SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 14 November 2017
Time: 2.00 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

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 31 October 2017.	1 - 6
4.	**COMMISSIONING FOR REFORM**	
a)	**WOMEN AND THEIR FAMILIES SERVICE PROCUREMENT** To consider the attached report of Gideon Smith, Consultant in Public Health Medicine.	7 - 12
b)	**TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS** To consider the attached report of the Director of Quality and Safeguarding.	13 - 32
c)	**ANGIOGRAPHY SERVICES** To consider the attached report of the Interim Director of Commissioning.	33 - 70
5.	**EXTENSION OF CURRENT CONTRACTUAL RELATIONSHIP (PRE-PLACEMENT AGREEMENT FOR PROVISION OF PERMANENT, TEMPORARY OR RESPITE CARE FOR OLDER PEOPLE IN A CARE HOME, WITH OR WITHOUT NURSING) TO 31 MARCH 2018** To consider a report of the Director of Adults, to follow.	
6.	**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).	
7.	**DATE OF NEXT MEETING** To note that the next meeting of the Single Commissioning Board will take place on Tuesday 12 December 2017 commencing at 2.00 pm.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker, Senior Democratic Services Officer, to whom any apologies for absence should be notified.

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TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

31 October 2017

Commenced: 2.00 pm **Terminated: 4.00 pm**

Present: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Steven Pleasant – Tameside Council Chief Executive & Accountable Officer for NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Dr Alison Lea – NHS Tameside and Glossop CCG
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance
Stephanie Butterworth – Director of Adult Services
Gill Gibson – Director of Quality and Safeguarding
Jessica Williams – Interim Director of Commissioning
Tom Wilkinson – Assistant Director of Finance
Sarah Dobson – Assistant Director, Policy, Performance & Communications
Ali Rehman – Head of Business Intelligence and Performance
Debbie Watson – Interim Assistant Director of Population Health

Apologies: Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC

56. DECLARATIONS OF INTEREST

Members	Subject Matter	Type of Interest	Nature of Interest
Christina Greenhough	Item 6(a) – Tameside and Glossop Proposal for Effective Urgent Care: Case for Change	Prejudicial	Director of Go-to-Doc

57. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 26 September 2017 were approved as a correct record.

58. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a jointly prepared report of the Director of Finance, Tameside and Glossop CCG / Tameside MBC and the Director of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust providing a 2017/18 financial year update on the month 5 financial positon, at 31 August 2017, and the projected outturn at 31 March 2018.

It was highlighted that Tameside and Glossop Integrated Care Foundation Trust had still to agree a financial control total with its regulator, NHSI Improvement and the Trust. However, as reported a previous meetings of the Single Commissioning Board, this was affecting the Trust's eligibility to access the targeted element of Sustainability and Transformation funding as providers must have accepted an agreed control total. The Chief Executive and Accountable Officer added that Jon Rouse, Chief Officer, Greater Manchester Health and Social Care Partnership, had written to the Department of Health expressing the Partnership's concern on this matter.

RESOLVED

(i) That the 2017/18 financial year update on the month 5 financial position at 31 August 2017 and the projected outturn at 31 March 2018 be noted.

(ii) That the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budged be acknowledged.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period be acknowledged.

59. PERFORMANCE REPORT

Consideration was given to a report of the Assistant Director (Policy, Performance and Communications) 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 positon. This was based on the latest published data at the end of July 2017. The following which were highlighted as exceptions:

- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Diagnostic standard failed;
- Ambulance response times were not met at a local or at North West level;
- 111 Performance against Key Performance Indicators.

In response to a previous request from members of the Single Commissioning Board, the Assistant Director outlined examples and suggestions of Children's Social Care performance. This was not intended to be exhaustive but rather a starting point for inclusion in future performance reports.

It was also reported that the North West Ambulance Service had recently introduced new standards to enable the service to identify patients' needs better and send the most appropriate response. Under the new standards there were four response categories:

- Category one – for calls about people with life-threatening injuries and illnesses;
- Category two – for emergency calls;
- Category three – for urgent calls; and
- Category four – for less urgent calls.

The Single Commissioning Board noted that these changes followed the largest study of an ambulance system and the bar would be set at 90% of calls to be reached in the target times rather than 75% under the old system. The North West Ambulance Service would be providing data on performance against the new standards from November 2017 and these would be integrated into future performance reports to the Single Commissioning Board.

The Director of Quality and Safeguarding made reference to the Quality and Safeguarding monthly exception report, discussions at the Quality and Performance Assurance Group and her intentions for future reporting arrangements.

RESOLVED

That the quality and performance update report be noted.

60. TAMESIDE AND GLOSSOP PROPOSAL FOR EFFECTIVE URGENT CARE: CASE FOR CHANGE

(Dr Greenhough declared her prejudicial interest as a Director of Go-to-Doc but as this was a consultation and not an award of contract she was advised there was no need for her to leave as there was no prejudicial conflict of interest.)

The Interim Director of Commissioning presented a report describing the vision for an enhanced offer of urgent care, i.e. support for conditions that needed prompt medical help to avoid a person deteriorating but were not life threatening. It set out the case for change summarising the national, Greater Manchester and local context, reflected the insights gained through previous pre-consultation engagement exercises and outlined the potential scenarios for the enhanced urgent care offer.

It was explained that key to the proposal was the simplification of access to urgent care whilst improving the level of service available. Multiple access points would be replaced by telephone access through a patient's own GP practices to book appointments as well as a single location for urgent walk-in services. This would reduce the need for people to 'self-triage' and maximise the opportunities for people to receive the right care in the right place at the first appointment. In addition, neighbourhood support would be strengthened through increased evening and weekend appointments alongside advice and treatment available through local opticians and pharmacists.

Reference was made to the proposed consultation, the aim of which was to inform the public about two options for the delivery of the new urgent care service. Both options created an urgent treatment centre, open 12 hours a day, seven days a week from 9.00 am to 9.00 pm. This would offer bookable, same day / urgent and routine general practice appointments, Walk-in access for urgent care and be able to provide direct access to urgent diagnostics along with safe transfer to more specialist services when necessary. In both options this would replace the existing Walk-in services at Ashton Primary Care Centre which would relocate to the hospital site and be developed to deliver the Urgent Treatment Centre. The two options varied in the number of Neighbourhood Care hubs where bookable appointments could be made in addition to the Urgent Treatment Centre when those hubs would be open. In summary, the options detailed in the report were as follows:

Option 1		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	9.00am to 1.00pm
South	6.30pm to 9.00pm	9.00am to 1.00pm
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm
Option 2		
Neighbourhood Care Hub	**Weekdays**	**Weekends**
North	6.30pm to 9.00pm	None*
South	6.30pm to 9.00pm	None*
West	6.30pm to 9.00pm	None*
East	6.30pm to 9.00pm	None*
Glossop	6.30pm to 9.00pm	9.00am to 1.00pm

* Able to book appointments at the Urgent Treatment Centre in Ashton or at Glossop Neighbourhood Care Hub.

The Single Commissioning Board heard that both options provided:

- Additional bookable appointments at the Urgent Treatment Centre;
- The ability for practices to arrange appointments directly at the Urgent Treatment Centre for patients likely to need diagnostics or additional hospital based care ;
- A single location for urgent walk in access that removes the need for the person attending to 'self-triage';
- Improved patient safety as people with emergency/serious conditions currently attending the Walk In Centre and then are transferred to A&E will already be in the correct place;
- Access to urgent diagnostics.

Reference was made to the detailed impact of the proposed options analysed through the Equality Impact Assessment in Appendix 1 and the quality implications set out in the Quality Impact Assessment in Appendix 2 to the report.

It was further reported that pre-consultation discussions, detailed in Appendix 3 to the report, had highlighted the fact that members of the public wanted a simple trusted arrangement that was well communicated to avoid confusion when an urgent need arose.

In responding to questions raised by members of the Single Commissioning Board, the Interim Director of Commissioning advised that initial financial analysis of both options showed that they were affordable within the current funding envelope. It was expected that efficiencies could be made through the bringing together of these services and therefore value for money increased.

RESOLVED

(i) That approval be given to consult on two options for the Tameside and Glossop urgent care offer as above and explained in detail in the report.

(ii) That the Equality Impact Assessment and Quality Impact Assessment in Appendices 1 and 2 to the report be noted.

61. IMPROVING DEMENTIA SERVICES IN THE NEIGHBOURHOODS

The Director of Adults Services submitted a report explaining that there were an estimated 2,691 people in Tameside and Glossop with dementia. As part of the Care Together development, Tameside and Glossop committed to improving the lives of people living with dementia and, through this, reduce reactive costs associated with the high volume of activity in unscheduled and long term care. In 2016 in Tameside, the rate of emergency admissions, aged 65+ with dementia was 4,839 per 100,000 population compared to the rate for England of 3,046 per 100,000 population.

It was further explained that 10 days in a hospital bed (acute or community) led to the equivalent of 10 years ageing in the muscles of people over 80. Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity and social activity.

The overall vision for Tameside and Glossop was linked to the development of a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their well-being and independence for as long as possible.

It was reported that the business case presented had three main objectives:

(i) Establish a pilot with Alzheimer's Society for Dementia Support Workers in each Neighbourhood in Tameside.
(ii) Establish Dementia Practitioners in each neighbourhood team by investing in three new roles to add to existing Pennine Care Foundation Trust Community Mental Health Team nurses, Willow Wood Dementia Nurse and Integrated Care Foundation Trust Admiral Nurse capacity.
(iii) Appoint an Executive Lead for dementia. This individual would have delegated responsibility from the locally partnership to represent the locality in all regional discussions about the strategic direction and performance of dementia services.

It was proposed that Dementia expertise was embedded within the integrated Neighbourhood Teams by integrating a Dementia Practitioner into each Neighbourhood Team. Dementia support was increased in each of the Tameside Neighbourhoods by investing in a three-year Dementia Support Worker pilot from the Alzheimer's Society through Adult Social Care Transformation Funding.

The business case detailed in the report, supported the Single Commission's Quality Innovation, Productivity and Prevention agenda. It was anticipated that as the cost savings from reduced unscheduled admissions would ultimately allow movement of money within the system that ensured the implementation was sustainable in the first instance, and cost saving in the medium and long term.

RESOLVED

(i) That the current position regarding unscheduled admissions related to dementia and the need for additional resources and actions to enable progression towards reducing a figure that was an outlier at a national level be recognised.

(ii) That the development of a rich post-diagnostic community offer supported by the clinical delivery of Dementia Practitioners and the co-ordinating role of the Dementia Support Workers would be a significant step in improving dementia care in Tameside be agreed.

(iii) That the investment of non-recurrent Adult Social Care Transformation budget to establish a pilot with the Alzheimer's Society to embed Dementia Support Workers in the Tameside Neighbourhood Teams to support people living with dementia from diagnosis to end-of-life care be agreed.

(iv) That compliance with procurement standing orders be waived to enable this pilot to be established from the Alzheimer's Society, a specialist provider.

62. PERSONAL HEALTH BUDGETS

Consideration was given to a report of the Director of Quality and Safeguarding explaining that a personal health budget was an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budges was to enable people who were frequent users of healthcare services to have greater choice, flexibility and control.

The expectation of Clinical Commissioning Groups to expand personal health budgets was outlined in the 'Forward View to Action: Planning for 2015/16' and the NHS England mandate was that by 2020 0.1-0.2% of the population would hold a personal health budget. In order to deliver the national mandate local trajectories had been set seeking to establish personal health budgets for 99 patients by March 2018 rising to 153 by April 2019.

It was reported that Greater Manchester was establishing a Personalisation Programme in which the locality would be actively engaged. It was hoped that this would expand from a health focus to encompass the national drive towards Integrated Personal Commissioning, a nationally led, locally delivered programme supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector. The programme aimed to ensure that services were tailored to people's individual needs, building on learning from personal budgets in social care and progress with personal health budgets. Through Integrated Personal Commissioning, people carers and families with a range of long-term conditions and disabilities were supported to take a more active role in their health and wellbeing, with better information and access to support in their local community, and greater choice and control over their care.

The Single Commissioning Board was advised that despite having focused approaches to marketing personal health budgets with frontline staff, there had been very little take-up and currently only 13 personal health budgets awarded, the lowest rate in Greater Manchester. An analysis of the locality's personal health budget approach and process had raised a series of actions that were now being taken forward.

It was recognised that if numbers were to be increased towards achieving the national target recurrent investment would be required, as well as the commitment to extract funding from block contracts to provide a viable budget to continue to expand personal health budget numbers in the

future. Due to the financial position, it was recommended that the economy worked within existing resources rather than increase investment at this time.

After assessing the risks, it was felt it would be better to delay the achievement of local trajectories and that a phased implementation plan for personal health budgets be agreed. This would align with the implementation of transformation plans including the move towards a more sophisticated contracting model and accountable care system.

RESOLVED

(i) That a phased implementation plan for personal health budgets be agreed.

(ii) That the associated impact on the ability of the Clinical Commissioning Group to meet the personal health budget target in 2017/18 and therefore the Improvement and Assessment Framework Standards, potentially resulting in reputational damage, be noted.

(iii) That the risks associated with the delay in achieving personal health budget target be escalated to the Tameside and Glossop NHS Clinical Commissioning Group Governing Body.

(iv) That the focus in 2017/18 would be to expand the offer of personal health budgets to patients already receiving individual packages of care, including Continuing Healthcare, Section 117 care and Transforming Care as this would be within existing resources.

(v) That the Clinical Commissioning Group lead would continue to work with Greater Manchester on the personalisation agenda.

63. URGENT ITEMS

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

64. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 14 November 2017 commencing at 2.00 pm at Dukinfield Town Hall.

CHAIR

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 November 2017
Officer of Single Commissioning Board	Gideon Smith, Consultant in Public Health Medicine
Subject:	**WOMEN AND THEIR FAMILIES SERVICE PROCUREMENT**

Report Summary:

This report requests permission to:

- proceed with a procurement exercise to replace the existing grant arrangement with the Women and Their Families Centre from 1 October 2018;
- extend the existing grant arrangement from 1 April 2018 to 30 September 2018 to allow time for the procurement to be completed.

The Single Commissioning Board agreed an extension of the grant arrangement for 2017/18 in order to align Public Health funding and provision to match that provided by the Office of the Police Crime Commissioner until 31 March 2018 - which was secured to expand this service into 2 additional areas. At that time it was noted that a form of market testing would be necessary to support consideration of continued support to Centre provision beyond 31 March 2018.

The current grant has enabled the delivery of an effective service that both achieves good value and has realised significant outcomes in the early intervention of women offenders and non-offenders.

