STRATEGIC COMMISSIONING BOARD

Day: Tuesday
Date: 12 December 2017
Time: 2.00 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

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.

8. 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).

9. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Tuesday 30 January 2018 commencing at 2.00 pm.

10. EXCLUSION OF THE PRESS AND PUBLIC

That under Section 100A of the Local Government Act 1972 (as amended) the public be excluded for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A to the Local Government Act 1972. Information relating to the financial or business affairs of the parties (including the Council) has been provided to the Council in commercial confidence and its release into the public domain could result in adverse implications for the parties involved. Disclosure would be likely to prejudice the Council's position in negotiations and this outweighs the public interest in disclosure.

11. PROVISION OF SPECIALIST MENTAL HEALTH SUPPORTED ACCOMMODATION FOR ADULTS WITH COMPLEX MENTAL HEALTH NEEDS 125 - 134

To consider the attached report of the Interim Director of Commissioning.

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.

TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

14 November 2017

Commenced: 2.00 pm **Terminated: 2.40 pm**

Present: Dr Christina Greenhough (in the Chair) – NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Jim Fitzpatrick – Tameside MBC
Dr Alison Lea – NHS Tameside and Glossop CCG
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance
Kathy Roe – Director of Finance
Stephanie Butterworth – Director of Adult Services
Gideon Smith – Consultant in Public Health Medicine
Alison Lewin – Deputy Director of Commissioning
Trevor Tench – Service Unit Manager, Joint Commissioning & Performance Management

Apologies: Dr Alan Dow – NHS Tameside and Glossop CCG
Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Steven Pleasant – Tameside Council Chief Executive & Accountable Officer for NHS Tameside and Glossop CCG

65. CHAIR'S OPENING REMARKS

In opening the meeting, the Chair made reference to a letter from the West Pennine Local Medical Committee congratulating Tameside and Glossop NHS Clinical Commissioning Group on the good news that all the practices in the Tameside and Glossop area had achieved Care Quality Commission ratings of Good or Outstanding.

66. DECLARATIONS OF INTEREST

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

67. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 31 October 2017 were approved as a correct record.

68. WOMEN AND THEIR FAMILIES SERVICE PROCUREMENT

The Consultant in Public Health Medicine presented a report requesting permission to proceed with a procurement exercise to replace the existing grant arrangements with the Women and Their Families Centre from 1 October 2018 and extend the existing 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 two 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 had enabled the delivery of an effective service that both achieved good value and had realised significant outcomes in the early intervention of women offenders and non-offenders. Continuing to provide the Women and Their Families Centre would enable the service to continue to embed and expand their work significantly to support women victims and offenders and their children to deal with the multiple issues and deprivation they faced.

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

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

The current grant was for £99,570 per annum and the proposal in the report requested funding over a 5 year period for a total investment of £497,850. The six month extension of £49,790 of the existing contract in 2018/19 to 30 September 2018 would be financed via the existing Population Health Service revenue budget as would the proposed contract from 1 October 2018.

It was noted that there were no inflationary costs included in the calculations as there was an assumption these would be offset by efficiencies. However, the Board felt it would be prudent to ensure the contract stipulated that there would be no inflationary costs for the duration of the contract.

RESOLVED

(i) That agreement be given for a procurement exercise to be undertaken to replace the existing grant arrangement with the Women and Their Families Centre from 1 October 2018.

(ii) That a total budget of £497,850 over five years for the procurement of this service be approved and that the contract specifies that there would be no inflationary costs for the duration of the contract.

(iii) That the existing grant arrangements be extended from 1 April 2018 to 30 September 2018 to allow time for the procurement exercise to be completed.

69. TRANSFORMING MENTAL HEALTH SERVICES: MEETING POPULATION NEEDS AND DELIVERING NATIONAL REQUIREMENTS

Consideration was given to a report of the Director of Quality and Safeguarding explaining that the Five Year Forward View for Mental Health set ambitious plans to improve parity of esteem for people with mental health needs, ensuring the same access to healthcare as physical health needs. The Tameside and Glossop NHS Clinical Commissioning Group was currently investing 9.7% of its total allocation on mental health services / support. The national average was 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, highlighted in the report, with existing mental health investment, to transform mental health provision in Tameside and Glossop.

The report was the second of three business cases regarding mental health services in 2017/18. 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. The second business case sought 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 had a proven return on investment to be delivered and focused on increasing capacity to meet demand and standards for three more priorities as follows.

- People with common mental health disorders (Improving Access to Psychological Therapies) – proposal to increase the capacity in the service by investing £27,250 in 5 whole time equivalent additional psychological therapists.
- People with First Episode of Psychosis – proposal to extend the capacity of the Early Intervention Team to better meet the national standards of 53% of people receiving NICE compliant care within 2 weeks of referral by investing £249,795 in 5.5 whole time equivalent additional staff.
- Children and Families where the child had a neurodevelopmental need, including Attention Deficit Hyperactivity Disorder and autism, and those who had behaviour that challenged – additional investment in two Band 6 posts £90,620 plus £16,000 non-recurrently was proposed.

The total value of the proposal was £123,337 in 2017/18 and £626,665 in 2018/19 and £610,665 recurrently thereafter and further details for the three schemes were detailed in the report. The report also included the national, strategic and local context, the evidence base and outcomes and benefits of the business case. Mental health resources had 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.

The Board recognised that investment in mental health was a key priority for Tameside and Glossop as this impacted on so many other elements of health and social care. Evidence showed that intervention in mental health at an early stage resulted in significant benefits and financial efficiencies and particularly in relation to secondary care costs. The costs quoted in the report had not yet been signed-off by providers but there was an overall financial envelope for mental health reported and managed by Greater Manchester as part of the mental health assurance process. All costs must be maintained within this financial envelope with regular monitoring to ensure delivery of commissioned outcomes and the business case set out in the report.

RESOLVED

(i) That the commitment of funding through the Clinical Commissioning Group Mental Health Investment Standard be approved in line with the business case to the value of £123,337 in 2017/18, £626,665 in 2018/19 and £610,665 in 2019/20 and recurrently thereafter.

(ii) All costs to be maintained within this financial envelope for the delivery of commissioned outcomes and any funding shortfall managed across other mental health services as necessary.

70. ANGIOGRAPHY SERVICES

Dr Alison Lea introduced a report which explained that Stockport Clinical Commissioning Group was 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-commissioned this service.

Angiography, a type of x-ray used to check the blood vessels, was 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 required angioplasty, a treatment to open up a narrowed artery.

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 was accredited to provide angiography but not angioplasty services. This meant that currently patients requiring further procedures had to be transferred to a specialist centre and undergo a second invasive procedure.

The report outlined the proposal from Stockport Clinical Commissioning Group to decommission the angiography service at Stepping Hill Hospital and relocate services to Specialist Centres in Greater Manchester. The University Hospital of South Manchester would be the nearest specialist treatment centre for most Tameside and Glossop patients but they could be referred to other specialist centres, the Central Manchester Foundation Trust and Pennine Acute Hospital. The proposal would enable patients from Tameside and Glossop to be referred directly to one of the specialist centres where they would be seen by a specialist, diagnosed and, if necessary, treated immediately after diagnosis rather than being transferred to another hospital.

As the main provider of the Service, the University Hospital of South Manchester had confirmed, in Appendix A to the report, that they would be able to meet the demand following the decommissioning of services from Stockport Foundation Trust. They had further confirmed that they had developed plans to ensure there would be sufficient capacity within the Trust to enable the safe and effective transfer of this activity.

The Board heard that a four week engagement process had commenced on 11 August 2017 led by Stockport Clinical Commissioning as the lead commissioners. Tameside and Glossop Clinical Commissioning Group, along with other co-commissioners, had advertised the on-line survey which was also available in hard copy on request. Interviews with current service users had been carried out and communication with local patient groups was also initiated by Stockport Clinical Commissioning Group. The full copy of the engagement process was contained in Appendix B to the report.

Reference was also made to a review of travel times for Tameside and Glossop residents to support the proposal carried out by Stockport Clinical Commissioning Group detailed in Appendix C to the report and a completed Equality Impact Assessment at Appendix D which included Tameside and Glossop patients.

The Board was advised that as an organisation the Tameside and Glossop Integrated Care Foundation Trust was closely involved in this process and supportive of the relocation of service to specialist centres in Greater Manchester. In considering the views of the Tameside and Glossop Cardiology Consultant, the Board noted that these represented his personal opinion on the proposals.

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

RESOLVED

(i) That the proposal from Stockport Clinical Commissioning Group to decommission the angiography service at Stepping Hill Hospital (Stockport NHS Foundation Trust) and relocate services to Specialist Centres in Greater Manchester, as detailed in the report, be supported by the Single Commissioning Board.

(ii) That Stockport Clinical Commissioning Group be notified of this decision for consideration at the Stockport Clinical Commissioning Group Governing Body meeting on 29 November 2017 along with feedback on the proposal from other co-commissioners.

71. 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

Consideration was given to a report of the Director of Adults Services seeking authorisation to extend the current congoing contractual agreement until 31 March 2018 to allow for continuing dialogue with the sector to ensure that future agreement was robust yet flexible enough to allow for changes based on the work of the Greater Manchester Health and Social Care Partnership. The extension would also allow time to continue dialogue with the contract and to explore the following proposals:

1) A change in policy to remove the off/on framework arrangement;
2) A different category of residential care;
3) To establish a new approved list using the Dynamic Purchasing System (whilst recognising service users' rights to choose any care home provider that was registered with the Care Quality Commission and meeting the conditions as laid out in the Care Act Guidance 2017).

It was explained that the current contract commenced on 10 December 2012 for a 5 year period ending on 9 December 2017. The market had significantly changed during the course of this contract, with the loss of beds in the borough, specifically nursing beds. This was causing a major problem in Tameside and surrounding areas in facilitating timely discharges from hospital.

The placement profile for the Council and Tameside and Glossop Clinical Commissioning Group had reduced over the last 5 years. By way of example, in August 2012 the Commissioners purchased an average of 940 beds per week, while in July 2017 the Commissioners purchased approximately 747 beds per week. This reduction was a demonstration of the impact of the local policy for supporting people to remain living at home, in their local communities for as long as possible.

