from early months data is significant as there is a limited basis to estimate from, plus the potential for change in the financial position overall and further risk of change in the allocation of the high cost patients risk pool. The benefit of providing this information is however deemed to outweigh this and therefore it is proposed to provide this at least quarterly, with an aspiration to provide this more frequently, however this will be clearly marked and discussed through neighbourhood meetings as indicative.

6.2 The proposal in terms of payments is to continue in 2017/18 of the principle of using an indicative achievement position based on M9 data from which to invite

practices/neighbourhoods to produce business case proposals for utilisation of these resources.

6.3 There is a risk that the month 12 refresh of achievement calculations reduces the amount due to practices. Timing of the month 12 data, available in June, could allow practices to plan a business case based on the achievement calculation forecast with month 9 data however business cases be reviewed in June be after receipt of month 12 data. This would give practices April and May to plan utilisation of their payments, however these figures be refreshed alongside submission of business cases in June so as to ensure affordability within the month 12 achievement figure.

6.4 The payments to be made to practices would be based on the month 12 achievement figures. Again, a 75% part payment could be paid to practices in early in 2018/19, with the balancing payment in 2019/20.

7. UTILISATION OF ACHIEVEMENT PAYMENTS

7.1 Recognising the learning from 2016/17 in respect of utilisation of achievement payments, the panel process for sign off of utilisation proposals will be repeated. This recognises the scale of potential payments and the need for scrutiny of the utilisation of resources across the economy whilst supporting the innovative thinking within neighbourhoods.

7.2 The spend proposal for practice achievement payments will be considered by the Clinical Commissioning Group in line with 2016/17, with a review process in place tiered on the basis of value of business cases. This recognises practices may wish to utilise their achievement funding on a number of schemes. The review process would be as follows:

Business Case Value	**Process**
£0 - £10,000	Email to Commissioning Business Manager and assessment within Single Commissioning Function, to include appropriate neighbourhood finance representative
£10,001 - £50,000	Virtual assessment by the Commissioning Improvement Scheme panel (see below)
£50,001 +	A presentation to the Commissioning Improvement Scheme panel (see below) may be required

The panel will consist of the following members:

- Commissioning Business Manager;
- Finance representative;
- Commissioning Directorate representatives – including the appropriate portfolio lead for the project topic;
- Lay / Patient Participation Group representative;
- Clinical Commissioning Group Clinical Lead for Primary Care.

7.3 Panel dates would be set for June and all practices encouraged to submit business cases to that timescale. There is a recognition that some proposals may require further lead time however a cut off date for all business cases to be submitted of 28 September 2018 proposed. Provisional panel dates will be set to review any proposals to that date.

7.4 As in 2016/17 the proposal is not to restrict the criteria for the investment of the funds through this scheme, but that we would want to see this investment in schemes which align to the strategy across Tameside and Glossop. For example, the delivery across the

economy of the Integrated Neighbourhood and Self Care workstreams and would suggest that practices consider the areas which are a priority for the locality. In communicating achievement, up to date information on workstreams will be communicated to support practices in considering business case proposals. Again the intention will be to enable practices to be proactive and innovative however we would ask practices to be mindful of the non-recurrent nature of the funding if establishing new ways of working (including any ongoing costs of any new equipment purchased) and that they will be going at risk if they proceed on the expectation of a successful outcome and evaluation.

8. RISKS

8.1 Maintaining practice and neighbourhood engagement and drive around improvements in effective use of NHS resources, the sustainability of the economy is crucial and this format of Commissioning Improvement Scheme has proven to be successful to that aim in 2016/17. There is risk around competing priorities and capacity within general practice as across the system and therefore the continuation of a Commissioning Improvement Scheme is a positive step to maintain engagement and focus on the financial challenge in 2017/18 and beyond and to realise the impact of actions and initiatives implemented in 2016/17.

8.2 There is a risk however that the year end impact of engagement by our member practices, alongside the impact of work by officers with the Single Commission and across the economy, cannot be reliably predicted and therefore the likely cost of a Commissioning Improvement Scheme cannot reliably forecast. The risk of not operating a Commissioning Improvement Scheme however, may exceed the risk around forecasting the resources required for achievements.

9. COMMUNICATION

9.1 Communication referencing a Commissioning Improvement Scheme for 2017/18 has already been made to practices in correspondence regarding the 2016/17 achievements, and the Professional Reference Group recommended further communication at the TARGET session on 18 May 2017, and therefore the focus has not been lost despite the timing of sign off of the detail of the 2017/18 proposal.

9.2 Neighbourhood meetings will be used as the communication route and a launch document produced to support this roll out and minimise the potential for some of the confusion and ambiguity of messaging which was seen in 2016/17. In addition, this launch document will be presented at Practice Manager Learning Forum.

9.3 The Commissioning Improvement Scheme launch will be a Single Commission Function and Integrated Care Foundation Trust document, as the success of the Commissioning Improvement Scheme is crucial in the overall system delivery of transformation and efficiencies.

9.4 Alongside the communication of the Commissioning Improvement Scheme, neighbourhood meetings will also be used to communicate the budget setting methodology for 2017/18 as this is a key factor within the scheme and was an area of discussion and challenge in 2016/17.

9.5 The finance agenda item at monthly neighbourhood meetings in year will reference the Commissioning Improvement Scheme, the framework of the scheme and give updates on the overall financial position of the neighbourhood and Clinical Commissioning Group

alongside practice financial and activity data to support practices in managing their position.

10. RECOMMENDATION

10.1 As set out on the front of the report.

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