Continuing to provide the Women and Their Families Centre will enable the service to continue to embed and expand their work significantly to support women victims and offenders (who are often both) and their children to deal with the multiple issues and deprivation they face.

The breadth of the work being provided, alongside the integration with major partners in Tameside detailing the number of clients and families seen, evidences the clear necessity to continue with such vital provision.

The Centre has been supported by a grant since 2011. Initially this was via the Tameside Council Community Safety Unit (Drug & Alcohol Action Team), moving to Public Health from 2013. Currently accommodation is provided by New Charter Housing, and in view of the success of the service on this site the preferred option for the future is to continue provision on this site.

Recommendations:

Single Commissioning Board is asked to agree:

1. A procurement exercise to replace the existing grant arrangement with the Women and Their Families Centre from 1 October 2018.
2. A total budget of £497,850 over five years for the procurement of this service.

3. To extend the existing grant arrangement from 1 April 2018 to 30 September 2018 to allow time for the procurement to be completed.

Financial Implications:

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

Budget Allocation (if Investment Decision)	Current budget allocation within Public Health Is £99,570 p.a. The proposal in this report requests funding over a 5 year period (total investment £497,850).
CCG or TMBC Budget Allocation	TMBC – Population 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	A previous cost benefit analysis (CBA) undertaken in 2016 suggested cost avoidance of £3.88 for every £1 invested in the Centre. This was based on a New Economy model which takes into account a number of factors including; mental health, reduced drug and/or alcohol use, reduced incidents of crime and reduced statutory homelessness. Outcomes measured demonstrate reductions in elements of police, criminal justice, temporary housing and health related An updated CBA was scheduled to be carried out during the Summer of 2017. This has not commenced to date due to the requirement of IT system related developments. It is recommended that the results of this analysis are considered prior to the award of any contract from 1 October 2018 should they be available at that time.
Additional Comments The six month extension (£49,790) of the existing contract in 2018/19 to 30 September 2018 will be financed via the existing Population Health service revenue budget, as will the proposed contract from 1 October 2018.	

	Members of the Single Commissioning Board should also note that the outcome of the updated cost benefit analysis (section 2.2) will not be available until a later date. It is recommended that the results of this updated analysis are considered prior to the award of the new contract from 1 October 2018 should they be available at that time.
Legal Implications: **(Authorised by the Borough Solicitor)**	Any procurement exercise must be undertaken in accordance with the Light Touch Regime for Social and Other Services under the Public Contracts Regulations 2015. A decision to extend the grant agreement for six months is not without risk however given the intention to undertake a procurement exercise the risk is minimal. It would be prudent to agree terms of occupation with New Charter Housing in advance of the procurement exercise to give certainty over the term of the contract.
How do proposals align with Health & Wellbeing Strategy?	The impact of the Women and Their Families Centre is mostly within the Starting Well, Developing Well and Living Well priorities, particularly: domestic abuse; reducing child poverty; ensuring children are ready for school; enabling a multi-agency approach to troubled families; emotional wellbeing; reducing homelessness; reducing reoffending.
How do proposals align with Locality Plan?	The Centre makes an important contribution to the implementation of Healthy Lives and Enabling self-care dimensions of the model of care for a very vulnerable group of women and their families.
How do proposals align with the Commissioning Strategy?	The Centre contributes to the delivery of the Clinical Challenges for Children and Families, and Mental Health.
Recommendations / views of the Professional Reference Group:	That the Single Commissioning Board be recommended: **(i)** To agree a procurement exercise to replace the existing grant arrangement with the Women and Their Families Centre from 1 October 2018; **(ii)** That the existing grant arrangement from 1 April 2018 to 30 September 2018 be extended, to allow time for the procurement to be completed; and **(iii)** That further options in respect of accommodation costs be explored before submission to Single Commissioning Board.
Public and Patient Implications:	The report includes details of self-reported wellbeing, case studies and comments by women who use the Centre.
Quality Implications:	The Centre is subject to quarterly monitoring. The report includes performance, cost-benefit, partner comments and users feedback.
How do the proposals help to reduce health inequalities?	The service is tailored to provide support to a very vulnerable group of women and their families. Long-term potential benefits are significant in terms of improving their life chances.

What are the Equality and Diversity implications?	The Centre provides access for women of all ages, ethnicities, abilities and protected characteristics.
What are the safeguarding implications?	The Centre is required to comply with Tameside Council adult and children safeguarding requirements.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications associated with this report.
Risk Management:	There are no risk management issues associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant in Public Health Medicine  Telephone: 0161 342 4251  e-mail: gideon.smith@tameside.gov.uk

1.0 BACKGROUND

1.1 In 2011, the Probation service, along with the Council's Community Safety Unit (Drug & Alcohol Action Team) agreed a proposal for a women-only centre to be provided in order to manage the women of Tameside who were both offenders and non-offenders in a completely different way, and The Women and Their Families Centre was established.

1.2 The Women and Their Families Centre offers a safe place for women to obtain advice and support and also a programme of courses which aim to offer new opportunities for women only. These include practical courses, health and wellbeing groups, groups for drugs and alcohol, domestic abuse and more. They provide group peer support and one-to-one support for women who want to make changes in their life, but don't know where to start.

1.3 Since the Centre opened many women have utilised its services. Based on the last year an average of 279 women have utilised the centre each quarter. This includes women who attend for more than one quarter. On average, approximately 45% are new attendees quarter. Only 30% of the women who attend do so to secure adequate completions of requirements for criminal justice purposes, the remaining 70% are referral by other agencies and self. The appended report, that was prepared to support discussion by Single Commissioning Board in February 2017 about the future of the service, provides further detail of the current provision.

1.4 The Centre has been supported by a grant since 2011. Initially this was via the Tameside Council Community Safety Unit (Drug & Alcohol Action Team), moving to Public Health from 2013. The service is provided by Purple Futures from accommodation at Cavendish Mill provided by New Charter Housing at no cost.

1.5 This report requests permission to proceed with a procurement exercise to replace the existing grant arrangement with the Women and Their Families Centre from 1 October 2018.

1.6 The Single Commissioning Board, at its meeting in February 2017, agreed an extension of the grant arrangement for 2017/18 in order to align Public Health funding and provision to match that provided by the Office of the Police Crime Commissioner until 31 March 2018 - which was secured to expand this service into 2 additional areas. The matched funding supports a twelve month staff post that runs until October 2018. Further funding via this route has not been announced to date.

1.7 At that time it was noted that a form of market testing would be necessary to support consideration of continued support to Centre provision beyond 31 March 2018, and also the grant would be subject to a review of all Single Commission grants. The grants review did not recommend any change to the Women and Families Centre grant.

2.0 COST BENEFIT ANALYSIS

2.1 In November 2016, the Public Service Reform team within the Office of the Police Crime Commissioner produced a brief cost benefit analysis using the recognised 'New Economy' model. Currently, based upon data for the women offenders within the centre, the report details that for every £1 spent on the Women Centre benefits realised show gross benefits of £3.88. Within the wider system of social care the benefits increase to £1:£25.32 and to the NHS alone £1 spent at the centre saves £6.71.

2.2 A repeat cost benefit analysis planned for summer 2017 has not yet been carried out. An IT development is required before the analysis can start.

3.0 THE CASE FOR PROCUREMENT

3.1 The current grant to the Women and Their Families Centre has enabled the delivery of an effective service that both achieves good value and has realised significant outcomes in the early intervention of women offenders and non-offenders.

3.2 The work of the Centre forms a critical part of the local work to support troubled families, and will feature as a key element within the current local Early Help needs assessment with recommendations endorsed by Tameside Children's Improvement Board. The needs assessment notes: "*It is also clear from the service mapping that there are a lot of services that cover universal services but very few that are able to support complex families and children in transition or in the step up/down multi-agency response type interventions."*
The work of the Centre has also been recognised as model of good practice within Greater Manchester.

3.3 The cost benefit analysis evidences some of the wider benefits realised from a small closely led team of probation workers and volunteers who have worked together to change the behaviours and lives of women and their children who attend the centre forever.

3.4 Continuing to provide a Women and Families Centre will enable the service to continue to embed and expand their work significantly to support women victims and offenders (who are often both) and their children to deal with the multiple issues and deprivation they face. This work will affect current and future generations of Tameside's female population to help deal with their problems, understand acceptable behaviour and grow mutually respectful relationships with their children and partners.

3.5 The breadth of the work being provided, alongside the integration with major partners in Tameside detailing the number of clients and families seen, evidences the clear necessity to continue with such vital provision.

3.6 Currently accommodation is provided for the service by New Charter Housing. Professional Reference Group suggested that alternative accommodation may be available within the existing public sector estate, but this would be very unlikely to be available ahead of recantment for Vision Tameside. In view of the success of the service at Cavendish Mill the preferred option for the future is to continue provision on this site. Funding required for accommodation is available from within the population health budget.

3.7 The current grant is for £99,570pa, and the requested procurement would be for a five year contract. The total budget for five years at £99,570pa should be £497,850.

4.0 RECOMMENDATIONS

4.1 As set out on the front of this report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 November 2017
Officer of Single Commissioning Board	Gill Gibson, Director of Quality and Safeguarding
Subject:	**TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS – BUSINESS CASE NO.2 OF 3**

Report Summary:

The Five Year Forward View for Mental Health sets ambitious plans to improve parity of esteem for people with mental health needs, ensuring the same access to healthcare as physical health needs. The Clinical Commissioning Group is currently investing 9.7% of its total allocation on mental health services/support. The national average is around 11%, which would equate to an additional £5m.

In July 2017 the Single Commissioning Board agreed an integrated commissioning strategy to meet the national and Greater Manchester expectations regarding mental health by aligning four additional mental health funding streams, with existing mental health investment, to transform mental health provision in Tameside and Glossop. The funding streams are:

1. Clinical Commissioning Group Mental Health Investment Standard;
2. Greater Manchester Mental Health Transformation funding;
3. Adult Social Care Transformation funding; and
4. Care Together Transformation funding for Mental Health.

The proposal was also supported at Locality Executive Group on 21 June 2017 and the focus for the Care Together Transformation Funding agreed at the Integrated Care Foundation Trust Joint Management Team on 15 June 2017.

This paper is the second of three business case regarding mental health services in 2017/8. The first, agreed on 1 March 2017, committed investment in adult Attention Deficit Hyperactivity Disorder services and increased capacity of RAID (mental health practitioners working in A&E). This second business case focuses on increasing capacity to meet demand and standards for three more priorities:-

- People with common mental health disorders (Improving Access to Psychological Therapies);
- People with a First Episode of Psychosis;
- Children and their families where the child has a neurodevelopmental need, including Attention Deficit Hyperactivity Disorder and autism, and those who have behaviour that challenges.

The third business case will cover mental health crisis care when the model has been agreed and signed off by the A&E Delivery Board, Neighbourhood Complex Needs and Peer Support and Recovery. It is expected that an additional £1m will be required to deliver these priorities. There is an expectation that there will be savings in other parts of the health system,

such as a reduction in mental health admissions to secondary care and MH inpatient admissions.

Recommendations:

It is recommended that the Single Commissioning Board approves the commitment of funding through the Clinical Commissioning Group Mental Health Investment Standard in line with this business case as follows:-

2017/18	2018/19	2019/20	
£132,377	**£626,665**	**£610,665**	recurrently

Financial Implications:

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

Budget Allocation (if Investment Decision)	£132,377 in 2017-18 rising to £610,665 recurrently in 2019-20
CCG or TMBC Budget Allocation	CCG/TMBC (Improved BCF non recurrent funding)
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	This investment is to comply with Five Year Forward View for Mental Health and is based on economic evidence for which we are being held to account on achievement of mental health standards.

Additional Comments

It is recognised that investment in mental health is a key priority for Tameside and Glossop as this impacts on so many other elements of health and social care. Evidence shows that intervention in mental health at an early stage results in significant benefits and financial efficiencies and particularly in relation to secondary care costs.

Finance Group supports the recommendations in this paper subject to the following caveats and comments:

- The paper suggests the Clinical Commissioning Group is under-investing in mental health relative to its peers. Although we recognise additional investment is urgently required in mental health it is important to acknowledge this calculation is extremely subjective as different Clinical Commissioning Groups include different services and costs as part of their mental health expenditure.
- The costs quoted in this paper have not yet been signed-off by providers but there is an overall financial envelope for mental health which is reported and managed by Greater Manchester as part of the mental health assurance process. All costs must be maintained within this financial envelope for the delivery of commissioned outcomes and any funding shortfall managed across other MH services as necessary.

	• Regular monitoring information is to be provided to demonstrate the delivery of outcomes and qualitative and quantitative benefits arising from the investment.
Legal Implications: **(Authorised by the Borough Solicitor)**	Regular monitoring to ensure the allocated monies remain in line with the business case set out in this report should protect against successful challenge. If compliance is compromised a further report to the Single Commissioning Board will be required to ensure there is sufficient governance for the decision to remain lawful. Members of the Board should ensure they have read, understood and agree with the Equalities Impact Assessment which supports the business case, and that they are satisfied the proposals will provide the desired outcomes for the mental health agenda within the allocated budget.
How do proposals align with Health & Wellbeing Strategy?	The proposal aligns with Living Well and Aging Well in the Health and Well-being Strategy.
How do proposals align with Locality Plan?	The proposal aligns with the ambition to embed mental health within all our developments.
How do proposals align with the Commissioning Strategy?	The proposal aligns to our Commissioning Strategy
Recommendations / views of the Health and Care Advisory Group:	The Health and Care Advisory Group recommends that the business case is supported.
Public and Patient Implications:	Healthwatch is engaged in the development and the proposals are in line with Healthwatch findings from service users. Healthwatch are establishing focus groups to confirm and challenge the detailed proposals.
Quality Implications:	The proposals will improve access, capacity and quality of mental health provision in Tameside and Glossop.
How do the proposals help to reduce health inequalities?	People with mental health needs often experience poor physical health and vice versa. The proposal of integrating mental health into the neighbourhood and across the hospital will reduce these inequalities.
What are the Equality and Diversity implications?	The proposal will not adversely affect protected characteristic group(s) within the Equality Act. See **Appendix 2** for Equality Impact Assessment. The service will be available to Adults with a mental health need regardless of ethnicity, gender, sexual orientation, religious belief, disability, gender reassignment, pregnancy/maternity, marriage/ civil partnership.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None.