It was noted that the Care Quality Commission introduced a revised rating system approximately 3 years ago. The rating profile of homes in the borough as at September 2017 was detailed in the report and was further broken down into Off, On Framework and Enhanced Payment providers.

The fees in Tameside had increased in line with the agreed methodology which took account of the providers' actual costs in delivery the service. The increase in the National Minimum Wage and the introduction of the National Living Wage were key factors that had driven the increase in the fees which were highlighted in the report. Providers had for some time noted that the recruitment and retention of competent nursing staff had been challenging. This was not just a local issue but was continually reported nationally. In addition, the providers had also stated that it was difficult to recruit and retain care workers due to other local providers, not in the care sector, paying more for staff for far less responsibility.

The Director of Adults Services reported that Tameside Council was leading the Care Home workstream on behalf of the Greater Manchester Health and Social Care Partnership, with the overall aim to develop a standardised contract / specification and costing model which would be used across the region, albeit with locally implemented elements to reflect local practice and price variations.

Discussions with the sector had been ongoing for some time regarding the future of the contract and the On/Off Framework structure. Unsurprisingly, those care homes Off Framework were keen for this to be removed and all homes to be treated the same. Those homes On Framework, and specifically those who received the Enhanced Payment, were keen to ensure that their fees would not be reduced should the Commissioners decide to have a single rate for all providers.

Following some of the more recent discussions, the providers had mooted the potential for an 'enhanced residential' model to provide for those service users presenting more challenges,

especially for the increased input required to meet the physical needs. Further work would be required to determine what this model would be, the criteria for people to be assessed for this, and the likely number of people who would be assessed to determine the cost.

The Council and the Clinical Commissioning Group had been working closely to build on current practice and to develop new processes and documentation to provide assurance that the service was being delivered in accordance with the contract and to support providers to be Care Quality Commission compliant. Further work was required to develop the process / documentation in consultation with the care sector.

Given the current agenda to fully integrate health and social care the Council and Clinical Commissioning Group had, for some time, been exploring the option of using the NHS Standard Terms and Conditions as the basis for contracting with the care sector. Work had been undertaken to compare both sets of conditions and, generally, the conditions were similar. However, there were elements of the NHS Standard terms that were more onerous than the current contract, which would put more pressure on the care sector. It was recently agreed that, as the fees were based on the current contract conditions and a new financial model had yet to be agreed, the existing terms and conditions would be reviewed and, where necessary, modified to better reflect the local requirements without putting additional undue pressure / burdens on the providers.

In conclusion, it was envisaged that providers who were currently on the Off Framework would object to the extension of the current contractual arrangements as they anticipated that from the 10 December the contract and fees would change. To help mitigate this risk the Council had discussions with the Off Framework providers to explain the rationale and to give assurance that, within the extension period, work would be undertaken for new arrangements, including discussions about feel levels, to be in place from 1 April 2018.

RESOLVED
That approval be given to extend the current ongoing contractual relationship with the care home providers until 31 March 2018 to allow for further dialogue about the contract and exploration of the following proposals:

(i) A change in policy to remove the Off / On Framework arrangement;
(ii) A different category of enhanced residential care;
(iii) To establish a new approved list using the Dynamic Purchasing System, whilst recognising service users' rights to choose any care home provider registered with the Care Quality Commission as laid out in the Care Act Guidance 2017.

72. URGENT ITEMS

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

73. 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: **STRATEGIC COMMISSIONING BOARD**

Date: 12 December 2017

Officer of Strategic Commissioning Board Jessica Williams, Interim Director of Commissioning and Care Together Programme Director

Subject: **GOVERNANCE OF THE SINGLE COMMISSION**

Report Summary: The purpose of this report is to update the Strategic Commissioning Board following a governance review by the Clinical Commissioning Group. This review has also been considered and supported by the local authority in respect of those aspects which impact upon the governance of the Single Commission.

The main impact of these changes which are pertinent to this Board are detailed within the appended Terms of Reference.

These Terms of Reference were approved by Council on 28 November 2017 and by the Governing Body on 27 September 2017.

Recommendations: The Strategic Commissioning Board is asked to note the decisions made by the two statutory bodies which came into effect following Council on the 28 November 2017.

Financial Implications:

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

Budget Allocation (if Investment Decision)	£970,000
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Aligned
Decision Body – SCB, Executive Cabinet, CCG Governing Body	CCG Governing Body – decision approved on 27 September 2017.
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Annual recurrent savings of £128,000.
Additional Comments The proposed amendments to the governance of the Strategic Commissioning Board from a clinical leadership perspective will realise annual savings of £128,000. These savings will therefore contribute towards the delivery of the medium term financial gap across the economy.	

Legal Implications:

(Authorised by the Borough Solicitor)

Members should be aware of the revised Terms of Reference which were approved on 27 September 2017 by the Clinical Commissioning Group and adopted by the Full Council on 28 November 2017 as they establish the rules for conducting Board business.

How do proposals align with Health & Wellbeing Strategy?	The decisions made by the statutory organisations are intended to streamline the governance to support the delivery of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The decisions made by the statutory organisations are intended to streamline the governance to support the delivery of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The decisions made by the statutory organisations are intended to streamline the governance to support the delivery of the Commissioning Strategy.
Recommendations / views of the Health and Care Advisory Group:	This is not applicable as this is not a clinical proposal.
Public and Patient Implications:	It is intended that the revised governance arrangements will make the workings of the Single Commission more effective. The meetings of the Strategic Commissioning Board will continue to be held in public to support open and transparent commissioning and decommissioning decision-making in accordance with Local Government legislation.
Quality Implications:	These revised governance arrangements will have no detrimental effect upon the care services commissioned by the Strategic Commissioning Board.
How do the proposals help to reduce health inequalities?	The changes to governance will making the decision-making processes more effective; it is the individual commissioning and decommissioning proposals being considered by the Strategic Commissioning Board that will help to reduce health inequalities within the locality.
What are the Equality and Diversity implications?	There will be no impacts in respect of equality and diversity as a result of these governance changes.
What are the safeguarding implications?	There are no safeguarding implications arising from these governance changes.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications arising from these governance changes. The two statutory organisations continue to have in place robust arrangements for the management of information governance. There has been no privacy impact assessment undertaken in respect of these governance changes; these changes do not change any data flows within the two statutory organisations.
Risk Management:	These governance changes will not increase the risk exposure of either of the statutory organisations.
Access to Information :	The background papers relating to this report can be inspected by contacting Paul Pallister, Assistant Chief Operating Officer, NHS Tameside and Glossop CCG, on:  Telephone: 07342 056010  e-mail: paul.pallister@nhs.net

1. BACKGROUND

1.1 In January 2016 the Interim Single Commissioning Board was established as a shadow joint committee between Tameside Metropolitan Borough Council (TMBC) and NHS Tameside and Glossop Clinical Commissioning Group (CCG). In April 2016 these arrangements became substantive and, since that date, the Single Commissioning Board (SCB) has been the body responsible for making commissioning decisions funded by the largest element of the Integrated Commissioning Fund as held within the section 75 agreement between the two organisations. The Integrated Commissioning Fund also contains TMBC and CCG Aligned Funds; the SCB makes recommendations to the statutory body regarding commissioning proposals to be funded from these aligned monies.

1.2 This report provides information regarding recent decisions by the CCG's Governing Body pertaining to its own governance. It is recognised that some aspects of these changes would impact upon TMBC due to the close working relationship of the two organisations. From this perspective the report concludes with a request that TMBC considers some proposed changes to the Single Commissioning Board.

1. INTRODUCTION

2.1 Over the past 18 months the Tameside and Glossop locality has implemented a comprehensive single health and social care commissioning system. This has involved the creation of a single decision-making structure with the introduction of a Single Commissioning Board, the appointment of a single substantive Accountable Officer, a single leadership team, and an Integrated Commissioning Fund currently at £483 million for 2017/18. These extensive developments have shown how strong relationships and clear leadership can drive integration and also have enabled the locality to meet stringent contract deadlines for 2017/18 despite an extremely challenging financial position.

2.2 The next step is to incorporate wider public sector commissioning roles and ensure alignment of health and social care into Place-based provision. This will move the locality further towards an accountable care system where a variety of providers can work together to take responsibility for improving population health outcomes, enable care and support to be accessed closer to home, and reduce health inequalities.

2.3 Strategic commissioning requires clear, consistent and effective governance structures and clinical leadership which is innovative, provides appropriate challenge to public services, and is able to work with and influence the whole economy. This report proposes some revisions to the joint committee to enhance the governance of strategic commissioning in the context of changes to the clinical commissioning leadership structure to drive improvements in provision across the life course, determine the required population outcomes, reduce health inequalities, and to hold providers to account for delivery. The proposals also include the strengthening of democratic accountability by increasing the elected representation on the SCB as well as including attendance by both a representative from Derbyshire County Council and from High Peak Borough Council.

2.4 This report marks an exciting time for the development of Place-based commissioning in the locality. It is recognised across Greater Manchester that Tameside and Glossop is leading the localities in its development of the Single Commission. It is hoped that the proposals set out within this report will support the strengthening of the partnership working between the two statutory organisations. By the further combining of clinical expertise and political leadership we will continue to build upon our successes to deliver excellent care to the residents of Tameside and Glossop.

2. GOVERNANCE OF THE STRATEGIC COMMISSION

Changes to the CCG's Governance

3.1 At its meeting on 26 July 2017 the CCG's Governing Body considered a report proposing revisions to its governance. The main driver for the review was the recognition that the governance arrangements for the Single Commission are becoming more embedded and mature and this provides an opportunity for reflection. There is the opportunity to consider if the existing structures continue to be fit for purpose, if the clinical leadership is appropriate for each constituent part, and if it is delivering value for taxpayers' money. Also it has previously been noted that at times it felt to Governing Body members and officers alike that there were two systems running in parallel and it was hoped that this review could help to remove aspects of duplication.

3.2 The Governing Body supported the following recommendations:

'The Governing Body **agreed** the following key proposals within the intended governance structure which include:

- Introduction of a Stakeholder/Partners Strategic Engagement Forum, to be held quarterly and chaired by the Executive Member for Health and Social Care
- Monthly meetings of the Strategic (to be renamed from Single) Commissioning Board, Finance Committee, Primary Care Committee, and Health and Care Advisory Group
- Introduction of a new Quality, Performance, and Assurance Group to meet bi-monthly and to be chaired by the CCG's Governing Body Nurse
- Audit Committee moves to five times a year and the Governing Body to quarterly. The Remuneration and Terms of Service Committee will continue to meet at least annually
- Proposed new Chair arrangements included for the majority of committees.

3.3 The Governing Body **agreed** the following recommendations in relation to the clinical leadership:

- Chair of the Single Commissioning Board/CCG Governing Body to continue the leadership role within the GM HSCP Primary Care Reform programme or other programme as appropriate, as well as within the locality
- Four new leadership GP roles are created with explicit responsibilities to support the Chair, provide clinical input into strategic commissioning decisions, and bring wider GP perspectives to Place-based public services
- Three of these GP leadership roles will drive commissioning of the Starting, Living, and Ageing Well public sector agenda. They will be accountable to the Chair of the SCB and be expected to work across organisational boundaries to support delivery of new models of care. For example, the Living Well agenda could be developed and led by a lead GP, with a senior commissioning manager, employment specialist, public health consultant, finance manager, and business intelligence lead collectively working to identify population outcomes which support a new method of commissioning mental health services, employment support, Active Tameside etc.
- The fourth GP leadership role will provide clinical support for General Practice and Primary Care
- One of the posts will need to be elected by the Governing Body membership as Clinical Vice-chair
- An additional clinical role is created as a Post-CCT Fellowship to cement Tameside and Glossop as an innovative place for training and development and also to aid succession planning within the strategic clinical commissioning leadership. The specific responsibilities for the post will be agreed with the successful candidate and according to their interests
- The role of Chair of the SCB/CCG GB moves to six sessions per week

- Four GP clinical leadership posts at three sessions per week with the Fellowship currently costed as two days per week
- Each of the leadership clinicians will need to take specific commissioning responsibility for a Neighbourhood and link to the corresponding ICFT Neighbourhood Leads
- An advert to be drafted to recruit three Governing Body GPs (from 1 April 2018) and to be employed by the CCG subject to clarification of the Employment Status of the Governing Body GPs
- The Chair ensures clarity on the deliverables required in each leadership area on an annual basis
- Each lead will be a member of the Strategic Commissioning Board and of the CCG Governing Body. Other statutory committees will not require representation from all and, collectively, the GP clinical leads will allocate responsibilities and determine best coverage and use of time
- The previous five CCG Neighbourhood Leads posts transferred to the ICFT on 1 April 2017. This arrangement needs to be formalised to provide the ICFT with £228,150 to support these sessions. Should the ICFT wish to increase the number of sessions, the additional funding will be a matter for the ICFT
- The Named GP for Children's Safeguarding remains with one session per week to ensure the continued focus in this area
- The Chief Finance Officer, Lay Members, and Governing Body Nurse costs all remain as agreed in the opening budget for 2017/18
- All other posts within the commissioning clinical leadership structures will be reviewed to determine future need for these roles and, if clear objectives remain, whether it is more appropriately a SC or ICFT role.

3.4 The Governing Body was of the opinion that these recommendations strengthen the clinical leadership within the Strategic Commission and Clinical Commissioning Group, reduce some capacity back into the system through a reduction in the frequency of some meetings, and represent good value for the public purse. It is noted that the introduction of the post-CCT Fellowship Governing Body role is highly innovative and will help to evidence how Tameside and Glossop is a dynamic place in which to work as a GP.

3.5 In line with the CCG's Constitution these recommendations were put to the wider GP membership of Tameside and Glossop by an email from Dr Alan Dow on 7 August 2017. The feedback received by the stated deadline of 31 August 2017 was overwhelmingly positive.

3.6 The key next steps taking place during September 2017 are as follows:

- The five GP Neighbourhood Groups are recording in the minutes of their September meetings that they have reviewed and supported the recommendations. This will provide useful evidence of the CCG's membership support when applying to NHS England for the Constitution changes
- Dr Alan Dow was invited to the 11 September meeting of the Local Medical Committee to explain the proposals to this GP representative group and these were supported
- At its meeting on 27 September the Governing Body meeting will receive a report summarising the membership responses and seeking formal support to approach NHS England in order to make the formal changes to the Constitution
- From October 2017 work will be undertaken in preparation for the anticipated approval from NHS England.

3.7 The Governing Body is proposing that the Professional Reference Group is replaced by a Health and Care Advisory Group that will consider commissioning proposals to ensure that they are aligned to clinical best practice and are predicated upon a sound clinical evidence base. It is proposed that the Health and Care Advisory Group is chaired by the CCG's Secondary Care Consultant Governing Body Member. The HCAG is a CCG body, not a

strategic commissioning body and its operating arrangements will be determined by the CCG.

3. PROPOSED CHANGES TO SINGLE COMMISSIONING BOARD

4.1 It is recognised that the changes listed in the section above will impact upon the joint working between TMBC and the CCG. It is anticipated that these impacts will be positive as the CCG's governance will now be better aligned to the governance of the Single Commission.

4.2 The most significant aspect of this is the proposed changes to the Single Commissioning Board, the joint committee of the two statutory organisations. The report invites the Council to consider the following changes to the Terms of Reference of the Single Commissioning Board:

- A name change to Strategic Commissioning Board (which will mirror the Single Commission moving into being a strategic commissioner with operational commissioning moving to the Integrated Care Foundation Trust)
- That the CCG's membership of the SCB increases to being all of its Governing Body GPs plus the Lay Member for Commissioning
- A requirement to ensure democratic accountability and balance the membership with an equal number of Elected Members
- The membership changes will drive a need to revisit quoracy as the total number of members will have increased. The intention will be to retain the requirement of there being at least one representative from both TMBC and the CCG and it is now stated that this requirement is not met by the Single Accountable Officer
- Confirming that the SCB has decision-making powers over the pooled funds, and that it makes recommendations to the relevant statutory body regarding commissioning proposals to be funded from the aligned funds
- Clarifying that approval of the Terms of Reference lies with the statutory bodies.

The draft Terms of Reference are appended to this report.

4. RECOMMENDATIONS

5.1 As set out on the front of the report

APPENDIX

Strategic Commissioning Board

Terms of Reference

Context

1. On 23 September 2015 the three Care Together partner organisation Boards met together to establish a set of principles for the development of the Integrated Care Foundation Trust and for the establishment of a single commissioning function. It was agreed that the Integrated Care Foundation Trust would be established from 1 April 2017, and that the Single Commission would be established from 1 April 2016 with interim arrangements in place from 1 January 2016 and these arrangements became permanent in April 2016.

2. The following document sets out the Terms of Reference for the Strategic Commissioning Board (SCB).

Statutory Framework

3. The Strategic Commissioning Board is not a statutory body. It is not intended to replace any of the existing statutory bodies in the locality; instead it is a joint committee of the two statutory organisations (Tameside Metropolitan Borough Council and NHS Tameside and Glossop Clinical Commissioning Group). The SCB has decision-making powers as have been delegated to it by the two statutory organisations.

Role of the Strategic Commissioning Board

4. The Strategic Commissioning Board has been established to enable members to make decisions on the design, on the commissioning, and on the overall delivery of health and care services including the oversight of their quality and performance.

5. In performing its role the Strategic Commissioning Board will exercise its functions in accordance with the Tameside and Glossop Locality Plan.

6. Members of the Strategic Commissioning Board have a collective responsibility for its operation. In undertaking its role clinical and democratic accountability will be implicit within all decisions as will respect for all professional areas of knowledge and expertise.

Geographical Coverage

7. The responsibilities of the Strategic Commissioning Board will cover the same geographical area as of NHS Tameside and Glossop CCG (that is fully coterminous with Tameside Metropolitan Borough Council and the Glossop locality of Derbyshire County Council).

Membership

8. The Strategic Commissioning Board shall consist of the following members:

   - The Chair of the CCG (Chair)
   - The five CCG Governing Body GPs
   - The CCG Governing Body Lay Member with responsibility for Commissioning
   - The Single Accountable Officer of the local authority and of the CCG
   - The Council's Executive Leader
   - The Council's Executive Member for Adult Social Care and Wellbeing (Deputy Chair)

- The Council's Executive Member for Healthy and Working
- The Council's Executive Member for Performance and Finance
- Councillor Gwynne
- Councillor Feeley
- Councillor Sweeton

In the event of the Chair being unavailable for a meeting the CCG's Clinical Vice-Chair will assume the chairing of the Board meeting to maintain the meeting being clinically-led. In the event that both the Chair and the Clinical Vice-Chair are conflicted regarding an agenda item and leave the meeting then the Deputy Chair will assume the chairing of the meeting.

The following will have a standing invitation to attend the meetings of the Strategic Commissioning Board:

- Single Leadership Team;
- The Chair and Programme Director of the Care Together Programme;
- A representative of Derbyshire County Council;
- A representative of High Peak Borough Council.

Meetings and Voting

9. The Strategic Commissioning Board will give no less than five clear working days' notice of its meetings. This will be accompanied by an agenda and supporting papers and sent to each member no later than five days before the date of the meeting.

10. Each member of the Board shall have one vote. The aim of the Board will be to achieve consensus decision-making wherever possible. However, should a vote be required it will be by a simple majority of members present but, if necessary, the Chair has a second or casting vote.

Conflict Of Interest

11. As a statutory Joint Committee formed by the two statutory organisations when making decisions as the Strategic Commissioning Board all members must comply with the standards set by the Local Government Act 2000 as set out in Part 5(a) of the Council's Constitution.

12. Members of the Board will be asked at each meeting to declare any conflicts of interest for any items of business for that meeting. In addition a Single Register of Interest will be maintained for the members of the Single Commissioning Board and published on the Council and CCG websites.

Quorum

13. The quorum will be three of the fourteen members to include both a member from the CCG and a member from the Council who is not the Single Accountable Officer.