Risk Management:	The paper clearly sets out the risks associated with the options included. These will be managed through the existing Clinical Commissioning Group risk management processes.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities: Telephone: 07792 060411 e-mail: pat.mckelvey@nhs.net

1. SUMMARY

1.1 The Five Year Forward View for mental health makes 58 recommendations for the NHS and system partners. The priorities include:

- Genuine Parity of Esteem between Physical and Mental Health;
- Prevention;
- Improved Waiting Times & New Commissioning Approaches to Transform Services;
- Integration of Physical and Mental Health Care;
- High Quality 7-day Services for People in Crisis;
- Provision Close to Home for those with Acute Intensive Needs, particularly Young People;
- Focus on Targeting Inequalities.

1.2 The Must Do's for 2017/19 are as follows:

- **IAPT**
  - Waiting times
  - Access – ratchet-up for up to 25%
  - Integrated (Long-term conditions / employment)
  - Recovery
- **Severe Mental Health Illness**
  - Early intervention in psychosis waiting times and NICE treatment compliant up to 53%
  - SMI IAPT
  - Individual placement and support prep
  - Physical health care – smoking / obesity
- **Dementia United**
  - Diagnosis
  - Post-diagnostic support
  - Carers
- **Armed Forces**
- **CAMHS**
  - Waiting times
  - Community Eating Disorders
  - Crisis care support & acute mental health liaison
  - Tier 4 collaborative
  - Early intervention and prevention – iThrive+
  - Perinatal – Specialist and early help
  - Transforming care
- **Crisis care**
  - A&E Psychiatric liaison – core 24 / RAID
  - All-age acute care pathway redesign (including CRHTs and Primary care MH)
  - Crisis care triage / support
  - Custody / liaison and diversion
- **Suicide prevention**
- **Secure care pathways**

1.3 Although further growth will be required in future years to meet the rising targets, based on an analysis of the requirements in 2017/19 the following areas require additional investment:

a. **Early Intervention in Psychosis** – Increasing team capacity to meet the national standards of 53% of people receiving NICE complaint care within 2 weeks of referral and increasing access to psychological therapy through £249,795 recurrently.
b. **Increasing Access to Psychological Therapies** – Increasing team capacity at Step 3 to reduce excessive waiting times by increasing capacity through 4 additional posts at £270,250 recurrently and support recruitment to Step 2 trainee practitioners through non-recurrent funding of £30,600. NB – we are also commissioning increased capacity at Step 1 through procuring a new provider to work in partnership with Pennine Care Foundation Trust to deliver an integrated service which will provide more access, greater choice and ensure effectiveness of NHS provision. See **Appendix 1** for details.

1.4 **Children and Young Peoples Mental Health** – increase capacity in specialist services for two groups through £90,620 recurrently and £16,000 non-recurrently to establish Positive Behavioural Support in the locality:-

- Children and young people with a neurodevelopmental condition (Attention Deficit Hyperactivity Disorder and Autistic spectrum Disorder)
- Children and young people with a learning disability and or autism and behaviour that challenges to support families at promote positive behavioural approaches at home and

school. This is in line with the Greater Manchester Transforming Care Early Intervention Project recommendations.

2. DESCRIPTION

2.1 The Five Year Forward View for Mental Health is based on economic evidence that investment in evidence based mental health services will result in savings in the rest of the system.

Current Situation

2.2 **Early Intervention in Psychosis**

- The national standard is "*More than 50% of people experiencing a first episode of psychosis will be treated with a NICE*[1] *approved care package within two weeks of referral"* in 2016/17 and 2017/18 rising to 60% by 2020.
- The team is unable to meet the demand of the increased referrals (since age range has been extended from 35y to 65y) and the need to provide a service for people who are diagnosed as being ARMS (At Risk Mental State). Referrals have risen from 95 in 2015/6 to 236 in in 2016/17.
- Team is currently struggling to meet the target of ensuring 50% of people access to NICE complaint care within 2 weeks of referral.
- There are long waiting times for Cognitive Behavioural Therapy and no family therapy within the team.
- The team is significantly small than the recommended model for a locality of our size - with 15.5 whole time equivalent compared to the national staffing model of 38 whole time equivalent.

It is proposed to extending the capacity of the Early Intervention Team to better meet the standards by investing £249,795 in 5.5 whole time equivalent additional staff.

2.3 **IAPT (Talking Therapies)**

- Although national standards of access and waiting times are being achieved at present, the secondary waits for Step 3 psychological therapy are excessive. In October 2017 239 people are waiting for more than 18 weeks for therapy, some up to 10 months.
- Recruitment of Step 2 staff has been challenging so the service will 'grow their own' through recruiting Psychological Wellbeing Practitioner trainees to permanent posts.
- The increased capacity within the service plus the addition of the new Step 1 partner (being commissioned by the Integrated Care Foundation Trust) will support the service working in a more integrated way within the neighbourhoods.

It is proposed to increase the capacity in the service by investing £270,250 in 5 WTE additional psychological therapists.

2.4 **Children and Young Peoples Mental Health**

- Integrated Neurodevelopmental Pathway – this pathway has been established between Child and Adolescent Mental Health Service, Integrated Service for Children with Additional Needs and Paediatrics and a sensory specialist is required. It is therefore proposed to fund a Band 6 Occupational Therapist
- Transforming Care Early Intervention - The Clinical Commissioning Group has been very successful in repatriating people with a Learning Disability and Mental Health needs from out of area specialist hospitals under the Transforming Care Programme. The cost for each placement is in the region of £100-200k p.a. - a significant long term cost. Our commissioner led a Greater Manchester project to ascertain what can be done better for the next generation, to prevent some of the demand by providing a comprehensive

[1] National Institute for Health and Care Excellence

approach in childhood. The findings support the need for a Positive Behavioural Support approach led by a specialist behaviour team working with young children and their families. It is proposed to invest in a Positive Behavioural Support specialist and establish a Specialist Behavioural Support Team from 0 to 25 years and to invest non-recurrent £16,000 in establishing approaches within Tameside and Glossop.

Additional investment in two Band 6 posts £90,620 plus £16,000 non-recurrently is proposed.

2.5 The business case seeks to improve mental health services in line with the Five Year Forward View for Mental Health and Transforming Care to enable more evidence based interventions that have a proven return on investment to be delivered.

Value of the Proposal

2.6 The total value of the proposal is £123,377 in 2017/18 and £626,665 in 2018/19 and £610,665 recurrently thereafter. Details for the three schemes are as follows:

Early Intervention in Psychosis					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Consultant Psychiatrist		0.3		£6,399	£38,393
Medical secretary	XN04mid	0.2	£26,100	£870	£5,220
Band 7 Therapist	XN07mid	1	£45,800	£7,633	£45,800
Band 3 Support worker	XN03mid	2	£22,400	£7,467	£44,800
Care Co-Cord Band 5	XN06mid	2	£38,200	£12,733	£76,400
	Total	5.5	Total Pay	£35,102	£210,613
			Non Pay	£1,100	£6,600
			Total Direct Costs	£36,202	£217,213.00
			Overheads 15%	£5,430	£32,582
			Total Costs	**£41,632**	**£249,795**
Improving Access to Psychological Therapies					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Band 7 Therapist	XN07mid	5	£45,800	£38,167	£229,000
			Total Pay	£38,167	£229,000
			Non Pay	£1,000	£6,000
			Total Direct Costs	£39,167	£235,000
			Overheads 15%	£5,875	£35,250
			Non-recurrent support to permanently recruit trainee PWP staff	£30,600	
			Total Costs	**£75,642**	**£270,250**
Children and Young People					
Posts		**WTE's**	**Salary**	**2017/8**	**2018/9**
Band 6 Therapists	XN06mid	2	£38,200	£12,733.33	£76,400
	Total	2	Total Pay	£12,733.33	£76,400
			Non Pay	£400.00	£2,400
			Total Direct Costs	£13,133.33	£78,800
			Overheads 15%	£1,970	£11,820
			Total Costs	**£15,103**	**£90,620**
			Non-recurrent PBS development		£16,000
				£15,103	**£106,620**

Notes

1. Costs are still to be agreed with Providers
2. Funding for posts will follow recruitment to new posts

3. NATIONAL, STRATEGTIC AND LOCAL CONTEXT

3.1 The Five Year Forward View for Mental Health (2016) is based on economic evidence that investment in the priorities will result in savings within the system. The Five Year Forward View for Mental Health is the basis for the Greater Manchester Mental Health Strategy and we are being held to account on our achievement of the mental health standards.

3.2 This business case supports the "Care Together Commissioning for Reform Strategy 2016-2020" commissioning priorities for improving population health and supporting positive mental health. This also supports the ambition to deliver integration of primary, community and secondary physical and mental health care, public health programmes and social care services as well as co-ordinating and commissioning services from other providers e.g. voluntary and faith sectors.

3.3 The business case supports the Single Commission's Quality, Innovation, Productivity and Prevention agenda:

Quality
- better service user and carer experience;
- better integrated health and social care approach;
- provision that meets NICE Quality Standards;
- better developed and trained workforce.

Innovation
- integration of primary and secondary care, health and social care and physical and mental health care;
- reduction in unnecessary referral and administration;
- incorporates best evidence to support a whole-system change.

Productivity
- reduced demand for acute inpatient provision;
- reduced demand for specialist mental health inpatient provision;
- increased response times;
- increased numbers of people receiving specialist assessment;
- more treatment provided in the community and home settings.

Prevention of
- inappropriate hospital admissions;
- people having to lose their independence;
- inappropriate drug prescribing;
- crises through good monitoring and early intervention in the community.

3.4 The business case has been developed with input from Pennine Care Foundation Trust, GP Clinical leads, Healthwatch, Mind and the Integrated Care Foundation Trust Neighbourhood leads through a series of workshops and discussions.

3.5 Healthwatch ran a series of focus groups with mental health service users in the summer and they have asked developed the following key messages:-

1. *Any person receiving mental health care is to be respected as a human being, who has feelings, with everyone cared for in a personalised way.*
2. *Getting the access to services right is critical. This includes the length of waiting times to start treatment, or for follow-up appointments. Appropriate support is needed at a time of crisis. The process to accessing care is complicated, with too many barriers.*
3. *Effective communication in all areas can make the difference between a positive and negative experience.*
4. *People want to feel supported. They want to be listened to and understood. They want to receive the right care at the right time, in the right place, and with the right service. They want employers to be understanding.*

5. *The health and wellbeing of carers needs to be considered alongside the treatment provided for service users.*
6. *Peer support is very important, and is often found at community and charity support groups.*
7. *When people are struggling with their mental health, they often do not want to burden their families, and suffer alone. If families understand mental health better, people may be more likely to discuss how they are feeling with those they are close to.*
8. *When anyone is being treated for both physical and mental health conditions, they are treated separately, and the impact on each other is not always considered – treat the person as a whole.*
9. *When a person is a multi-service user, all the agencies involved need to work together, whilst respecting confidentiality.*
10. *The way a member of staff interacts with service users is remembered. For example, do they always smile, even when they are busy?*

3.6 This is what they want from mental health services:-

- *I expect caring, compassionate support, delivered by competent, understanding staff, who realise that I need to trust them if they are going to help me.*
- *I want to get the right type of help when things start to be a problem, at the right time, in the right place, and without having to wait until things get worse.*
- *I should be listened to, given time to tell my story, and feel like what I say matters.*
- *I have a voice to control the planning and delivery of my care and support.*
- *I want to feel safe in hospital.*
- *I have the information to keep me up to date about my care and to stay healthy.*
- *My family is supported which helps me to cope. I want them to understand the issues so that we can support each other.*
- *I want my situation to be treated sensitively, and I should be respected and not feel judged.*
- *I want my physical and mental health to be treated together.*
- *I want to feel that services are shaped around my needs, and not the other way around, especially if I need to see different people and services.*

4. OUTCOMES AND BENEFITS

4.1 The likely outcomes anticipated from the proposal are:

1. Reduction in waiting times for specialist mental health services, resulting in more effective intervention due to early access.
2. Increased number of people receiving NICE compliant interventions and support for their mental health.
3. Increase in positive patient reported experience.
4. Positive Behavioural Support readily available for families who have children with a learning disability and or autism who have behaviour that challenges resulting in families feeling more able to cope and a reduction in complex behaviours becoming entrenched.
5. Sensory assessment and approaches included within the neurodevelopmental pathway supporting parents, carers, schools and staff to better understand needs and plan appropriate interventions.

4.2 The outcomes detailed above will be measured and monitored as follows:

1. Ongoing achievement of the Improved Access to Psychological Therapies standards for Access, Waiting times for first treatment and Recovery.
2. Reduction in length of time with respect to Secondary Waits for Step 3 Improved Access to Psychological Therapy.
3. Increase in numbers of people with complex needs receiving psychological therapy.
4. Integration of Improved Access to Psychological Therapy services into the five neighbourhoods through having a link worker and resources aligned to neighbourhoods (where clinic space supports).
5. Achievement of the 2 week from referral to NICE compliant care for all people suspected to have a first episode of psychosis.
6. Increased number of people in EIT accessing family intervention therapy and cognitive behaviour therapy.
7. Increase in the number of families receiving early intervention from the Specialist Behaviour Support Team with a view to supporting families to care and therefore reducing the need for high cost placements.
8. Improved assessment and interventions for children with Attention Deficiency Hyperactivity Disorder and autism.

5. EVIDENCE BASE

Early Intervention in Psychosis

5.1 In 2011, '*No Health Without Mental Health'* highlighted the effectiveness of Early Intervention in Psychosis services for people experiencing first episode psychosis. There is good evidence that these services help people to recover and to gain a good quality of life. Early Intervention in Psychosis services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost-effective and improve employment, education and wellbeing outcomes.

Improving Access to Psychological Therapy

5.2 The Improving Access to Psychological Therapy Manual, reports that depression and anxiety disorders are extremely costly to individuals, the NHS and society.

5.3 The impact on the person, families and carers – Depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes. These may include:

- Greater distress and poorer quality of life, including higher levels of self-reported misery and disruption to a person's social, work and leisure life.
- Poorer physical health. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, stroke, lung disease, asthma or arthritis.
- Unhealthy lifestyle choices. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.
- Poorer educational attainment and employment outcomes. There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance and reduced earnings.
- Increased risk of relapse if treatment is not appropriate or timely.

5.4 The impact on the NHS – The Healthcare costs for those with coexisting mental health problems and long term conditions are significantly (around 50%) higher. A large proportion of this cost is accounted for by increased use of physical health services (not mental health services). For example:

- depression is associated with increased rehospitalisation rates in people with cardiovascular disease and chronic obstructive pulmonary disease, compared with the general population;
- chronic repeat attenders account for 45% of primary care consultations and 8% of all emergency department attendances; the most common cause of frequent attendance is an untreated mental health problem or medically unexplained symptoms;
- people with medically unexplained symptoms who were not offered psychological therapies as part of their care were found to have a higher number of primary care consultations, than those who were; similarly, people with chronic obstructive pulmonary disease who were not offered psychological therapies as part of their care were found to have a higher number of urgent and emergency department admissions, than those who were.