Frequency of meetings

14. It is anticipated that the Strategic Commissioning Board will routinely meet at monthly or six-weekly intervals.

15. The meetings of the Strategic Commissioning Board shall be held in public:

    a) subject to any exemption provided by law as set out under 13(b)
    b) the Strategic Commissioning Board may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings)

whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by both the Public Bodies (Admission to Meetings) Act 1960 (as amended or succeeded from time to time) and the Local Government Act 1972.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	12 December 2017
Officer of Single Commissioning Board	Kathy Roe – Director of Finance – Tameside & Glossop CCG and Tameside MBC Claire Yarwood – Director Of Finance – Tameside and Glossop Integrated Care NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 OCTOBER 2017 AND PROJECTED OUTTURN TO 31 MARCH 2018**
Report Summary:	This is a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the consolidated financial position of the Economy. The report provides a 2017/2018 financial year update on the month 7 financial position (at 31 October 2017) and the projected outturn (at 31 March 2018). The Tameside and Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The Clinical Commissioning Group and the Council are also required to comply with their constituent organisations' statutory functions. A summary of the Tameside and Glossop Integrated Care NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended to note / acknowledge: • The 2017/2018 financial year update on the month 7 financial position (at 31 October 2017) and the projected outturn (at 31 March 2018). • The significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget. • The significant amount of financial risk in relation to achieving an economy balanced budget across this period.

Financial Implications:

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

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

Decision Body – SCB, Executive Cabinet, CCG Governing Body	Details contained within the report
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Details contained within the report

Additional Comments

This report provides the consolidated financial position statement of the 2017/18 Care Together Economy for the period ending 31 October 2017 (Month 7 – 2017/18) together with a projection to 31 March 2018 for each of the three partner organisations.

The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy.

A risk share arrangement is in place between the Council and Clinical Commissioning Group relating to the residual balance of net expenditure compared to the budget allocation at 31 March 2018, the details of which are provided within the report.

It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and Clinical Commissioning Group.

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

Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the presentation
Access to Information :	Background papers relating to this report can be inspected by contacting : Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council  Telephone:0161 342 3726  e-mail: stephen.wilde@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group  Telephone:0161 342 5626  e-mail: tracey.simpson@nhs.net David Warhurst, Associate Director Of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust  Telephone:0161 922 4624  e-mail: David.Warhurst@tgh.nhs.uk

1. EXECUTIVE SUMMARY

1.1 This report aims to provide an update on the financial position of the care together economy as at month 7 in 2017/18 (to 31 October 2017) and to highlight the increased risk of achieving financial sustainability. Supporting details are provided in **Appendix 1**.

1.2 The report includes the details of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2017/18 financial year. The total ICF is £485m in value, however it should be noted that this value is subject to change throughout the year as new Inter Authority Transfers (IATs) are actioned and allocations are amended.

1.3 The Tameside & Glossop Care Together Strategic Commissioning Board are required to manage all resources within the Integrated Commissioning Fund and comply with both organisations' statutory functions from the single fund.

1.4 It should be noted that the report includes details of the financial position of the Tameside and Glossop Integrated Care NHS Foundation Trust. This is to ensure members have an awareness of the projected total financial challenge which the Tameside and Glossop Care Together economy is required to address during 2017/18.

1.5 Please note that any reference throughout this report to the Tameside and Glossop economy refers to the three partner organisations within the Care Together programme, namely:

- Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT)
- NHS Tameside and Glossop CCG (CCG)
- Tameside Metropolitan Borough Council (TMBC)

2. FINANCIAL SUMMARY

2.1 **Table 1** provides details of the summary 2017/18 budgets, net expenditure and forecast outturn of the ICF and Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT). Supporting details of the forecast outturn variances are explained in sections 2 and 3 of **Appendix 1**. Members should note that there are a number of risks that have to be managed within the economy during the current financial year, the key one's being:

- Significant budget pressures for the CCG relating to Continuing Care related expenditure of £4.4m;

- Children's Services within the Council is managing unprecedented levels of service demand which is currently projected to result in additional expenditure of £7.2m when compared to the available budget;

- The ICFT are working to a planned deficit of £24.5m for 2017/18. However it should be noted that efficiencies of £10.4m are required in 2017/18 in order to meet this sum.

2.2 **Table 2** provides details of the Strategic Commission risk share arrangements in place for 2017/18. Under this arrangement the Council has agreed to resource up to £5m in each of the next two financial years (2017/18 and 2018/19) in support of the CCG's Quality, Innovation, Productivity and Prevention savings target which is conditional upon the CCG agreeing to a reciprocal arrangement in 2019/20 and 2020/21. Any variation from budget is shared in the ratio 80:20 for CCG:Council. A cap is placed on the shared financial exposure for each organisation (after the use of £5m) in 2017/18 which is a maximum £0.5 m contribution from the CCG towards the Council year end position and a maximum of £2.0 m contribution from the Council towards the CCG year end position. The CCG year end position is adjusted prior to this contribution for costs relating to the residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure.

Table 1 – Summary of the Tameside and Glossop Care Together Economy – 2017/18

	2017/18		
	Budget	**Forecast**	**Variance**
	£'000	**£'000**	**£'000**
Strategic Commission	484,816	495,988	(11,172)
ICFT	(23,344)	(23,344)	0
Total Whole Economy	**460,472**	**471,644**	**(11,172)**

Table 2 – Risk Share

Strategic Commission - Risk Share	**£'000**
TMBC - Non Recurrent Contribution	(4,324)
TMBC	(6,348)
CCG	(500)
Total	**(11,172)**

There are a number of additional risks which each partner organisation is also managing during the current financial year, the details of which are provided within **Appendix 1** :

- S

2.3 The additional risks which each constituent organisation is required to manage are provided within **Appendix 1**:

- Section 2 : The Strategic Commissioner (CCG and the Council))
- Section 3 : Tameside and Glossop Integrated Care NHS Foundation Trust

3. 2017/18 EFFICIENCY PLAN

3.1 The economy has an efficiency sum of £ 35.1 m to deliver in 2017/18, of which £ 24.7 m is a requirement of the Strategic Commissioner.

3.2 **Section 4** and **Annex 1** of **Appendix 1** provides supporting analysis of the delivery against this requirement for the whole economy. It is worth noting that there is a forecast £4.1m under achievement of this efficiency sum by the end of the financial year, £3.5m of which relates to the Strategic Commissioner.

3.2 It is therefore essential that additional proposals are considered and implemented urgently to address this gap and on a recurrent basis thereafter.

4. RECOMMENDATIONS

4.1 As stated on the report cover

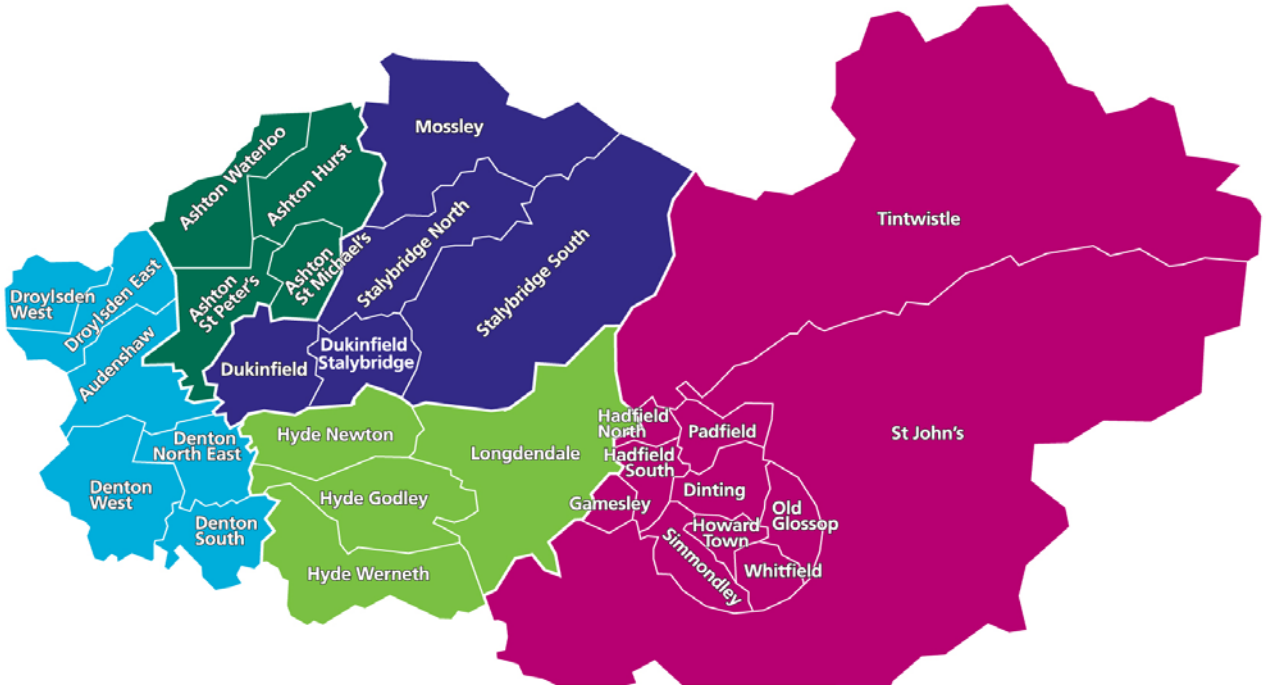
TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

Financial Monitoring Statements

Period Ending 31 October 2017 [Month 7]

Kathy Roe
Claire Yarwood



Contents and Glossary of Terms

APMS	Alternative Provider Medical Services	ICF	Integrated Commissioning Fund
AQP	Any Qualifying Provider	ICFT	Integrated Care Foundation Trust
BCF	Better Care Fund	NCSO	No Cheaper Stock Obtainable
CCG	Clinical Commissioning Group	NHSI	NHS Improvement
CHC	Continuing Healthcare	OOA	Out of Area
CIS	Commissioning Improvement Scheme	QIPP	Quality, Innovation, Productivity & Prevention
CQUIN	Commissioning for Quality and Innovation	QOF	Quality and Outcomes Framework
GMHSCP	Greater Manchester Health & Social Care Partnership	RADAR	Rapid Access Detoxification Acute Referral
IAT	Inter Authority Transfer		

Overall Risk Rating - Medium

The care together economy position has **-£11.172m** deficit – how do we turn this around?

-£4.4m projected overspend on continuing care driven by number of patients accessing service

-£7m projected overspend on Children's Services predominantly driven by out of area placements

The ICFT are working to a planned deficit of **-£24.5m**

£10.4m ICFT efficiencies required to meet this total

Integrated Commissioning Fund will receive extra non-recurrent contributions to ensure balanced position is maintained

Section 1 - Care Together Economy Revenue Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

Organisation	YTD Position			Forecast Position			Forecast Position	
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Total Strategic Commission	287,592	291,590	-3,998	484,816	495,988	-11,172	-11,449	277
ICFT	-15,107	-16,367	-1,260	-24,344	-24,344	0	0	0
Total Economy Position	272,485	275,223	-5,257	460,472	471,644	-11,172	**-11,449**	**277**

Key Headlines:

- YTD Position across the economy is currently: **£5.257m adverse variance**
- 2017/18 Projected year end position across the economy is currently: **£11.172m Deficit**
- Movement in forecast year end position is: **£277k Favourable**

Revenue Forecast Position

- The forecast financial deficit of £11.172m on the strategic commissioner budgets and is mostly driven by Continuing Health Care and Children's Social Care. It should be noted that there are significant risks to ensure financial control totals are met.
- The ICFT are working to a planned deficit of £24.5m for 2017/18. Efficiencies of £10.4m are required in order to meet this total.
- The Integrated Commissioning Fund will receive extra non-recurrent contributions as appropriate during 2017-18 to ensure a balanced position is maintained.

Section 2 - T&G Strategic Commissioner Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

£000's	YTD Position Budget	YTD Position Actual	YTD Position Variance	Forecast Position Budget	Forecast Position Forecast	Forecast Position Variance	Forecast Position Previous Month	Forecast Position Movement in Month
Acute	117,722	118,786	- 1,064	203,801	205,209	- 1,408	- 713	- 695
Mental Health	17,204	17,659	- 454	29,483	30,698	- 1,215	- 916	- 299
Primary Care	49,578	48,815	763	84,023	83,428	596	336	260
Continuing Care	7,931	10,314	- 2,383	13,628	18,063	- 4,434	- 4,527	93
Community	16,022	15,961	62	27,473	27,566	- 93	- 93	-
Other	18,779	15,728	3,052	25,129	18,574	6,554	5,914	641
QIPP	-	-	-	-	4,324	- 4,324	- 4,694	370
CCG Running Costs	3,283	3,261	22	5,197	5,197	0	-	0
Adult Social Care	26,291	26,196	95	44,181	44,018	163	182	- 19
Children's services	18,329	22,526	- 4,197	35,192	42,387	- 7,195	- 6,992	- 203
Public Health	12,451	12,344	107	16,708	16,524	184	55	129
Integrated Commissioning Fund	**287,592**	**291,590**	**- 3,998**	**484,816**	**495,988**	**- 11,172**	**- 11,449**	**277**
CCG Expenditure	230,521	230,524	- 3	388,735	393,059	- 4,324	- 4,694	370
TMBC Expenditure	57,071	61,066	- 3,995	96,081	102,929	- 6,848	- 6,755	- 93
Integrated Commissioning Fund	**287,592**	**291,590**	**- 3,998**	**484,816**	**495,988**	**- 11,172**	**- 11,449**	**277**
A: Section 75 Services	159,543	160,622	- 1,079	264,310	268,323	- 4,013	- 4,227	214
B: Aligned Services	108,093	111,449	- 3,356	186,962	194,149	- 7,187	- 7,101	- 86
C: In Collaboration Services	19,896	19,518	377	33,544	33,516	28	- 121	149
Integrated Commissioning Fund	**287,532**	**291,590**	**- 4,058**	**484,816**	**495,988**	**- 11,172**	**- 11,449**	**277**

Single Commission Risk Share (£000's)	11,172
TMBC - Non Recurrent Contribution	4,324
CCG	500
TMBC	6,348

- Non Rec repayable contributions between CCG/TMBC across 4 year period
- 80:20 Risk share arrangement between CCG/ TMBC as per contributions to ICF
- £500k upper threshold on CCG contribution to TMBC & £2m cap on TMBC contribution to CCG

Key Headlines:

- 2017/18 Projected year end position across the economy is currently: **£11,275m Deficit** (i.e. QIPP savings still to be delivered to meet financial control totals)
- Movement in forecast year end position is: **£277k Favourable** following M6 review of QIPP position
- Negative reserve over and above QIPP will need to be cleared in order to meet control total (driven by increased CHC spend)

Financial Summary – Forecast Position

£4.4m projected overspend on continuing care causing significant pressures

More work required to turn amber/red rated QIPP schemes green and to bring new schemes forward

Reporting that financial control totals will be met, but significant risk attached to this:

- Deliver a surplus of 1% against opening allocation (£3.496m), plus carry forward of £3.678m from 16/17
- Achieve a £23.9m QIPP target.
- Keep 0.5% of allocation uncommitted to fund a national system risk reserve
- Demonstrate growth in Mental Health spend of 2%
- Remain within the running costs allocation

Section 2 - T&G Strategic Commissioner Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Acute	• To support new operational structures within the finance team, some independent sector budgets have moved from the 'other' section of this report into 'acute'. Diagnostics are included in this, which has been overspend against budget all year. • Several high cost OOA patients have resulted in a pressure of £300k on the NCA budget. • Overspend at Central/South Manchester, Salford & Christies is continuing to place a pressure on QIPP delivery.	• Cost pressures at ICFT – risk to block contract. • Specialist IAT under review which may offset pressures in Salford and Christies contracts.
Mental Health	• Overspend relates to high cost placements, managed by individualised commissioning and within scope of CHC recovery plan. • Most of the adverse movement relates to a single patient, who has been assessed as requiring a secure NHSE funded bed. However, as no suitable beds available commissioning responsibility remains with CCG until patient is transferred.	• Transforming Care – movement of commissioning responsibility from specialist to CCG's. • Pennine Care Sustainability.
Primary Care	• Benefit on delegated commissioning following review of position with NHSE (release of prior year accruals). • Underlying QIPP delivery of £2.2m is offset by uncontrollable external pressures.	• NCSO pressure of £1.2m - Quetiapine and Olanzapine (anti psychotic drugs) is limiting the value of QIPP delivery.
Continuing Care	• Overall projections around individualised commissioning has increased by around £200k. • Pressure in mental health placements (£300k), offset by a reduction in the number of fast track patients being treated (£100k).	• Transforming Care – movement of commissioning responsibility from specialist to CCG. • Continuing growth in fast track patients.

Section 2 - T&G Strategic Commissioner Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Community	• Block contract in place with ICFT	• Awaiting outcome of VAT reclaim on wheelchairs.
Other	• Negative reserve to clear over and above the outstanding QIPP still to be delivered.	• Nothing in position for additional critical care/ambulance costs associated with Healthier Together. • Estates schedules from Propco still outstanding. Also risk on market rents allocation.
QIPP	• £12.4m (52%) of targeted savings banked at M7. • £1m reduction in expected savings since M6 as in-year expectations around high and medium risk schemes are reviewed to make forecast more realistic. • Expected savings stable due to increase in banked schemes.	• Still need to deliver further £4.3m savings (plus clear the negative reserve). • Only 52% of expected savings delivered on recurrent basis.
CCG Running Costs	• YTD QIPP savings of £778k released at M7. • On track to remain within running cost allocation and deliver £1.1m QIPP savings.	• Proposed changes to clinical governance are built into the projected QIPP.
Public Health	• £42K Cost reductions resulting from an in year service redesign which includes a part year saving from the deletion of a management post. The full year effect of £74k will be realised in 2018/19. • Expenditure forecast to be less than budget as a result of delayed recruitment to vacant posts. £34K	

Section 2 - T&G Strategic Commissioner Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Adult Social Care	• £160k of Direct Payment (DP) clawbacks in year following client finance audits. These occur when clients no longer require the level of care originally stipulated in their DP agreement or where the allowance has not been used by the client in the agreed way • Increase of £84k in Fairer Charging income received for community based services, this is income based on the individual client financial assessments of approximately 1000 clients (this number varies slightly throughout the year). • Employee related spend is forecast to be £400k less than budget. The number of assessed hours required for the Council provided Learning Disabilities Homemaker Service are less than budgeted due to services being delivered by the independent sector. • Increased numbers of Nursing bed placements (201 at April 2017 to 221 at the end of October) has resulted in forecast spend being £656k in excess of budget (the average net cost of a nursing placement excluding Funded Nursing Care (FNC) is £29k per year). The additional placements have contributed to reductions in DTOC numbers since April 2017. The current daily average DTOC is 12 compared to 30+ in April 2017. The age of admission is also reducing which is leading to an increase in length of stay (average age of admission last year was 82 compared to 80 currently) which could have a future financial impact.	• Continued volatility in Care Home placement numbers over the winter period. • Increasing length of stay in Care Homes due to earlier admission resulting in additional costs • Nursing bed capacity in Care Homes is currently stretched with vacancy levels of 5% (28 beds) across the borough – discussions are currently being held with providers to increase capacity. • Transitions through from Children's Social Care – detailed work is underway to understand the cost implications and external market capacity to ensure all care requirements can be met.