5.6 The impact on society – Together, depression and anxiety disorders are estimated to reduce England's national income (GNP) by over 4% (approximately £80 million). This reduction in economic output results from increased unemployment, absenteeism (a higher number of sick days) and reduced productivity. This is accompanied by increased welfare expenditure.

Children and Young People

5.7 Neurodevelopmental therapist - early diagnosis, intervention and self-awareness of the strengths and weaknesses of having an autistic spectrum disorder/attention deficit hyperactivity disorder is cost-effective to society as it facilitates education, career and life choices.

5.8 Behavioural support for children with a learning disability and/or autism - children with learning disabilities whose behaviour challenges need the right support early in childhood. Early intervention using methods such as Positive Behaviour Support can reduce the severity and frequency of challenging behaviour and improve quality of life. The right support provided at the right time, and delivered in partnership with families can also avoid the high costs of crisis intervention.

6. FINANCIAL CONSIDERATIONS

6.1 Mental health resources have been aligned to the priorities over the next five years, showing the growth in investment through the Mental Health Investment Standard, the Greater Manchester Mental Health Transformation Funding, the Care Together Transformation Funding and the Adult Social Care Transformation Funding, with an indication of the expected costs.

6.2 This is the second of three mental health business cases to be considered this year. Work is underway to ascertain the developments required regarding Crisis Care, Neighbourhood Complex Needs and Peer Support and Recovery.

7. PERFORMANCE MONITORING

7.1 Performance against the anticipated outcomes for this scheme will be monitored through the Pennine Care Foundation Trust monthly performance reports.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

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APPENDIX 1

TAMESIDE AND GLOSSOP
Caretogether

Scheme:	Integrated Neighbourhood
Project Name:	Integrated IAPT Plus
Project Ref:	

SRO:	Trish Cavanagh
Operational /Clinical Lead:	Jeanette Leach / Lisa Gutteridge
Project Lead:	Andrew Manners
Finance Lead:	Suzanne Holroyd

PROJECT OVERVIEW: (1. Summary of the aims of the project and how it is to be achieved 2. Summary of strategic alignment and key enablers. Evidence basis for opportunity)

As part of the Care Together programme we are working to improve mental health care services across Tameside and Glossop. There is currently a gap in mental health provision across our area in primary care for low level mental health needs. This project aims to deliver an integrated Improving Access to Psychological Therapies (IAPT) Step 1 Primary Care and Mental Wellbeing Service in Tameside and Glossop which would meet patient needs as well as National and Greater Manchester mental health priorities.

The proposed model combines the Pennine Care delivered Step 2-3 IAPT service with a new element at Step 1, commissioned from a service provider, working to a single service specification. The service will be located within the neighbourhoods, have a single entry point and clear pathways into a wider range of support and treatment. It is recommended that the integrated service has a new name to avoid confusion. The new service will sit within other neighbourhood services, connecting effectively with the Social Prescribing and Asset Based Approaches, supporting the Self Care Education College as well as, when established, the new neighbourhood mental health offer for people with complex needs. The service specification has been written to allow the provers, as the service experts, the flexibility to offer a service that they feel best meets the needs of the specification, however, we expect that this will include face to face drop in sessions, active monitoring and limited counselling sessions for people with early presentation of low level mental health concerns in a community setting.

The proposed service fits in with the Integrated Neighbourhoods and increases our mental health capacity. A similar IAPT model is working well for another local provider and they have seen amongst other benefits, a 73% reduction in likelihood of patients using the service needing GP services for mental health care. There is a solid evidence base for integrated IAPT and our proposed service is in line with the Stepped Care model and NICE Guidance for the provision of services for people with common mental health disorders.

There is new funding available within the Care Together programme of £280,000 per annum for three years to support the new service. The tender value means we will need to procure using a light tough regime and build in a break clause to allow the Trust to retract the contract if funding is pulled.

Common mental health disorders such as depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and social anxiety disorder, may affect up to 15% of the population at any one time.

Depression and anxiety disorders can have a lifelong course of relapse and remission. There is considerable variation in the severity of common mental health disorders but all can be associated with significant long-term disability. For example, depression is estimated to be the second greatest contribution to disability-adjusted life years throughout the developed world. It is also associated with high levels of morbidity and mortality and is the most common disorder contributing to suicide.

At any one time, roughly one in six of us is experiencing a mental health problem. Mental health problems are also expected to cost the economy £105 billion per year. Over recent years national, local and regional agencies around mental health including early intervention, promotion of mental wellbeing and psychological therapies have been gathering pace.

The NHS 'Everyone Counts: Planning for Patients 2014/15 to 2018/19' document outlines IAPT roll-out as key to achieving the outcome ambition of improving the health related quality of life of the 15+ million people with one or more long-term condition, including mental health conditions.

'No Health Without Mental Health' reinforces the link between metal health and good physical health, and required IAPT programmes to work with primary care services in improving overall health and wellbeing and ensure a family focus to deliver overall benefits. The strategy focuses on early intervention, recovery, good mental health and positive experiences of care and support.

In October 2014, NHS England and the Department of Health jointly published 'Improving access to mental health service by 2020'. This document outlines a first set of mental health access and waiting time standards for introduction during 2015/16 and sets out an ambition to introduce access and waiting time standards across all mental health services between 2016 and 2020. NHS England published in February 2015, the new 'Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16' which outlines the required improvements towards meeting the first of these standards.

The policy context includes: The NHS Plan, the NSF for mental health, NICE guidelines, 'NHS Everyone Counts 2012/13, Equality Act 2010, No health without mental health strategy for England, Department of Health 2011, white paper 'Our Health, Our Care, Our Say'.

The Department of Health requires all Clinical Commissioning Groups to ensure access to a range of psychological therapies that can respond to the needs of their residents with a variety of mental health needs.

Improving Access to Psychological Therapies is a national programme concerned with raising standards of recognition of treatment for, the large number of people (of all ages) who suffer from depression and anxiety disorders and improving the health and wellbeing of the population by promoting social inclusion and improving economic productivity. The programme is at the heart of the Government's drive to give greater access to, and choice of talking therapies to those who would benefit. The programme seeks to support the wider public health agenda and to promote effective treatment options in mental health services that are founded on good evidence.

The service model is designed to support:

- Care outside a hospital setting where possible
- Care closer to home
- Improved access
- Improved quality
- Supporting individual care plans

RESOURCE REQUIREMENTS (summary of any resources to deliver the project – WTE, capital etc)

Transformational funding is required to fund a three year tendered contract to deliver mental health services as described above. Fall back revenue for estates if suitable may be required, if safe and cost neutral accommodation is not available in the community. Value TBA.

KEY MILESTONES

Milestone	Owner	Start date	Due Date	Comments
Business case signed off	Andrew Manners	18/09/17	23/10/17	
Develop service specification	Andrew Manners / Pat McKelvey	25/09/17	30/10/17	
Procurement Process	Kevin Fletcher	23/10/17	15/12/17	
Awarded contract to successful provider	Kevin Fletcher	15/12/17	15/12/17	
Commence implementation of service	TBA	TBA	TBA	
Ensure all in place for ongoing contract monitoring	Jeanette Leach	TBA	Ongoing	

KEY INTERDEPENDENCES

[List any other projects that this project is dependent on OR will influence]

Social Prescribing, Healthy Minds, Neighbourhood Mental Health Development, and the workforce development process for integration of Neighbourhood teams will support the successful delivery of this programme

KEY STAKEHOLDERS [List the key stakeholders in the project: CCG teams, GPs, Providers, Local Authorities, Care Homes etc]
CCG commissioning team, GPs, TMBC Social care team, Care Home providers, Tameside and Glossop residents, voluntary sector partners

FINANCE (to be filled in by finance)	**FY16/17**	**FY17/18**	**FY18/19**	**FY19/20**	**TOTAL**
Approved funding (eg GM)		70,000	280,000	490,000	840,000
Planned costs					
Funding overspend / (slippage)	***0***				
Funding requirement	***0***	***0***	***0***	***0***	0
Planned gross benefit					
Planned net benefit / (cost)	***0***	***0***	***0***	***0***	
Actual costs					
Actual gross benefit					
Actual net benefit / (costs)	***0***	***0***	***0***	***0***	
Net benefit / cost variance	***0***	***0***	***0***	***0***	

APPENDIX 2

Equality Impact Assessment

Subject / Title	**Mental Health Strategy Business Case No. 2 of 3**

Team	**Directorate**
MH and LD Commissioning Team	Commissioning

Start Date	**Completion Date**
October 2017	

Project Lead Officer	Pat McKelvey
Contract / Commissioning Manager	Pat McKelvey
Assistant Director/ Director	Gill Gibson

EIA Group (lead contact first)	**Job title**	**Service**
Pat McKelvey	Head of MH and LD	Commissioning
Al Ford	CYP Commissioner	Commissioning

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	Expand evidence based services for people with 1. Common Mental Health Disorders 2. First Episode of Psychosis 3. Families who have a child with learning disability and/or autism who have behaviour that challenges
1b.	**What are the main aims of the project, proposal or service / contract change?**	Increasing capacity of existing services as follows:- 1. IAPT (Improving Access to Psychological Therapies) 2. Early Intervention Team 3. Behavioural Support for Children with Additional Needs

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age			**x**	
Disability	**x**			There will be increased behavioural support for children who are disabled.
Ethnicity		**x**		IAPT Services are charged with ensuring that they are meeting the needs of BAME communities.
Sex / Gender			**x**	
Religion or Belief			**x**	.
Sexual Orientation			**x**	
Gender Reassignment			**x**	
Pregnancy & Maternity			**x**	
Marriage & Civil Partnership			**x**	
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	**X**			Proposal will have a positive impact for people with MH needs
Carers	**x**			Carers and family members will benefit from additional support
Military Veterans			**x**	Direct access is already in place
Breast Feeding			**X**	

Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (e*.g. vulnerable residents, isolated residents, low income households)*

Group (*please state)*	Direct Impact	Indirect Impact	Little / No Impact	Explanation
None				.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The developments proposed will have a positive impact on all groups and contractual monitoring is in place to monitor impacts for the target groups.	

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 November 2017
Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**ANGIOGRAPHY SERVICE**

Report Summary:

Angiography is a type of X-ray used to check the blood vessels. It is an invasive test used for people with chest pain to investigate the risk of a heart attack or stroke. As a result of the angiography test, some patients require treatment. This treatment is to open up a narrowed artery and this is called angioplasty.

Stockport Clinical Commissioning Group are currently the lead commissioners for the angiography service and Tameside and Glossop Clinical Commissioning Group, East Cheshire Clinical Commissioning Group and North Derbyshire Clinical Commissioning Group co-commission this service.

For the period 1 July 2016 to 30 June 2017, 712 patients used the angiography service at Stockport Foundation Trust; 282 of these patients were registered with a Tameside and Glossop GP practice (39%). Approximately 35% of patients undergoing angiography would go on to have a further procedure. Stockport Foundation Trust is accredited to provide angiography but not angioplasty services. This means that currently patients requiring further procedures have to be transferred to specialist centre and require a second invasive procedure.

This report outlines the proposal from Stockport Clinical Commissioning Group to de-commission the angiography service at Stepping Hill Hospital (Stockport NHS Foundation Trust) and relocate services to Specialist Centres in Greater Manchester[1]. University Hospital of South Manchester is the nearest specialist treatment centre for most Tameside and Glossop patients but they can be referred to the other specialist centres around Greater Manchester. The other specialist centres are Central Manchester Foundation Trust (MRI) and Pennine Acute Hospital.

The Tameside and Glossop Integrated Care Foundation Trust are closely involved in this process and are supportive of the relocation of services to specialist centres in Greater Manchester[1]. This is also being reported via Theme 3 at Greater Manchester level.

Stockport Clinical Commissioning Group along with the other co-commissioners are in support of this proposal and have all sought approval to the proposal outlined in this paper via their governance structures. The feedback from all the co-commissioners will be considered at the Stockport Clinical Commissioning Group Governing Body meeting to be held on 29 November 2017.

[1] Specialist heart centres provide both angiography for diagnosis and angioplasty for treatment, on one site. This means that patients are able to have angiography and angioplasty at the same time i.e. one invasive procedure for diagnosis and treatment. Based on evidence that specialist centres deliver the best outcomes for people at risk of heart attacks,

Recommendations:

The Single Commissioning Board are asked to feedback on the decision of Single Commissioning Board to Stockport Clinical Commissioning Group for their consideration at their Governing Body meeting on 27 November 2017.

Financial Implications:

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

Budget Allocation (if Investment Decision)	This is not an investment proposal and would be cost neutral as activity and cost transfer out of Stockport Foundation Trust and into the 3 proposed specialist providers at the same price.
CCG or TMBC Budget Allocation	Angiogram procedures and diagnostic cost are wrapped up in the Healthcare Resources Group (HRG) pricing system once the patient is referred on for further treatment and would depend on the determined pathway for each HRG outcome. As we do not contract based on Primary Diagnosis, then the financial allocation/budget for this service with Stockport Foundation Trust has been based on a proxy forecast using the Month 1-5 data from Secondary Use Services in 2017/18 using a defined set of primary diagnosis covering both angiography and arteriography that has been mapped to the HRG. Based on the data at month 5 and using a straight-line profile, the budget resource to be de-commissioned would be circa £276,766. This needs to be consistent with the approach taken by Stockport Clinical Commissioning Group.
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Cost Neutral
Additional Comments – none.	

Legal Implications: **(Authorised by the Borough Solicitor)**	An open and transparent engagement process is required to attract maximum public engagement in order to ensure the public sector equality duty has been complied with. This should be reflected in the Equality Impact Assessment which decision makers must have due regard to before making any decision.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The proposals align with the Locality Plan through the delivery of improved management of conditions which will reduce the incidence and impact of heart related long term health conditions.
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. The Angiography Service enables improvement in quality of life and reduction in the incidence of heart related long term health conditions which aligns with the locality Commissioning Strategy.
Recommendations / views of the Health & Care Advisory Group (HCAG):	This paper was considered by the HCAG with the following recommendations: • That the views of the Tameside and Glossop Cardiology Consultant was sought. *This was subsequently received, and in summary it he felt that this service should remain at Stepping Hill until such a time that CT coronary angiography (a non-invasive way of performing coronary angiography using modern CT scanners) can be viably offered locally to patients at Tameside (as per the latest NICE guidance) - this would be dependent on the appropriate business case.* • A copy of the joint consultants' letter to Stockport Foundation Trust was requested for the Single Commissioning Board to review. • Clarification was also sought on the number of patients who needed a second procedure.
Public and Patient Implications:	This report outlines the engagement process which Stockport Foundation Trust have carried out on behalf of the co-commissioners. The report includes a full Equality Impact Assessment.
Quality Implications:	Stockport Foundation Trust, as Lead Commissioners have not carried out a separate Quality Impact Assessment, this forms part of the Equality Impact Assessment.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of the Angiography Services which to meet individuals' needs across the locality and addresses health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment has been undertaken by Stockport Clinical Commissioning Group and is attached to this report.
What are the safeguarding	In the de-commissioning of the service from Stockport Foundation

implications?	Trust and relocation of the Angiography Service to Specialist Centres in Greater Manchester the commissioners and Foundation Trusts will ensure that the service meets all appropriate safeguarding requirements.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Stockport Foundation Trust, as lead commissioners have considered the information governance implications. The commissioner will seek assurance from all parties involved in the delivery of Angiography Services that appropriate arrangements are in place.
Risk Management:	This re-location will be managed by Stockport Foundation Trust and therefore they will report and monitor any risks and advise co-commissioners as appropriate. Currently, following angiography, if angioplasty is required, patients are risk stratified by the consultants before the choice of hospital is determined. This is to reduce the likelihood of the patient needing to be transferred to another hospital for an additional invasive procedure.
Access to Information :	The background papers relating to this report can be inspected by contacting Heather Palmer, Commissioning Business Manager :  Telephone: 07791570979  e-mail: hpalmer@nhs.net

1. BACKGROUND AND INTRODUCTION

1.1 Angiography is a type of X-ray used to check the blood vessels. It is an invasive test used for people with chest pain to investigate the risk of a heart attack or stroke.

1.2 An angiography investigation involves a thin flexible tube to be inserted into a patients artery, a dye is then injected into the area being examined (e.g. heart), and the flow of blood (e.g. to the heart muscle) can then be assessed. Images can then be taken and reviewed. The results may show that the patient will require a further procedure (e.g. this treatment is to open up a narrowed artery and this is called angioplasty) which in some hospitals can be undertaken at the same time as the angiography. However, this cannot be done at Stockport Foundation Trust and the patient will require two invasive procedures instead of one

1.3 Stockport Clinical Commissioning Group is currently the lead commissioner for the angiography service and Tameside and Glossop Clinical Commissioning Group, East Cheshire Clinical Commissioning Group and North Derbyshire Clinical Commissioning Group are co-commissioners.

1.4 For the period 1 July 2016 to 30 June 2017, 712 patients used the angiography service at Stockport FT; 282 of these patients were registered with a Tameside and Glossop GP practice (39%).

1.5 Approximately 35% patients undergoing angiography would go on to have a further procedure. Stockport Foundation Trust is accredited to provide angiography but not angioplasty services. This means that currently patients requiring further procedures have to be transferred to a specialist centre and require a second invasive procedure.

1.6 The specialist centres are:

- Cardiothoracic Critical Care Unit - University Hospital of South Manchester (UHSM) (Wythenshawe Hospital);
- Manchester Heart Centre Central Manchester Foundation Trust (MRI) – Central Manchester Foundation Trust (MRI);
- Silver Heart Unit – Pennine Acute Hospital.

1.7 This report outlines the proposal from Stockport Clinical Commissioning Group to de-commission the angiography service at Stepping Hill Hospital (Stockport NHS Foundation Trust) and relocate services to Specialist Centres in Greater Manchester[1]. University Hospital of South Manchester is the nearest specialist treatment centre for most Tameside and Glossop patients but they can be referred to the other specialist centres around Greater Manchester. The other specialist centres are Central Manchester Foundation Trust (MRI) and Pennine Acute Hospital.

1.8 Stockport Clinical Commissioning Group (as lead commissioners), together with the other co-commissioners, East Cheshire Clinical Commissioning Group and North Derbyshire Clinical Commissioning Group are in support of this proposal and have all sought agreement via their governance structures to approve the proposals outlined in this paper.

1.9 The Integrated Care Foundation Trust are closely involved in this process and are supportive of the relocation of services to Specialist Centres in Greater Manchester[1]. This is also being reported via Theme 3 at Greater Manchester level,

2. PROPOSED TIMESCALE AND MILESTONES

2.1 The proposal to decommission this service was based on recommendations produced the by Greater Manchester and Cheshire Cardiovascular Network, which has now been replaced by the Strategic Clinical Network. This was reported to the Tameside and Glossop Professional Reference Group in April and June 2015.

2.2 Stockport Clinical Commissioning Group (as Lead Commissioners) are considering this proposal at their Governing Body meeting to be held on 29 November 2017. All the co-commissioners have been requested to take this proposal through their governance structures prior to the Stockport Clinical Commissioning Group Governing Body meeting at which the feedback from all the co-commissioners will be reported on prior to a final decision being made.

2.3 If the proposal is agreed and ratified at the Stockport Clinical Commissioning Group Governing Body meeting on 29 November 2017, Stockport Foundation Trust would be provided with 6 months' notice of intention to decommission as per the requirements of the contracting arrangements.

3. DEFINITION OF THE ANGIOGRAPY SERVICE

3.1 Angiography is a type of X-ray used to check the blood vessels. It is an invasive test used for people with chest pain to investigate the risk of a heart attack or stroke[2].

3.2 An angiography investigation involves a thin flexible tube to be inserted into a patients artery, a dye is then injected into the area being examined (e.g. heart), and the flow of blood (e.g. to the heart muscle) can then be assessed. Images can then be taken and reviewed. The results may show that the patient will require a further procedure (e.g. this treatment is to open up a narrowed artery and this is called angioplasty)

4. CASE FOR CHANGE

4.1 Following recommendations made by the Greater Manchester Cardiac Strategy (2012-2015), Stockport Clinical Commissioning Group (as lead commissioner) have registered their intent to decommission Angiography services from the Stepping Hill site.

4.2 A series of meetings took place with Co-Commissioners, North West Commissioning Support Unit and the local Strategic Clinical Network, and the recommendations for change were considered. The case for change considered the available capacity/waiting times/travel times to the following Specialist Centres in Greater Manchester:

- Cardiothoracic Critical Care Unit - University Hospital of South Manchester (Wythenshawe Hospital);
- Manchester Heart Centre Central Manchester Foundation Trust (MRI) – Central Manchester Foundation Trust (MRI);
- Silver Heart Unit - Pennine Acute Hospital.

4.3 Currently if angioplasty is required, patients are risk stratified by the consultants before the choice of hospital is determined. This is to reduce the likelihood of the patient needing to be transferred to another hospital for an additional invasive procedure. However, this stand-alone service is no longer in line with recommendations, such as those made by the GM

[2] http://www.nhs.uk/Conditions/Angiography/Pages/Introduction.aspx

Cardiac Strategy (2012-2015) this is based on evidence that specialist centres deliver the best outcomes for people at risk of heart attacks.

4.4 In some hospitals the angioplasty can be undertaken at the same time as the angiography. However, this cannot be done at Stockport Foundation Trust and the patient will require two invasive procedures instead of one.

4.5 This proposal will enable patients to be referred directly to one of the specialist centres and will be seen by a specialist, diagnosed and, if necessary, treated immediately after diagnosis rather than being transferred to another hospital.

4.6 NICE Guidelines recommend the use of non-invasive functional imaging[3] – such as Computed Tomography (CT) angiography – and therefore as the capacity for CT angiography increases, the need for coronary angiography will decrease.

4.7 The University Hospital of South Manchester (UHSM) would be the main provider of the service, they have confirmed (**Appendix A**) that they would be able to meet the demand following the decommissioning of services from Stockport Foundation Trust. They have further confirmed that they have developed plans to ensure there would be sufficient capacity within the Trust to enable the safe and effective transfer of this activity.

5. STRATEGY DEVELOPMENT AND ENGAGEMENT

5.1 A four week engagement process commenced on 11 August 2017 which was led by Stockport Clinical Commissioning Group as the lead commissioners. Tameside and Glossop Clinical Commissioning Group (along with the other co-commissioners) advertised the on-line survey which was based on the Stockport Citizen's web page and linked this to their own Clinical Commissioning Group websites. The survey was also available in hard copy on request. Face to face interviews with current service users was carried out. Communication with local patient groups was also initiated by Stockport Clinical Commissioning Group.

5.2 Forty-four people took part in the survey including ten existing users of the angiography service. They were registered with a GP in Stockport (55%), Eastern Cheshire (25%), Tameside and Glossop (9%), North Derbyshire (9%) and Other (1%). Fifty-percent of the respondents were female, forty-three percent were male and seven percent declined to say. Eleven percent of the respondents advised that they were an NHS staff member.

5.3 Ten patients (who were current service users), had face to face interviews. These were registered with GP's in Eastern Cheshire and Tameside and Glossop. Existing users' responses were added to the online survey by Stockport Clinical Commissioning Group staff following the interviews.

5.4 The results of the survey were that 66% did not agree with the proposals; 34% agreed with the proposals to decommission the service from Stockport Foundation Trust. The full copy of the engagement responses is appended as **Appendix B.**

5.5 Those who agreed with the proposal indicated that:

- If they were able to receive the best diagnostics and treatment then they would travel to a Specialist Centre.
- If they were able to have the angiography and angioplasty on the same day then this would be beneficial to them.

[3] https://www.nice.org.uk/sharedlearning/ct-coronary-angiography

5.6 Following evaluation of the stakeholder responses, several key themes and were identified, which were:

- Waiting times;
- Travel;
- Case for Change.

Waiting Times/Capacity

5.7 Stockport Clinical Commissioning Group have consulted with the local providers (e.g. Central Manchester Foundation Trust, University Hospital of South Manchester and Pennine Acute Hospitals Trust), to understand if they would be able to achieve the key performance indicators required and have the capacity to meet the demand if the service was re-located to their sites. The primary provider of this service would be the University Hospital of South Manchester who have provided a capacity assurance letter (**Appendix A**) indicating that they would be able to meet the demand if the angiography service was relocated to their site.

Travel

5.8 A review of travel times for Tameside and Glossop residents to support the proposal has been carried out by Stockport Clinical Commissioning Group (**Appendix C**). Information from this has indicated that 'Direct public transport routes to the airport means it is relatively easy to get around between Tameside and Wythenshawe with all routes starting from near Ashton-Under-Lyne'

Case for Change

5.9 The engagement highlighted local people to 'the case for change' i.e. the reasons why the changes were being proposed to the way the Angiography Service is delivered.

5.10 Stockport Clinical Commissioning Group has completed an Equality Impact Assessment (**Appendix D**) for the proposal which included Tameside and Glossop patients. They also included Healthwatch Stockport in the pre-engagement work.

6. PROPOSED MODEL FOR ANGIOGRAPHY SERVICES FOR PATIENTS OF TAMESIDE AND GLOSSOP

6.1 The proposal is to decommission Stockport Foundation Trust for the angiography services and relocate the angiography service to specialist centres in Greater Manchester.

6.2. Three such specialist centres are available:

- Cardiothoracic Critical Care Unit - University Hospital of South Manchester (UHSM) (Wythenshawe Hospital);
- Manchester Heart Centre Central Manchester Foundation Trust (MRI) – Central Manchester Foundation Trust (MRI);
- Silver Heart Unit – Pennine Acute Hospital.

6.3 Patients would be offered a choice of these three centres.

6.4 This proposal will enable patients to be referred directly to one of the specialist centres and will be seen by a specialist, diagnosed and, if necessary, treated immediately after diagnosis rather than being transferred to another hospital.

7. FINANCIAL MODEL

7.1 Angiogram procedures and diagnostic cost are wrapped up in the HRG pricing system once the patient is referred on for further treatment and would depend on the determined pathway for each Healthcare Resource Group outcome. As such, the cost of carrying out these diagnostic tests will be no different at the proposed specialist centres to those charged by Stockport Foundation Trust. The key principal of payment by results (PbR) is that price should not be a factor when making a referral into secondary care and as such each provider is to charge the same price for the same test or procedure.

7.2 As we do not contract based on Primary Diagnosis/Procedure the financial allocation/budget for this service with Stockport Foundation Trust has been based on a proxy forecast using the Month 1-5 data from SUS in 17/18 using a defined set of primary procedure covering both angiography and arteriography that has been mapped to the Healthcare Resource Groups. These are detailed below;

K631 Angiocardiography of combination of right and left side of heart;
K632 Angiocardiography of right side of heart NEC;
K633 Angiocardiography of left side of heart NEC;
K634 Coronary arteriography using two catheters;
K635 Coronary arteriography using single catheter;
K636 Coronary arteriography NEC.

7.3 Based on the data at month 5 and using a straight-line profile, the budget resource to be de-commissioned would be circa £276,766 full year. This would be the annual cost we would see in the other associate providers on a like for like basis. This approach needs to be consistent with that taken by Stockport Clinical Commissioning Group.

8. ENGAGEMENT

8.1 The proposal included in section 6 includes the intention by Stockport Foundation Trust to de-commission the existing angiography service at Stepping Hill and re-locate this service to a specialist centre in Greater Manchester. This is not a level of change to service delivery which requires a period of formal consultation and Stockport Foundation Trust have carried out the required four week engagement period.

9. EQUALITY IMPACT ASSESSMENT

9.1 A Equality Impact Assessment have been undertaken by Stockport Clinical Commissioning Group (including Tameside and Glossop patients) to support the proposals included in this document, which has been used to support the engagement process. This can be seen at **Appendix D.**

10. RECOMMENDATION

10.1 As set out on the front of the report.

UHSM
Your Hospital

University Hospital
of South Manchester NHS
NHS Foundation Trust

Wythenshawe Hospital
Southmoor Road
Wythenshawe
Manchester
M23 9LT

0161 998 7070

www.uhsm.nhs.uk

12th July 2017

Dear Gillian,

Thank you for inviting us to meet with you on the 4th July to discuss the provision of Cardiology services in light of the decision to decommission angiography services at Stockport NHS Foundation Trust.

UHSM first received notification from Stockport CCG of this intention in 2015, and as such developed plans to ensure there would be sufficient capacity within the Trust to enable the safe and effective transfer of this activity. As part of the existing partnership with Medtronic Integrated Healthcare Solutions ltd, UHSM commissioned a new cardiac catheter laboratory which opened fully in January 2017. The development also included a new 'cardiac day lounge' which is a purpose built facility for patients before and after their angiogram procedure. As well as being a pleasant environment for patients, this avoids the use of inpatient bed capacity.

Concurrently to the build of the 5th catheter lab at UHSM, a consultation process has been undertaken with staff in order to build a more flexible service outside of the core hours of 9am-5pm. The staffing model now in place provides an extended working day (8am until 8pm) Monday to Thursday, as well as weekend cath lab sessions.