Section 2 - T&G Strategic Commissioner Financial Position

Overall Risk Rating - Medium

Theme	Highlights	Key Risks
Children's Social Care	• Forecast spend on employee related costs forecast to be £874k in excess of budget. The service continues to recruit Social Workers to support the additional caseload demands since the 2017/18 budget was approved. The ongoing strategy is to transition agency employees onto permanent contracts within the service as this is a lower cost alternative and also improves the quality and stability of service delivery. • Alongside the recruitment of agency Social Workers, there is also additional estimated expenditure to the approved budget on a number of additional senior positions as the Council and its partners take action to make the required improvements to the service, including the appointment of a new Director of Children's Services. • The number of Looked After Children has increased from 519 at April 2017 to 579 in November 2017. The current budget allocation will finance approximately 450 placements, assuming average weekly unit costs for placements. This unprecedented level of demand has led to a forecast deficit position of £6.635m on the placement budget in 2017-18.	• Capacity of in-borough care provision • Additional demand requiring high cost independent sector placements • Retention of Social Workers and associated impact on service delivery and budget allocation • Impact of the additional resource implications to support the required improvements on the strategic commission budget

Section 3 - ICFT Financial Position

Overall Risk Rating - Medium

Revenue Financial Position

Financial Position:

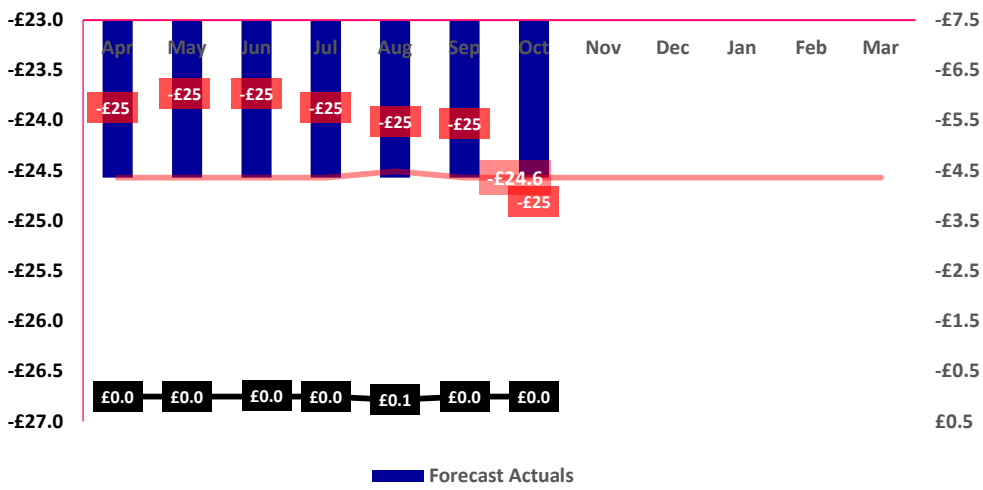
Organisation	YTD Position			Forecast Position		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Income	119,237	120,006	768	204,701	204,701	-
Expenditure	- 129,110	- 130,958	- 1,848	- 219,916	- 219,916	-
EBITDA	**- 9,873**	**- 10,952**	**- 1,079**	**- 15,215**	**- 15,215**	**-**
Financing	- 5,234	- 5,415	- 181	- 9,129	- 9,129	-
Normalised Surplus/ (Deficit)	**- 15,107**	**- 16,367**	**- 1,260**	**- 24,344**	**- 24,344**	**-**
Exceptional Items	- 93	1,351	1,444	- 162	- 162	- 0
Net Deficit after Exceptional Costs	**- 15,201**	**- 15,016**	**185**	**- 24,506**	**- 24,506**	**- 0**

Key Headlines:

- YTD Position across at the ICFT is currently: **£1.26m overspent**
- This is an adverse movement in month of **£0.1m**

Revenue Forecast Position

Forecast detail - £m's



Financial Summary – Key Risks

- The Trust is paying escalated rates to clinical staff due to gaps in medical rotas and a change in tax regulation. Consequently this is putting significant pressure on the Trust's financial position.
- The Trust has a number of escalated beds that are unfunded. Closing these beds will be difficult whilst the Trust's bed occupancy continues to be high.
- Income on smaller clinical contracts is falling and there is a focus on ensuring costs fall in relation to the loss of income.
- The Trust's efficiency programme is currently forecasting to underachieve, which will result in a financial pressure that will be managed within the overall ICFT financial position.

Section 4 - Health Economy Efficiency Position

Overall Risk Rating - Medium

Health Economy Position - At a glance

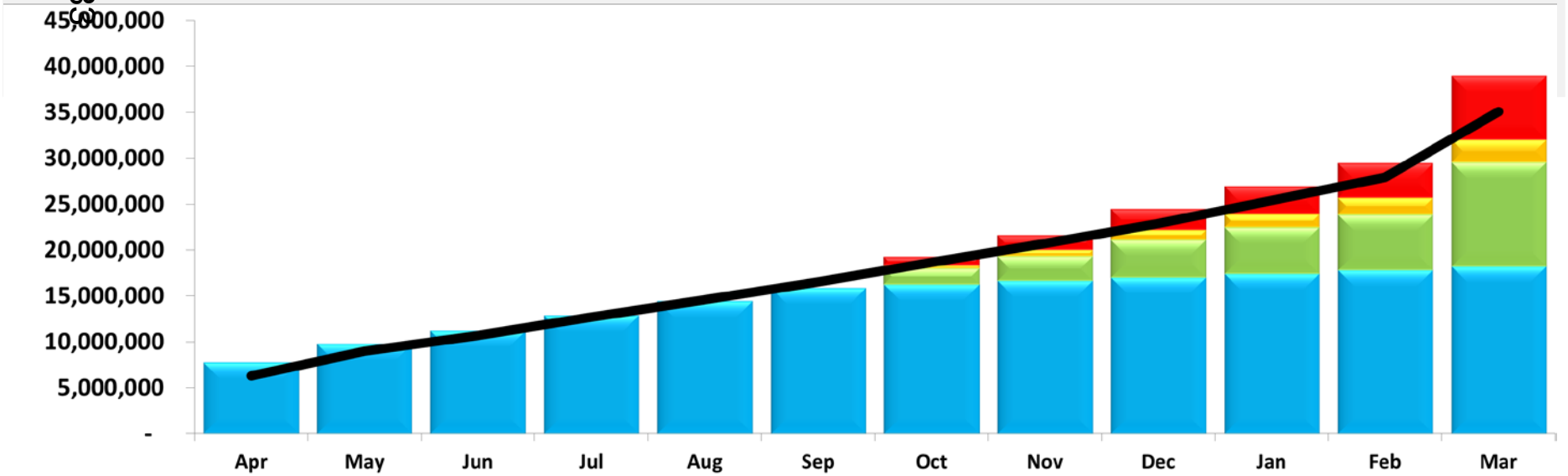
	YTD			2017/18 FORECAST BREAKDOWN £000'S								
	Target	Delivered	Variance	In Year Posted	Low	Medium	High	Forecast Savings	Forecast Savings Excl High Risk	Target	Variance	Status
ICFT	4,880	4,802	(78)	7,133	2,574	77	1,569	11,354	9,785	10,397	(612)	
T&G CCG	13,299	12,406	(893)	12,406	7,170	866	2,172	22,614	20,442	23,900	(3,458)	
LOCAL AUTHORITY	451	451	0	451	177	145	0	773	773	773	0	
TOTAL	18,630	17,659	(971)	19,990	9,921	1,088	3,741	34,741	31,000	35,070	(4,070)	

In Month/YTD Position

- 17/18 YTD Delivery across the economy is currently: **£17,699k**
- This is an underachievement against plan of **£971k**

Forecast Position

- 2017/18 Projected Economy saving forecast: **£4,070k Shortfall to plan**
- This represents an deterioration since M6 of: **£1,022k**



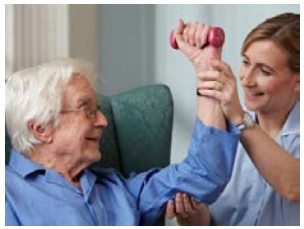
NB: Red Schemes are not included within the forecast savings figures due to high risk of non-financial delivery

Children's services

Cost of Children's placements

Urgent Care

A&E streaming and longer term plans for urgent care centre



Intermediate Care

Public consultation

Areas of concern

Individualised Commissioning

Recovery plan & associated financial pressures

CHC

Increased cost of CHC and social care assessments

Due Diligence

Complexities & timelines of due diligence to support transfer of services

Annex 1 - ICFT Efficiency Plan

Overall Risk Rating - Medium

ICFT Position - At a glance

	In Month £000			YTD £000			Forecast £000							Movement £000	
Theme	Plan	Actual	Var	Plan	Actual	Var	Plan	Delivered FYE	Low	Medium	High	Total Exc Red	Var	Previous Var	Change
Technical Target	£104	£139	£35	£725	£1,068	£343	£1,243	1,213	487	0	0	£1,701	£458	£439	£19
Pharmacy	£22	£19	-£3	£187	£352	£166	£392	448	155	0	25	£603	£211	£211	£0
Divisional Target - Corporate	£81	£234	£153	£566	£943	£377	£1,020	1,232	0	6	61	£1,238	£218	£108	£110
Workforce Efficiency	£10	£0	-£10	£71	£70	-£1	£121	70	70	0	0	£140	£19	£33	-£14
Divisional Target - Surgery	£55	£45	-£10	£363	£302	-£61	£640	622	0	18	0	£640	£0	£0	£0
Transformation Schemes	£0	£49	£49	£133	£208	£75	£1,000	453	547	0	431	£1,000	£0	£0	£0
Estates	£24	£22	-£2	£174	£99	-£75	£557	168	347	38	3	£554	-£4	-£3	-£1
Divisional Target - Medicine	£68	£56	-£11	£459	£379	-£80	£803	589	114	0	83	£703	-£100	-£93	-£7
Paperlite	£10	£0	-£10	£73	£0	-£73	£125	0	16	15	78	£31	-£94	-£94	£0
Medical Staffing	£55	£32	-£23	£336	£193	-£142	£716	354	185	0	240	£539	-£177	-£165	-£12
Nursing	£85	£28	-£57	£557	£395	-£162	£975	429	345	0	0	£774	-£201	-£191	-£10
Demand Management	£141	£111	-£30	£920	£613	-£307	£1,732	1,185	85	0	461	£1,270	-£461	-£389	-£72
Procurement	£46	£25	-£22	£317	£179	-£138	£1,073	371	222	0	186	£593	-£480	-£451	-£30
TOTAL ICFT - TEP	702	761	60	4,880	4,802	-78	10,397	7,133	2,574	77	1,569	9,785	-612	-596	-16

Performance to date and forecast:

Forecast position
£0.6m Forecast Shortfall in year and **£1.1m** Recurrently.

Most improved scheme
Corporate +£110k

Movement from Month 6
£16k adverse In Year
£200k adverse recurrently

Most adverse movement
Demand Mgt -£72k

Key issues and recovery:

- **Amber/Green –** Still over £2.6m to deliver in the last 5 months of the financial year. Deep dives to be undertaken for all low risk schemes to confirm delivery.
- **2018/19 –** New schemes need to be developed for next year's TEP target, high level proposals due by end of November 17.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	12 December 2017
Reporting Member / Officer of Single Commissioning Board	Sarah Dobson, Assistant Director (Policy, Performance and Communications)
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**
Report Summary:	This paper provides the Strategic Commissioning Board with a Health and Care performance report for comment. Assurance is provided for the NHS Constitutional indicators. In addition information on a range of other indicators are included to capture the local health economy position. This is based on the latest published data (at the time of preparing the report). This is as at the end of September 2017. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following have been highlighted as exceptions: • A&E Standards were failed at Tameside Hospital Foundation Trust; • 111 Performance against Key Performance Indicators; • Percentage of service users who are in receipt of direct payments; • Total number of learning disability service users in paid employment. Attached is an appendix on 111.
Recommendations:	The Strategic Commissioning Board is asked to note the contents of the Health and Care performance report.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of Commissioning for Quality and Innovation and Quality, Innovation, Productivity and Prevention targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.
Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all part sot account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality.