Given the completion of these developments, it is with pleasure UHSM can confirm it has the capacity to accommodate the required volume of activity with immediate effect.

As discussed, there are plans to replace one of our existing labs in the autumn of this year as part of our rolling capital replacement programme. This does not however preclude the transfer of Stockport activity, as the flexible working practices described above will enable us to maintain the required capacity during this work.

As you are aware, pending approval from the Competition and Mergers Authority and NHS Improvement, UHSM will merge with Central Manchester NHS Foundation Trust (CMFT) in October (Single Hospital Service). The plan to accommodate the Stockport angiography activity at UHSM will be entirely unaffected by this merger, and indeed the clinical and managerial leadership team at CMFT are fully aware of and supportive of this development.

As described at the meeting, we are working with consultant colleagues at Tameside and Stockport to increase the capacity and availability of non-invasive tests such as stress echo and coronary CT scans for chest pain. We would anticipate that this will provide increased diagnostic

accuracy and reduce the need for invasive stand-alone angiography, with the resulting patient benefits. We will be contacting colleagues at Macclesfield to engage in similar discussions.

As requested we have attached an outline of how a revised chest pain pathway at Stockport might work based on the current model of non-invasive testing (developed by Gavin Freeman), but including invasive testing at UHSM. You will notice that the attached pathway leads to a relatively small proportion of patients needing invasive assessment for chest pain. It may be possible to develop a similar pathway over the next 6 months at Tameside.

We look forward to working with you and provider colleagues to mobilise the transition of angiography services to the UHSM hub, and continue the development of non-invasive services to ensure delivery of sustainable, high quality and efficient pathways for patients across the region.

Yours sincerely,

Graham Lomax
Divisional Director of Operations
Scheduled Care

Dr Sanjay Sastry
Clinical Lead, Cardiology

APPENDIX B

NHS
Stockport
Clinical Commissioning Group

Angiography Service - Engagement Responses 2017

NHS Stockport Clinical Commissioning Group will allow people to access health services that empower them to live healthier, longer and more independent lives.

NHS Stockport Clinical Commissioning Group
7th Floor
Regent House
Heaton Lane
Stockport
SK4 1BS

Decommissioning Angiography Service – Stockport

Engagement Responses – Friday 11th August to Friday 8th September.

Contents:

1. Introduction

The purpose of this report is to inform key stakeholders about the responses to the engagement activity for the proposed decommissioning of the Angiography Service currently provided by Stockport NHS Foundation Trust.

2. Overview

On Friday 11th August 2017, Stockport CCG started a four week engagement period during which it informed stakeholders of the proposed plans to change the way the Angiography Service in Stockport is delivered. As a CCG we have a statutory duty to inform the public of any proposed changes to the services we commission and allow them to be involved in the development and consideration of the plans.

During the engagement period we conducted an online survey, along with patient interviews at Stepping Hill Hospital and communication with local patient groups.

3. Topics of engagement

During the engagement we highlighted to local people about:

- The case for change – the reasons why we are proposing the changes to the way the Angiography Service is delivered.

  - specialist heart centres
  - Clinical guidance on quality and outcomes
  - Patients having tests and treatment in one location.
  - Choice

We wanted to know:

- What people think about the proposed service changes and how any concerns may be alleviated?

4. Audiences

Our audience was those people who primarily access the angiography service at Stockport Foundation Trust and those who may access the service in the future. This includes people who live within the Stockport CCG area, and people living within the areas covered by; Tameside and Glossop CCG, North Derbyshire CCG and East Cheshire CCG.

- New and existing users of the angiography service
- Members of the public

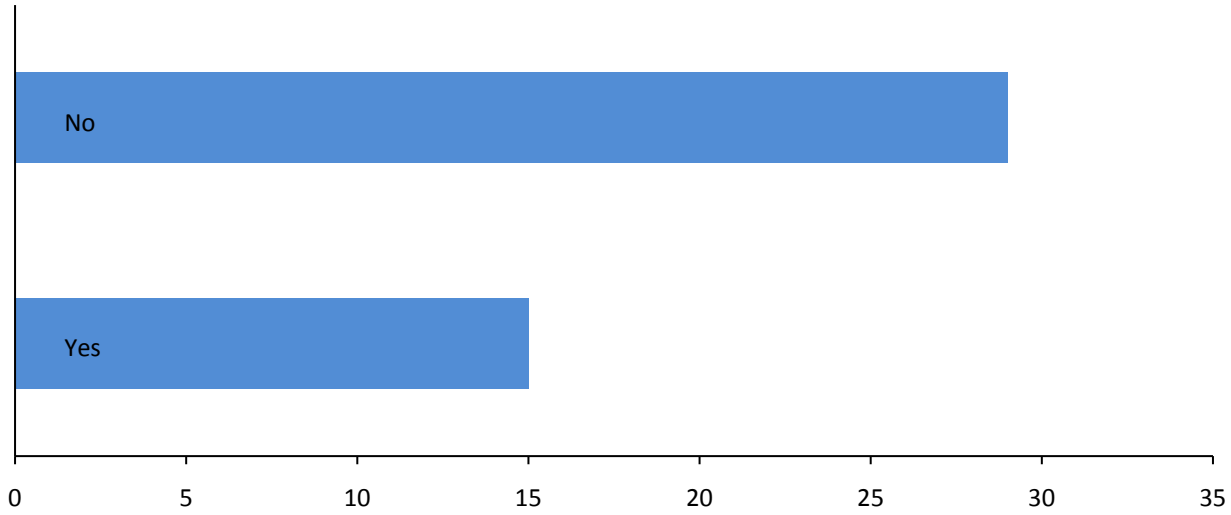
5. Online Survey and Patient Interviews

Forty-four people took part in the survey including ten existing users of the angiography service. They were registered with a GP in Stockport (55%), Eastern Cheshire (25%), Tameside & Glossop (9%), North Derbyshire (9%) and Other (1%). Fifty-percent of the respondents were female, forty-three percent were male and seven percent declined to say. Eleven percent of the respondents advised that they were an NHS staff member.

The patients' who were interviewed were registered with GP's in Eastern Cheshire and Tameside & Glossop. Existing users' responses were added to the online survey by Stockport CCG staff following the interviews.

Respondents were asked the following question:

At present there is a two stage process via Stepping Hill, then a Specialist Heart Centre. The proposed change is to move services for patients who need testing and treating to a Specialist Centre. Do you agree with the proposal?



Option	Percentage
No	**66%**
Yes	**34%**

Respondents were then asked whether they had any comments and concerns that they would like to add. There were 36 responses to this part of the question and further detail of individual responses is in the addendum of this paper. Several broader concerns were identified from the evaluation of the responses.

- Respondents expressed concern about having to travel further to a Specialist Centre, particularly from areas such as Glossop and High Peak.
- That the waiting times for the angiography procedure would increase at the Specialist Centres as a result of the decommissioning of the angiography service at Stepping Hill Hospital.
- That many patients may not require angioplasty and therefore it wouldn't be more convenient to have to travel to a specialist centre. Some respondents questioned whether the angiography and angioplasty could be performed in the same day.
- An excellent local service could be closed.

Those who agreed with the proposal indicated that:

- If they were able to receive the best diagnostics and treatment then they would travel to a Specialist Centre.
- If they were able to have the angiography and angioplasty on the same day then this would be beneficial to them.

6. Addendum Stakeholder Responses - Themes and trends

Following evaluation of the stakeholder responses, several key themes and were identified, which are outlined below.

Transport
1. Patients in certain areas will have to travel further. 2. Demographically Stepping Hill hospital works best serving 3 districts from what I see. The journey onto specialist centres is too far if only a diagnostic test is needed. 3. I would not like to have to travel to another hospital when my local one is close by and able to provide an excellent service. 4. I am very, very, concerned to learn that you are planning to take a. It is taking a service away from Stockport residents at a time when they would need less stress in their life, you will be greatly adding to the stress of seriously ill patients by forcing them to travel further, worry about transport needs and having to ask family members to take longer times off work to take them further afield for life saving treatment. I am disgusted that you would propose to take this service away from stepping hill hospital. 5. It [will] cost more money to travel further and already costs enough to park. 6. I don't drive and can't get a lift and they [specialist centres] do take a long time to get there by public transport, and very expensive to get there by taxi. 7. I do not think it is fair to have to travel to another hospital. Also how is this a proper consultation when you haven't even said where this 'specialist centre' is? Maybe you should change this to include where we would have to travel so we know what we're agreeing or not agreeing to. 8. I can see the logic in this BUT the Specialist Centre needs to be easily accessible by

bus or train journey for Glossop residents.

9. The implication is that the specialist centre would be elsewhere, and it is difficult enough for many patients to get to Stepping Hill now.

10. The problems regarding traveling from High Peak on public transport to any of the proposed specialist hospitals.
    Has this been considered or is this already been decided never mind any consultation.

11. There is no bus service - it's terrible it takes so long; I may feel anxious on the way to my appointment. The buses and trains don't always run on time and if you turn up late they won't see you. The cost would be a lot more.
    I much prefer to attend a local service. What about the elderly who aren't so mobile? How will they get to visit someone? I've done this before going to other hospitals it's not nice. Why try and fix something that's not broken?

12. I come from Buxton so would find it extremely difficult to get to Wythenshawe especially for a morning appointment. I would also need to know the recovery time after having an angioplasty. It's easier for me to get to Stepping Hill twice rather than Wythenshawe.

13. Parking at Wythenshawe is terrible it's a pain to get to from here. The bus to Wythenshawe takes an hour - there is not metro or tram link.

14. There is no bus service - it's terrible it takes so long, I may feel anxious on the way to my appointment. The buses and trains don't always run on time and if you turn up late they won't see you. The cost would be a lot more.

15. Wythenshawe would be a problem as I don't have a car. If I had to go for further tests I would use public transport or ask my daughter to take me.

Waiting times

1. The patient waiting times will go up if this [decommissioning] goes ahead, waiting times are already higher at the other Trust than at Stepping Hill.

2. The distance and the time waiting for an appointment, as surely removing this service from Stepping Hill will increase work load/ waiting time at the other hospitals.

3. I am concerned that the specialist centres would not be able to adequately handle the sheer volume of patients sent there for diagnostic angiograms from Stockport, Macclesfield and Tameside. Especially when patients stay on wards waiting for an inpatient angiogram or angioplasty currently. If the facility is available to take on 700 + patients now, why are inpatients waiting so long?

4. Surely the wait times at the specialist centres will increase significantly as they will be doing many more angiographies?

5. [The] impact of the closure on waiting times at alternative specialist centres.

6. I am concerned that there will be longer waiting lists at the more easily accessible hospitals.

7. From having first-hand experience of working in both a specialist cardiology centre and at stepping Hill catheter lab, I am worried that the waiting times for patients awaiting elective angiograms will dramatically increase if the proposed goes ahead. Knowing that the specialist centres already struggle to treat the inpatient angiograms due to bed pressures and primary PCI, it seems to me that adding the Stepping Hill patient workload to these centres will cause patients waiting times to rise.
This could result in a less efficient service in the long run, as patients who do require further treatment are left longer, putting them at risk and potentially admitted to hospital as a result of their condition being undiagnosed.

8. The speed at which I got the appointment at Stepping Hill was excellent (4 days) which I can't fault as speed is important to me. Would that happen if the service transferred to a specialist centre?

   If I required both angiography and angioplasty and it could be done at the same site on the same day then this would be better. However, if the procedure does transfer to a specialist centre would waiting times increase?

Case for change

1. 80% of the patients will not require angioplasty.

2. Most procedures after doing personal research could NOT be stented there and then as is proposed. As the 20% states in the proposal not all diagnostic tests lead to two procedures either. Some people probably need nothing at all or surgery. As a service user this has been functioning effectively from what I have seen and heard for 11 years. If its not broken why fix it?

3. I recently had a coronary angiogram at Stepping Hill Hospital and am very pleased with the service. I would be very concerned if I required this again and it was not available to me here, I would not like to have to travel to another hospital when my local one is close by and able to provide an excellent service.

4. Is this not a service which actually makes money for the Trust? It provides an excellent service and excellent care to its patients. A lot of patients, wouldn't need to go to the next level of care, so could just be treated in a local hospital, which surely would be less stressful for them.

5. We would prefer to keep services local!

6. I am concerned that the specialist centres would not be able to adequately handle the sheer volume of patients sent there for diagnostic angiograms from Stockport, Macclesfield and Tameside. Especially when patients stay on wards waiting for an

inpatient angiogram or angioplasty currently. If the facility is available to take on 700 + patients now, why are inpatients waiting so long? Also this catheter lab was built partly to minimise travelling for patients and reduce waiting times in the 3 areas. I fear that this will now increase on both counts if this was to go ahead. Especially as stated, only around 20% of patients have been referred on for angioplasty. Seems a very small proportion of people in the grand scheme of things. So to me I disagree with this proposed decommission, there is a lot of conflicting information.

7. I have always attended appointments for my heart condition at Stepping hill hospital and I have had an angiogram to check my heart arteries and have been extremely pleased with the service. I would be reluctant to have to wait for appointments and procedures at a different hospital when it is possible to have my checks at Stockport. The doctors and nurses who have looked after me have been wonderful.

8. I know many elderly patients who have been attended to here and to send them further afield is ridiculous! For most patients surely a quick diagnosis at their closest hospital is more important than having to make 2 trips - sounds like this proposal is just another way of cutting costs (2 procedures for the price of 1!) rather than what's best for the patients. How disappointing. At least be honest when proposing it rather than making out it's in the patients best interest - try asking the patients in the clinic!

9. I live within4 miles of Stepping Hill and have just had pacemaker fitted in the centre you propose to close. The staff were all fantastic a truly dedicated team and most had been there for several years. The unit was first established in 2005 due to a sterling effort by Dr Malick what a waste!!!! In my case I would have had to travel 15 miles to have the procedure which would have meant reliance on relatives , friends or a taxi! Will it mean that I in future have to travel to Wythenshawe for the yearly check?? Since the unit was set up hundreds of angiogram procedures have been carried out it would be interesting to know in how many of those cases was it necessary to refer the patient urgently to. A specialist heart centre?? I don't agree with the proposal and would strongly do all I could to oppose it !!!!!!!!!

10. The outcome of my angiography is mild angina so it can be controlled with medication. If I was to go to a specialist centre and needed an angioplasty I'm not sure I would want it on the same day. I would rather discuss with the doctor about other options I may have and have the time to discuss this with my family.
    The speed at which I got the appointment at Stepping Hill was excellent (4 days) which I can't fault as speed is important to me. Would that happen if the service transferred to a specialist centre? Listening to a number of patients today ,not a lot have gone on to have an angioplasty.