How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Health and Care Advisory Group:	This section is not applicable as this report is not received by the Health and Care Advisory Group.
Public and Patient Implications:	Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2017/18
Access to Information :	The background papers relating to this report can be inspected by contacting Ali Rehman, Head of Business Intelligence and Performance, by: Telephone: 01613425637 e-mail: alirehman@nhs.net

Health and Care Improvement Dashboard

December 2017

Indicator	Standard	Latest	Previous	Latest	Direction of Travel
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95%	Sep-17	94.0%	92.8%	▼
* Delayed Transfers of Care - Bed Days	3.5%	Sep-17	4.8%	4.6%	▼
* Referral To Treatment - 18 Weeks	92%	Sep-17	92.5%	92.3%	▼
* Diagnostics Tests Waiting Times	1%	Sep-17	0.7%	0.9%	▲
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93%	Sep-17	96.5%	96.4%	▼
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93%	Sep-17	98.7%	95.2%	▼
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96%	Sep-17	100.0%	100.0%	◀▶
Cancer - 31-Day Wait For Subsequent Surgery	94%	Sep-17	92.9%	100.0%	▲
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98%	Sep-17	100.0%	100.0%	◀▶
Cancer - 31-Day Wait For Subsequent Radiotherapy	94%	Sep-17	100.0%	97.1%	▼
Cancer - 62-Day Wait From Referral To Treatment	85%	Sep-17	91.8%	87.8%	▼
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90%	Sep-17	100.0%	90.0%	▼
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade		Sep-17	76.7%	72.2%	▼
MRSA	0	Sep-17	0	1	▲
C.Difficile (Ytd Var To Plan)	0%	Sep-17	-1.0%	-1.0%	◀▶
Estimated Diagnosis Rate For People With Dementia	66.7%	Sep-17	81.4%	81.8%	▲
Improving Access to Psychological Therapies Access Rate		Jun-17			◀▶
Improving Access to Psychological Therapies Recovery Rate	50%	Aug-17	50.8%	50.9%	▲
Improving Access to Psychological Therapies Seen Within 6 Weeks	75%	Aug-17	88.1%	85.4%	▼
Improving Access to Psychological Therapies Seen Within 18 Weeks	95%	Aug-17	100.0%	100.0%	◀▶
Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral	50%	Sep-17	50.0%	33.3%	▼
Mixed Sex Accommodation	0	Sep-17	0.10	0.70	▼
Cancelled Operations		17/18 Q2	1.0%	1.0%	◀▶
Ambulance: Red 1 Calls Responded to in 8 Minutes	75%	Jul-17	57.1%	63.3%	▲
Ambulance: Red 2 Calls Responded to in 8 Minutes	75%	Jul-17	60.6%	62.9%	▲
Ambulance: Category A Calls Responded to in 19 Minutes	95%	Jul-17	88.2%	89.7%	▲
Cancer Patient Experience		2016	8.70	8.77	▲
Cancer Diagnosed At An Early Stage		2015	44.2%	49.2%	▲
General Practice Extended Access		Sep-17	74.4%	84.2%	▲
Patient Satisfaction With GP Practice Opening Times		Mar-17	74.4%	76.0%	▲

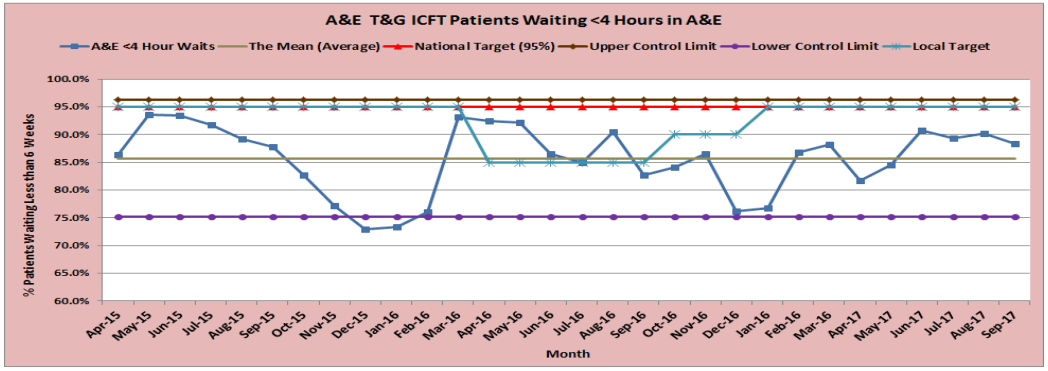
* data for this indicator is provisional and subject to change

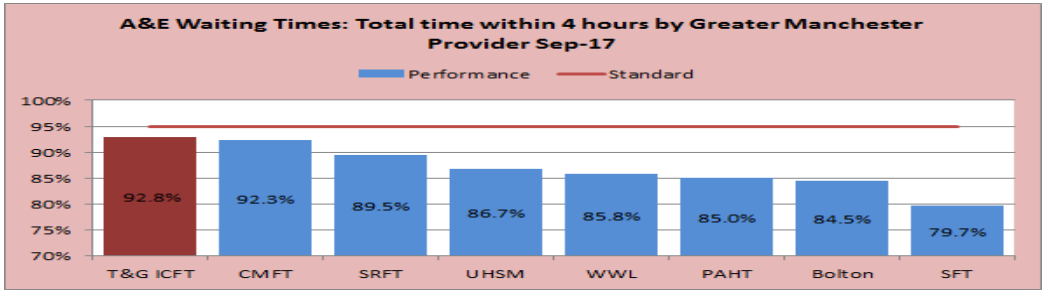
Indicator	Standard	Latest	Previous	Latest	Direction of Travel
Maternal Smoking at delivery		17/18 Q2	15.1%	14.6%	▼
%10-11 classified overwieight or obese		2013/14 to 2015/16	33.6%	33.6%	◀▶
Personal health budgets		17/18 Q1	4.50	5.30	▲
% of deaths in hospital		16/17 Q2	49.80	50.40	▲
LTC feeling supported		2016 03	62.40	61.40	▼
Quality of life of carers		2016 03	0.77	0.78	▲
Emergency admissions for urgent care sensitive conditions (UCS)		16/17 Q4	3212	3066	▲
Patient experience of GP services		Jul-05	83.2%	83.5%	▲
Adult Social Care Indicators					
Part 2a - % of service users who are in receipt of direct payments	28.1%	17/18 Q2	12.76%	13.60%	▲
Total number of Learning Disability service users in paid employment	5.7%	17/18 Q2	4.71%	4.50%	▼
Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64	13.3	17/18 Q2	3.71 (5 Admissions)	10.38 (14 Admissions)	▲
Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	628	17/18 Q2	143.77 (56 Admissions)	277.27 (108 Admissions)	▲
Total number of permanent admissions to residential and nursing care homes aged 18+		17/18 Q2	61	122	▲
Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital	82.7%	17/18 Q2	81.8%	81.8%	◀▶
% Nursing and residential care homes CQC rated as Good or Outstanding (Tameside and Glossop)		Sep-17	55%	55%	◀▶
% supported accomodation CQC rated as Good or Outstanding (Tameside and Glossop)		Sep-17	80%	80%	◀▶
% Help to live at homes CQC rated as Good or Outstanding (Tameside and Glossop)		Sep-17	50%	67%	▲

Exception Report

Health and Care Improvement- December

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





September Performance: 92.84%

16/17 ytd: 88.21%

17/18 ytd: 93.40%

Key Risks and Issues:

The A&E Type1 and type 3 performance for September was 92.84% which is below the National Standard of 95% but above the GM agreed target of 90%. Late assessment due to lack of capacity in the department is the main reason for breaches.

- Bed capacity across the organisation was problematic (Medical bed-pool occupancy was routinely at >96%).;
- Delayed-transfers-of-care occupied >6% of the 'General and Acute' bed pool, a reduction from 10% in January;
- Medical bed-pool occupancy was routinely at >97% leading to reduced capacity on AMU and IAU;
- Increased acuity, as measured using the Charlson Comorbidity Index (43% of patients with a Charlson comorbidity; 34% in 2009-10).

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.
A&E Streaming is in place but timing meant October rotas were not always filled as hoped so impact may be lessened.

Actions:

- Organisational initiative 'Back to the 90s', commenced taking a whole-systems approach to patient flow;
- Additional beds temporarily opened on IAU (8 beds in use);
- Clinical Fellow now allocated to the Ambulatory Care area to enhance the service provision and handle GP calls;
- Additional medical staffing resources deployed, especially on days of expected increased activity (Monday/Tuesday).
- A&E Streaming started on 1st October.
- Detailed plans shared with GM and implementation being monitored through A&E Delivery Board.
- Further work concerning the handling of GP calls;
- Review of the speciality response times to ED and escalation processes.

Operational and Financial implications:

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

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

Next month FORECAST

* Please note that Tameside Trust local trajectory for 17/18 is Q1, Q2 and Q3 90%, and Q4 95%.
* Type 1 & 3 attendances included from July 2017.