11. Personally I don't know why you would have to move the service. I've been impressed with the NHS treatment and service I've had today. For me to stay stop it here and move it elsewhere is a bit harsh.
    I appreciate I've not got the full picture, and economics plays a part but as a first time patient I can't think of a reason to move the service.

12. My understanding is more often than not the angioplasty would not take place on the same day as the angiogram, so would be surprised if Wythenshawe could book you in

for an angioplasty in the afternoon if you've only had the angiogram in the morning.

13. Why try and fix something that's not broken?

14. Seriously, a very bad idea, and I also believe this section of the hospital is the only part that made a profit over all the rest, so why move it, if it isn't broke, why try to fix it.

15. I am also really pleased with the services here at Stepping Hill and have had an excellent experience throughout my treatment.

Other

1. How much did the opening and closing of this service cost?

2. Can they not add to this unit here instead of taking it elsewhere?

Support for the proposal

1. If I required both angiography and angioplasty and it could be done at the same site on the same day then this would be better.

2. If you can get both the test and the treatment done on SAME DAY then I would be happy to travel to either of the specialist centres.

3. Earlier specialist diagnosis and treatment would be best.

4. I would choose now to go to Chesterfield Hospital rather than Stepping Hill. The distance that people living in Buxton have to travel to a hospital is one hour - in peak time traffic this is extended. Local hospitals - The Cottage and Cavendish - are having their services reduced. I would prefer to go to a consultant and a specialist hospital with any health problems. I have had some recent health issues and have chosen to go to Chesterfield.

5. I'd prefer to go to the centre where I can get the best diagnostics & treatment. It may not be the nearest to my home but that's a minor detail.

APPENDIX C

Wythenshawe Hospital Travel Times

Areas Surrounding Stockport

Starting location	Bus route(s)	Train(s)	Number of changes	Earliest and latest departure from home	Earliest and latest departure from Wythenshawe	Total journey time	Other comments
Glossop	Journey 1: Train to Piccadilly Train to Mauldeth Road, 278 bus to Burton Road, 179 to Wythenshawe Hospital	Journey 1: Glossop to Manchester Piccadilly Piccadilly to Deansgate Deansgate to Roundthorn (Tram) Journey 2: Glossop to Manchester Piccadilly Piccadilly to Sale (tram) Sale to Wythenshawe (tram) Journey 3: Glossop to Manchester Piccadilly Piccadilly to Manchester Airport Manchester Airport to Roundtree (tram)	3	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) 6:30am Sundays: Realistically (under 3 hours) 7:20 am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) 10:40pm Sundays: Realistically (under 3 hours) 9:30pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:55am Sundays: Realistically (under 3 hours): 6am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 12:40am Sundays: Realistically (under 3 hours): 9:50 pm	Between 1hr 20mins and 2hrs 30 mins (It takes roughly an hour to get to Stepping Hill)	Technically the latest trams 12:40 am, but you'd be waiting a while for it. You'd be lucky to do the journey in 1hr 20- 1hr 40mins is about the average.

Buxton	Journey 1: Train to Davenport 309 to Ladybridge road 368 to Wythenshawe Hospital Journey 2: Train to Stockport 11 to Wythenshawe interchange 19 to Wythenshawe Hospital Journey 3: 199 to Stockport College 11 to Wythenshawe Hospital Journey 4: 199 to Manchester Airport Tram to the hospital	Journey 1: Train Buxton to Stockport Journey 2: Train Buxton to Davenport	Between 2 and 3	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) 4:30am Sundays: Realistically (under 3 hours) 3:30am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 9:30pm Sundays: Realistically (under 3 hours): 11pm	Latest departures: Weekdays/Saturday: Realistically (under 3 hours) 10:40pm Sundays: Realistically (under 3 hours) 9:40pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5:20pm Sundays: Realistically (under 3 hours): 4:13am	Between 1hr 40mins and 2hrs 30mins (It takes around an hour at present)	
High Peak	Journey 1: 199 to Stockport, 11 to Wythenshawe Journey 2: 199 to Stockport, 11 to Ferndown Road, 19 to Hospital Journey 3: 199 to Manchester		Between 1 and 2	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) 4:20am Sundays: Realistically (under 3 hours) 6:20am Latest departures: Weekdays/Saturday:	Latest departures: Weekdays/Saturday: Realistically (under 3 hours) 10:30pm Sundays: Realistically (under 3 hours) 10 pm Earliest departures: Weekdays/Saturday: Realistically (under 3	2hrs to 2hrs 40 mins (Currently 1 hour to 90 minutes to get to Stepping Hill)	

	Airport Tram to Wythenshawe Interchange 278 to Wythenshawe Hospital			Realistically (under 3 hours) : 10pm Sundays: Realistically (under 3 hours): 9:30pm	hours) : 4:15am Sundays: Realistically (under 3 hours): 5:30am		
Macclesfield	Journey 1: Take 130 bus to Boots, High Street, Cheadle. Take 11 bus to Wythenshawe Interchange. Take 278 bus to Ledson Road, Roundthorn. Walk 2 mins to Wythenshawe Hospital. Journey 2: Take 130 bus to Green lane, Wilmslow. Take the 200 bus to Manchester Airport. Take the 43 bus to Portway. Take 11 bus to Ledson Road. Walk 2 mins to Wythenshawe Hospital. Journey 3: Take 27 bus to Knutsford. Take 88 bus to Altrincham Interchange. Take 11 bus to Ledson Road. Walk 2 mins to	Journey 1: Train to Manchester Piccadilly. Take E Tram to Cornbrook Road. Take F Tram to Southmoor Road. Walk 6 mins to Wythenshawe Hospital. Journey 2: Train to Piccadilly. Train to Manchester Airport. Take F Tram to Roundthorn. Journey 3: Train to Stockport. Take 24 from Stockport Bus Station to Barlow Moor Road, West Didsbury, Take 179 to Wythenshawe Hospital.	2/3	Earliest Departures: Weekdays/Saturday (under 2 hours) 05:28am Sundays: (under 2 hours) 9:00am bus / 10:30am train Latest Departures: Weekdays/Saturday: 21:59pm/23:35pm	Earliest Departures: Weekdays/Saturday: (under 2 hours) 04:13am Sundays: (under 2 hours) Realistically 09:29am	Between 1hr to 2hr 35 mins	

	Wythenshawe Hospital.						
Tameside	Journey 1: 330 Ashton-under-Lyne to Manchester Airport Manchester Airport to Roundthorn (tram) Journey 2: Ashton-Under-Lyne to Piccadilly Gardens (tram), 102 Piccadilly Gardens to Wythenshawe Hospital	Journey 1: Stalybridge to Piccadilly, Piccadilly to Altringham (tram) 11 (bus) to hospital Journey 2: Ashton-Under-Lyne to Deansgate (tram) Deansgate to Roundthorn (tram)	Between 1 and 2	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) All night Sundays: Realistically (under 3 hours) All night Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : All night Sundays: Realistically (under 3 hours): All night	Latest departures: Weekdays/Saturday: Realistically (under 3 hours) 12:30am Sundays: Realistically (under 3 hours) 12:30am Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 6am	1hr 30mins to 2hrs 30mins (Currently around 1 hour 30 minutes to get to Stepping Hill)	Direct routes to the airport means its relatively easy to get around between Tameside and Wythenshawe All routes start from near Ashton-Under-Lyne
Whaley Bridge	Journey 1: 119 to Manchester Airport, tram to Roundthorn	Journey 1: Whaley bridge Station to Stockport Station 11 to hospital	1	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:15pm Sundays: Realistically (under 3 hours): 9:45pm	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 10:30pm Sundays: Realistically (under 3 hours) 4am Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:30am Sundays: Realistically (under 3 hours): 10pm	Between 1hr 30 mins and 3 hours (Currently 30 minutes to get to Stepping Hill)	
New Mills	Journey 1: 199 to Manchester Airport Tram to Roundthorn	Journey 1: New Mills station to Stockport Station 11 bus to hospital	1	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 10:30pm Sundays: Realistically	1 hour 15 mins to 2 hours (Currently 40 minutes to get	Routes late at night become very convoluted, going via Manchester Piccadilly

				(under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11 pm Sundays: Realistically (under 3 hours): 9:40pm	(under 3 hours) 10 pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:30am Sundays: Realistically (under 3 hours): 5:15am	to Stepping Hill)	

Town Centre, Manchester Piccadilly,

Bramhall, Bredbury, Brinnington, Compstall, Hazel Grove, the Heatons (save Mersey) High Lane, Manor, Marple, Mellor, Offerton Portwood, Reddish North and South, Romiley, Stepping Hill, and Woodsmoor all have routes passing through either Stockport town centre or Manchester Piccadilly. Whilst many also have alternate routes, often going through the centre is the quickest or least convoluted way.

Manchester Piccadilly Train Station	Journey 1: 101 from Whitworth Street Journey 2: Tram to Altringham, 11 bus to Wythenshawe Hospital	Journey 1: Train to Manchester Airport, Tram to Roundtree Journey 2: Train to Deansgate, Tram to Wythenshawe Hospital Journey 3: Tram to Cornbrook, Tram to Wythenshawe Hospital	0-2	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 3am Sundays: Realistically (under 3 hours) 3am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:40pm Sundays: Realistically (under 3 hours): 11:10pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 3am Sundays: Realistically (under 3 hours) 3am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:40pm Sundays: Realistically (under 3 hours): 11:40 pm	45 minutes to 1 hour 15 mins (currently around 45 minutes)	The majority of the routes for outlying regions pass through either Stockport bus/train station, or Manchester Piccadilly
Stockport Bus Station	Journey 1: Bus 11 to Wythenshawe hospital Journey 2: 330 to Manchester Airport,		Changes 0- 1	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4:20 am Sundays: Realistically	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 12:40am Sundays: Realistically	50 minutes to 1hr 15 minutes (currently around 20	The majority of the routes for outlying regions pass through either Stockport bus/train station, or Manchester

	tram to Roundtree Journey 3: Bus 11A to Ferndown Road, Bus 11 to Hospital Journey 4: X5 to Orton Road, 19 to Wythenshawe			(under 3 hours) 6am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:20pm Sundays: Realistically (under 3 hours):11 pm	(under 3 hours) 11pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 4am	minutes)	Piccadilly

Routes from the borough

Starting location	Bus route(s)	Train(s)	Number of changes	Earliest and latest departure from home	Earliest and latest departure from Wythenshawe	Total journey time	Other comments
Adswood (primary school)	Journey 1: 368 to Wythenshawe Interchange, tram to Roundtree Journey 2: 309 to Boots on A560, 11A to Baguley Tesco, 19 to Hospital Journey 3: 313 to St Thomas Hospital, 11A to Baguley Tesco, 19 to Hospital		1 to 2	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11pm Sundays: Realistically (under 3 hours): 11pm	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:30 Sundays: Realistically (under 3 hours) 11pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:30 Sundays: Realistically (under 3 hours): 4am	1 hour (currently takes 30 mins)	Routes via Manchester Piccadilly all night, but slightly convoluted in terms of walking/many changes
Bramhall (station)	Journey 1: Bramhall to Cheadle (train), 368 to Wythenshawe interchange, tram to Roundthorn Journey 2:	Journey 1: Bramhall to Manchester Piccadilly, 101 bus to Wythenshawe Hospital Journey 2: Bramhall to	1 to 2	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10pm Earliest departures: Weekdays/Saturday: Realistically (under 3	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 5am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3	1 hour to 90 minutes (Currently 30 minutes to 1 hour)	

		Levenshulme, 168 to Chorlton, tram to Roundthorn		hours) : 5:30am Sundays: Realistically (under 3 hours): 7:30am	hours) : 10:15pm Sundays: Realistically (under 3 hours): 9:15pm		
Bredbury	Journey 1: 330 bus to Manchester airport, tram to Wythenshawe Hospital	Journey 2: via Manchester Piccadilly	1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:45pm Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 7am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 10:30 Sundays: Realistically (under 3 hours): 11pm	1 hour to 1 hour 30 minutes (Currently 40 minutes)	
Brimington (station)	Journey 1: 325 to Stockport town centre See routes from Stockport town centre	Journey 1: train to Manchester Piccadilly See routes from Manchester Piccadilly	1-3 changes	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 1:30am Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:30am Sundays: Realistically (under 3 hours): 6:30	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 10:30 pm Sundays: Realistically (under 3 hours): 11pm	Between 1 hour 15 minutes and 2 hours (Currently 33 minutes)	
Cheadle (station)	Journey 1: 368 to Wythenshawe interchange, 101 to hospital		1 to 2	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 5am	45 minutes to 1 hour (Currently 40 minutes)	

	Journey 2: 368 to Simonsway, tram to Roundtree Journey 3: 309 to Boots on A560, 11A to Baguley Tesco, 19 to Hospital			Sundays: Realistically (under 3 hours) 10:30 Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 6am	Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11pm Sundays: Realistically (under 3 hours): 10:30 pm		
Cheadle Heath (Gorsey Bank park)	Journey 1: 11A to Baguley Tesco, tram to Roundtree Journey 2: 368 to Simonsway, tram to Roundtree Journey 3: 199 to Manchester airport, tram to Roundtree Journey 3: 368 to Wythenshawe interchange, 19 to hospital		1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:30pm Sundays: Realistically (under 3 hours) 11pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5:30am Sundays: Realistically (under 3 hours): 4am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 10:45pm Sundays: Realistically (under 3 hours): 11pm	50 minutes to 1 hour 20 minutes (Currently 20 to 45 minutes)	
Compstall	Journey 1: 383 bus to Stockport Station, 11 bus to Wythenshawe Hospital	Journey 1: Walk to Marple train station, train to Manchester Piccadilly, see routes from Manchester Piccadilly	1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 6:30am Sundays: Realistically	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4:30am Sundays: Realistically (under 3 hours) 7am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 10pm Sundays: Realistically (under 3 hours): 10pm	1 hour 30 minutes to 2 hours (Currently 45 minutes)	

				(under 3 hours): 8:30			
Davenport (station)	Journey 1: 374/378/309/192 bus to Stockport town centre, see routes from Stockport town centre Journey 2: 309 to Boots on A560, 11 bus to Hospital Journey 3: 309 to Councillor Lane, 368 to Wythenshawe Interchange, 102 to Hospital		1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10:45pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 5am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4:15am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:15pm Sundays: Realistically (under 3 hours): 11:15pm	1 hour (Currently 20 minutes)	All night via Piccadilly
Edgeley	Journey 1: Number 11 bus Journey 2: 368 to Wythenshawe Interchange, 19 to Hospital Journey 3: 368 to Manchester airport, tram to Roundthorn		0-1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 10:45pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 11:50pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:45pm Sundays: Realistically (under 3 hours): 11pm	1 hour to 1 hour 15 minute (Currently 30 minutes)	All night via Piccadilly
Gatley	Journey 1: Number 11 bus	Journey 1: Train to Heald Green, 368 to Wythenshawe	0-1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 3am	30 minutes (Currently 50 minutes)	

		Hospital		Sundays: Realistically (under 3 hours) 11pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 3:30am Sundays: Realistically (under 3 hours): 3:30	Sundays: Realistically (under 3 hours) 3am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11pm Sundays: Realistically (under 3 hours): 11pm		
Heaton Chapel/Moor (station)	Journey 1: Bus 25 to Barlow Moor Metrolink Tram to Roundthorn Journey 2: 192 to Stockport, see routes from Stockport Town Centre	Journey 1: Train to Stockport, see routes from Stockport Town Centre	1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:30pm Sundays: Realistically (under 3 hours) 10:45pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:30am Sundays: Realistically (under 3 hours): 3am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:30 Sundays: Realistically (under 3 hours): 11pm	1 hour (Currently 30 minutes)	All night via Piccadilly
Heaton Mersey	Journey 1: Tram to St Werburgh's Road, Tram to Roundthorn	Journey 1: Train from Burnage to Manchester Airport, tram to Roundthorn Journey 2: Train from Burnage to Heald Green, 368 to Wythenshawe interchange, 101 to Hospital	1 to 2	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 12am Sundays: Realistically (under 3 hours) 10:40 pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours):	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 12:30am Sundays: Realistically (under 3 hours) 11pm Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 5:30am	50 minutes to 1 hour 20 minutes (Currently 40 minutes)	

		Journey 3: Train to Gatley, 11 to Hospital		5:30am			
Heaton Norris (Norris Bank)	Journey 1: Bus 179 to hospital Journey 2: 19 to Wythenshawe Metrolink 370 to hospital Journey 3: Bus 25 to Barlow Moor Metrolink Tram to Roundthorn Journey 4: X5 to Sale Road, 19 to Hospital		0-1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:20pm Sundays: Realistically (under 3 hours) 11pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 4am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4:15am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:30pm Sundays: Realistically (under 3 hours): 11:30pm	1 hour (Currently 35 minutes)	Routes all night via Manchester Piccadilly
Hazel Grove	Journey 1: Train to Davenport 309 to Councillor Lane, 368 to Wythenshawe hospital Journey 2: Bus/train into Stockport, see routes from Stockport town centre		1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4:14 am Sundays: Realistically (under 3 hours): 4:14am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4:30am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:30pm Sundays: Realistically (under 3 hours): 11pm	1 hour to 90 minutes (Currently from 10 minutes)	Routes all night via Piccadilly
Heald Green	Journey 1: 368 to Wythenshawe Interchange 19 to Hospital		1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11:20pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 5am	30 to 40 minutes (Currently 45 minutes to 1	

	Journey 2: 368 to Wythenshawe Interchange, 11 to Hospital			Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 6am	Sundays: Realistically (under 3 hours) 5:30am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:15pm Sundays: Realistically (under 3 hours): 10:30pm	hour)	
High Lane	Journey 1: 199 to Manchester airport, Tram to Roundthorn	Journey 1: Train to Stockport, see routes from Stockport town centre	1	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 10pm Sundays: Realistically (under 3 hours) 10pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 4am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4:30am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) :10:15pm Sundays: Realistically (under 3 hours): 10pm	90 minutes (Currently 20 minutes)	
Marple (station)	Journey 1: 384 to Stockport town centre, see routes from Stockport Town Centre	Journey 1: Train to Manchester Piccadilly, see routes from Manchester Piccadilly.	1-3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 10:40pm Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 6am Sundays: Realistically (under 3 hours):	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 5:30am Sundays: Realistically (under 3 hours) 6:30am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 10:15pm Sundays: Realistically (under 3 hours): 10:15 pm	90 minutes to 2 hours (Currently 45 minutes to 1 hour)	

				8:30am			
Mellor	Walk to Marple See above					2 hours to 2 hours 30 minutes (Currently 1 hour 30 minutes)	
Offerton (lane)	Journey 1: 192/384/314 to Stockport town centre See routs from Stockport Town Centre		1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 4am Sundays: Realistically (under 3 hours): 4am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 4am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11pm Sundays: Realistically (under 3 hours): 11pm	1 hour to 90 minutes (Currently 5 to 20 minutes)	
Reddish (Reddish Bath)	Journey 1: 203 bus to Stockport See routes from Stockport Borough Council Journey 2: 278 to Hospital	Journey 1: Train to Manchester Piccadilly, see routes from Manchester Piccadilly	0 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11 pm Sundays: Realistically (under 3 hours) 10:40pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 5:30am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4:30am Sundays: Realistically (under 3 hours) 5am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:15pm Sundays: Realistically (under 3 hours): 11:15pm	1 hour to 90 minutes (Currently 45 minutes)	
Romiley	Journey 1:	Journey 1:	1-3	Latest departures:	Earliest departures:	1 hour to 90	

(station)	383 to Stockport Town Centre See routes from Stockport Town Centre	Train to Manchester Piccadilly, See routes from Manchester Piccadilly		Weekdays/Saturday: Realistically (under 3 hours): 10:40pm Sundays: Realistically (under 3 hours) 10:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 6:30am	Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 6:30am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 11:15pm Sundays: Realistically (under 3 hours): 10:50pm	minutes (Currently 40 to 50 minutes)	
Woodford	Journey 1: 42B to Boots (A560), 11 to hospital. Journey 2: 42B to Station Road, 368 to Simonsway, tram to hospital Journey 3: 42B to Cheadle Post Office, 11A to Ferndown Road, 19 to hospital		1 to 2	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 8pm Sundays: Realistically (under 3 hours) 7:30pm Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 6am Sundays: Realistically (under 3 hours): 7:30am	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 6am Sundays: Realistically (under 3 hours) 8:45am Latest departures: Weekdays/Saturday: Realistically (under 3 hours) : 7:10pm Sundays: Realistically (under 3 hours): 6:30pm	1 hour 20 to 2 hours (Currently 1 hour to 1 hour 20 minutes)	
Woodley	Journey 1: 330 to Stockport See routes from Stockport Town Centre		1 to 3	Latest departures: Weekdays/Saturday: Realistically (under 3 hours): 11pm Sundays: Realistically (under 3 hours) 10:30pm	Earliest departures: Weekdays/Saturday: Realistically (under 3 hours): 4am Sundays: Realistically (under 3 hours) 5am Latest departures:	1 hour to 1 hour 30 minutes (Currently 45 minutes)	

				Earliest departures: Weekdays/Saturday: Realistically (under 3 hours) : 5am Sundays: Realistically (under 3 hours): 5am	Weekdays/Saturday: Realistically (under 3 hours) : 11pm Sundays: Realistically (under 3 hours): 11pm		

Please note that this list is not exhaustive.
Community Transport Operators:
Stockport Car Scheme (only within GM)
St John's Ambulance
Transport for Sick Children (only within GM)
Easy Go Community Transport

Equality Impact Assessment

NHS Stockport Clinical Commissioning Group

1.	**Name of the Strategy / Policy / Service / Project**	Stockport Foundation Trust – Angiography Service
2.	**Champion / Responsible Lead**	Mark Chidgey
3.	**What are the main aims?**	To decommission all angiography service provision from Stockport FT as per the recommendations from Cardiac Strategy 2012-2015
4.	**List the main activities of the project:**	1. Decommission Stockport FT angiography services 2. Ensure all CCGs' (either as co-commissioners, NCA or secondary care referral) utilising the service are clearly notified of the change in provision 3. Ensure that local UHSM, CMFT and Pennine Acute are able to percutaneous coronary intervention (PCI) manage the current SFT activity
5.	**What are the intended outcomes?**	Clinical Effectiveness - Patients receive the necessary treatment minimising the number of invasive procedures carried out Patient Satisfaction - Patients will be offered the relevant procedures on one pathway as one spell i.e. PCI Cost Savings – Only required to pay once as a PCI through Payment by Results (PbR)
IMPACT ON SERVICE USERS		
6.	**Who currently uses this service?**	**Angiographs 1/7/16 to 30/6/17**

Commissioner	Angiographs
TAMESIDE AND GLOSSOP CCG	282
STOCKPORT CCG	178
EASTERN CHESHIRE CCG	136
NORTH DERBYSHIRE CCG	59
OLDHAM CCG	18
NORTH STAFFORDSHIRE CCG	17
NORTH MANCHESTER CCG	4
Unknown or not applicable	4
STOKE ON TRENT CCG	3
HEYWOOD, MIDDLETON AND ROCHDALE CCG	3
CENTRAL MANCHESTER CCG	2
TRAFFORD CCG	1
CALDERDALE CCG	1
BETSI CADWALADR UNIVERSITY LHB	1
GLOUCESTERSHIRE CCG	1
SOUTH CHESHIRE CCG	1
ST HELENS CCG	1
Grand Total	**712**

		<table><tr><th>Gender</th><th>Angiographs</th></tr><tr><td>M</td><td>440</td></tr><tr><td>F</td><td>272</td></tr><tr><td>Grand Total</td><td>712</td></tr></table> <table><tr><th>Ethnicity</th><th>Angiographs</th></tr><tr><td>White: British</td><td>556</td></tr><tr><td>Not stated</td><td>113</td></tr><tr><td>Asian or Asian British: Pakistani</td><td>12</td></tr><tr><td>Asian or Asian British: Indian</td><td>8</td></tr><tr><td>Any other White background</td><td>6</td></tr><tr><td>White: Irish</td><td>4</td></tr><tr><td>NULL</td><td>3</td></tr><tr><td>Asian or Asian British: Bangladeshi</td><td>3</td></tr><tr><td>Mixed: White and Black Caribbean</td><td>2</td></tr><tr><td>Black or Black British: Caribbean</td><td>2</td></tr><tr><td>Mixed: White and Asian</td><td>1</td></tr><tr><td>Any other Asian background</td><td>1</td></tr><tr><td>Any other Ethnic Group</td><td>1</td></tr><tr><td>Grand Total</td><td>712</td></tr></table> <table><tr><th>Age</th><th>Angiographs</th></tr><tr><td>90+</td><td>1</td></tr><tr><td>80-89</td><td>77</td></tr><tr><td>70-79</td><td>228</td></tr><tr><td>60-69</td><td>218</td></tr><tr><td>50-59</td><td>133</td></tr><tr><td>40-49</td><td>47</td></tr><tr><td>30-39</td><td>8</td></tr><tr><td>Grand Total</td><td>712</td></tr></table> <table><tr><th>Carer Support</th><th>Angiographs</th></tr><tr><td>NULL</td><td>509</td></tr><tr><td>NO</td><td>201</td></tr><tr><td>YES</td><td>2</td></tr><tr><td>Grand Total</td><td>712</td></tr></table>
7.	**Are there any clear gaps in access to this service?** (e.g. low access by ethnic minority groups)	No
8.	**Are there currently any barriers to certain groups accessing this service?** (e.g. no disabled parking / canteen doesn't offer Kosher food / no hearing loop)	No
9.	**How will this project change the service NHS Stockport offers?** (is it likely to cut any services?)	New pathways will be developed Stockport Foundation Trust will no longer provide an angiography service but will still provide first line diagnostic tests for chest pain.

		Approximately 50% of the existing service users will be referred to a specialist centre rather than be treated at Stockport Foundation Trust.	
10.	**If you are going to cut any services, who currently uses those services?** (Will any equality group be more likely to lose their existing services?)	See point 6. No evidence that any equality groups will be more likely to lose their existing service.	
11.	**If you are creating any new services, who most likely to benefit from them?** (Will any equality group be more or less likely to benefit from the changes?)	No new services will be created – patient referrals will be diverted through to the local percutaneous coronary intervention centres.	
12.	**How will you communicate the changes to your service?** (What communications methods will you use to ensure this message reaches all community groups?)	Communications will need to be sent through the following organisations: • CCGs' currently utilising the service (see point 6) • All co-commissioners to the SFT contract • Other GM NHS Trusts • Cardiac Acute Transfer System (CATS) • NWAS • Patient panels i.e. health watch	
13.	**What have the public and patients said about the proposed changes?** (Is this project responding to local needs?)	The project is responding to clinical recommendations taken from the Cardiac Strategy 2012-2015. Local engagement will be undertaken.	
14.	**Is this plan likely to have a different impact on any protected group?** (Can you justify this differential impact? If not, what actions will you add into the plan to mitigate any negative impacts on equality groups?)	**IMPACT**	**MITIGATION**
	Age	No	
	Carers	No	
	Disability	No	
	Gender Reassignment	No	
	Marriage / Civil Partnership	No	
	Pregnancy & Maternity	No	
	Race	No	
	Religion & Belief	No	
	Sex	No	
	Sexual Orientation	No	
IMPACT ON STAFF			
15.	**How many staff work for the current service?**	28 in total (headcount)	
16.	**What is the potential impact on these employees?** (including potential redundancies, role changes, reduced hours, changes in terms and conditions, locality moves)	Placed at risk; redeployment / role changes / job plan changes / potential risk of redundancy	
17.	**Is the potential impact on staff**	**IMPACT**	**MITIGATION**

	likely to be felt more by any protected group? If so, can you justify this difference? If not, what actions have you put in place to reduce the differential impact?		
	Age	No	
	Carers	No	
	Disability	No	
	Gender Reassignment	No	
	Marriage / Civil Partnership	No	
	Pregnancy & Maternity	No	
	Race	No	
	Religion & Belief	No	
	Sex	No	
	Sexual Orientation	No	
18.	**What communication has been undertaken with staff?**	Engagement sessions & formal consultation	
19.	**Do all affected workers have genuinely equal opportunities for retraining or redeployment?**	Yes	
IMPACT ON STAKEHOLDERS			
20.	**Who are the stakeholders for the service?**	See point 6	
21.	**What is the potential impact on these stakeholders?**	No longer able to utilise Stockport Foundation Trust as a site for angiography services.	
22.	**What communication has been undertaken with stakeholders?**	All the relevant stakeholders will be notified of the changes and the new pathways – see point 12.	
23.	**What support is being offered to frontline staff to communicate this message with service users / family / carers?**	This will be communicated through staff at SFT as part of their succession plans.	
24.	**How will you monitor the impact of this project on equality groups?**	Data from Specialist Centres. Feedback from SFT. Healthwatch to advise on any adverse impact.	
EIA SIGN OFF			
25.	*Your EIA should be sent to Head of Compliance for approval and publication:*		
	Date of EIA Approval:		