111- **Lead Officer: Elaine Richardson** **Lead Director:** Jess Williams **Governance: Contracts**

Indicators - access & quality		North West including Blackpool	North West including Blackpool	Scoring out of 40 Areas Highest		Lowest	
Calls per month per 1,000 people							
Calls per month via 111 per 1,000 people							
Of all calls offered, % abandoned after at least 30 seconds		5%	2	Luton and Bedfordshire	5%	South Essex	0%
Of calls answered, % in 60 seconds		81%	36	East London and City	98%	East Kent	74%
Of calls answered, % triaged							
Of answered calls, % transferred to clinical advisor		89%	15	North Central London	107%	Luton and Bedfordshire	70%
Of transferred calls, % live transferred		19%	36	East Kent	46%	Lincolnshire	13%
Average NHS 111 live transfer time							
Average warm transfer time							
Of calls answered, % passed for call back		8%	27	Staffordshire	8%	Lincolnshire	13%
Of call backs, % within 10 minutes		39%	22	Outer North East London	71%	Cornwall	20%
Average episode length							
Of answered calls, % calls to a CAS clinician		8%	30	East Kent	40%	Yorkshire and Humber	6%

Dispositions as a proportion of all calls triaged	T&G CCG	North West including Blackpool	North West including Blackpool	Scoring out of 40 Areas Highest		Lowest	
111 dispositions: % Ambulance dispatches	16%	15%	7	Devon	19%	Hertfordshire	8%
111 dispositions: % Recommended to attend A&E	9%	9%	25	East London and City	15%	Leicestershire and Rutland	5%
Recommended to attend primary and community care	54%	57%	29	Cambridgeshire and Peterborough	65%	Lincolnshire	49%
Of which - % Recommended to contact primary and community care		42%	16	South East Coast excluding East Kent	48%	Nottinghamshire	34%
- % Recommended to speak to primary and community care		12%	18	Hertfordshire	19%	Outer North East London	8%
- % Recommended to dental		2%	39	Yorkshire and Humber	13%	Devon	1%
- % Recommended to pharmacy		0.3%	22	Yorkshire and Humber	0.8%	Norfolk including Great Yarmouth and Waveney	0.1%
111 dispositions: % Recommended to attend other service	2%	2%	32	Lincolnshire	19%	Bristol, North Somerset & South Gloucestershire	1%
111 dispositions: % Not recommended to attend other service	19%	17%	8	North Essex	22%	North East	9%
Of which - % Given health information		4%	1	North West including Blackpool	4%	Yorkshire and Humber	0.1%
- % Recommended home care		3%	39	South East London	8%	Lincolnshire	1%
- % Recommended non clinical		10%	9	North Essex	16%	Cambridgeshire and Peterborough	3%

Key Risks and Issues:

The North West NHS 111 service performance has improved in all of the key KPIs for August although only abandoned calls performance was achieved:
- Calls Answered (95% in 60 seconds) = 83.99%
- Calls abandoned (<5%) = 3.99%
- Warm transfer (75%) = 33.13%
- Call back in 10 minutes (75%) = 40.91%

Average call pick up for the month was 60 seconds. This is significant decrease from the previous month of 25 seconds.

Performance was particularly difficult to achieve over the weekend periods.

Actions:

NWAS has agreed a further remedial action plan with commissioners.
NWAS has continued to deploy all available staff, and is actively managing staff absence and attrition in order to best meet the service needs.

The call handling processes implemented to improve the service appear to be having an impact.
A part of the GM arrangements appropriate T&G patients receive enhanced clinical assessments from GtD out of hours however the in hours pilot has now ended.
A 111 health and wellbeing group has been formed to develop long term plans to support staff to maintain attendance at work.
The service is currently recruiting and training a large number of staff to manage the increased demand that will be seen over the winter and festive period.

Operational and Financial implications:

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

Unvalidated next month FORECAST

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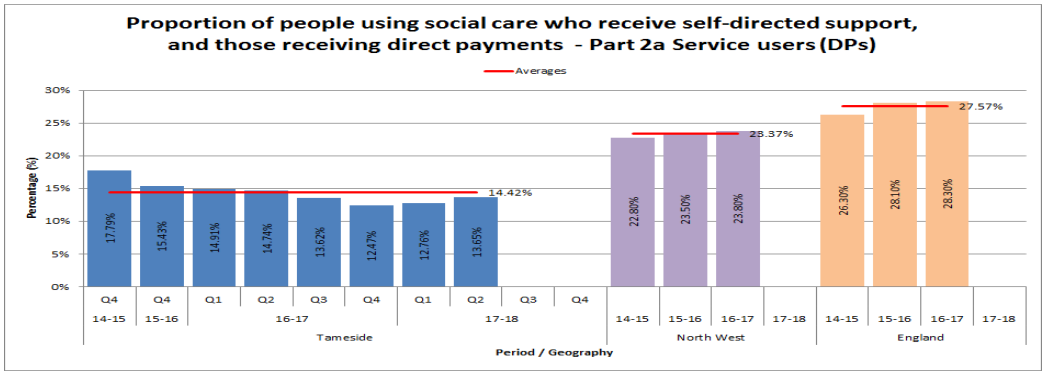
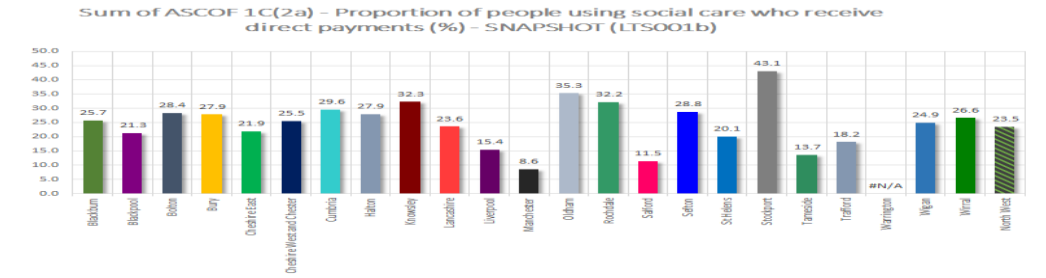
Exception Report

Health and Care Improvement- December

ASCOF 1C- Proportion of service users in paid employment | **Lead Officer:** Sandra Whitehead | **Lead Director:** Steph Butterworth | **Governance**: Adults Management team





Key Risks and Issues:

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

Actions:

Additional Capacity to be provided within the Neighbourhood teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the ASC transformation funding. The project post was not successfully recruited too therefore in order to increase capacity a different approach has been implemented. We use to have 2 Direct Payment workers this has now been increased to 4 Direct Payment Workers, one in each neighbourhood. A publicity campaign will now be developed to increase numbers over the coming months.

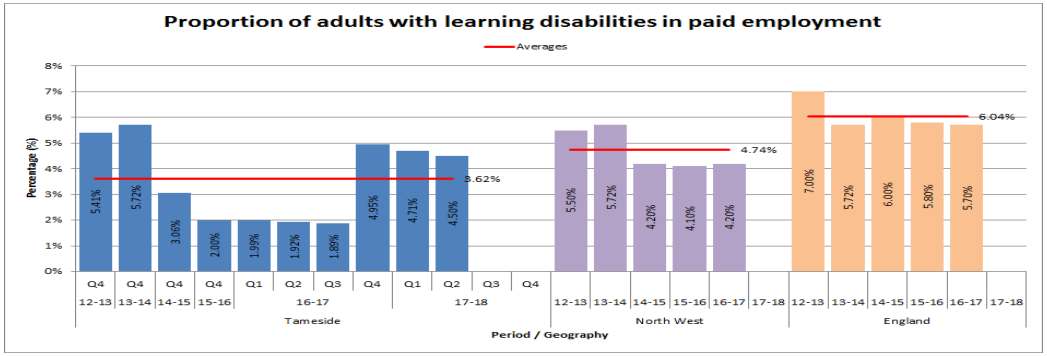
Operational and Financial implications:

None

Unvalidated Next Quarter FORECAST

* Benchmarking data is as at Q2 17/18.

ASCOF 1E- Total number of Learning Disability service users in paid employment **Lead Officer:** Sandra Whitehead **Lead Director:** Steph Butterworth **Governance:** : Adult Management meeting



Key Risks and Issues:

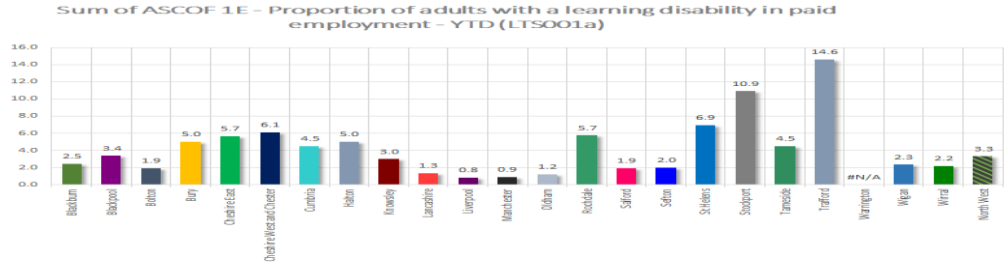
The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. 2nd Quarter 2017/18 figure is 4.5%

Actions:

- We have moved the remaining Employment Support staff into the Employment and Skills corporate team to ensure a more focused approach to employment and access to wider resource and knowledge base
- In order to improve performance, additional resource is required to increase capacity. An additional post has been funded through the ASC transformation funding and a vacant post that was held in the team has also been released to increase capacity in the team with an expectation that more people will be supported into paid employment.
- Work has been undertaken with Routes to Work to strengthen their recording of Supported Employment services and to clarify the links with this indicator.
- The development of a new scheme focused on supporting people with pre-employment training and supporting people into paid employment including expansion of the Supported Internship Programme for 16-24 year olds.

Operational and Financial implications:

None



Unvalidated next Quarter FORECAST

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Quality and safeguarding exception report narrative-September 2017.

Associate Contracts: Optegra

The CQC inspected surgery and outpatients departments at Optegra Eye Hospital Manchester in July 2017. The report was published on the 21 November 2017. CQC rated this service as *Requires Improvement* overall. Manchester CCG (lead commissioner) has requested the following actions:

- Optegra provides their improvement plan by 8 December 2017
- The two serious incidents identified by CQC are reported appropriately by 8 December 2017
- Assurance that one particular practice has stopped, or that action has been taken to ensure that patients are safe during transfer. This is in regard to *"patients being prepared for cataract surgery in the anaesthetic room and then instructed to transfer from the bed and walk into the operating theatre. Patients who were disorientated due to sedation, or walking without their glasses. Patients required support from theatre staff in order to safely make the transfer"*.

The improvement plan will be monitored by Manchester CCG on behalf of all co- commissioners.

PCFT Mixed Sex Accommodation Breaches: PCFT reported 4 mixed sex accommodation breaches in September. The CCG will continue to closely monitor the breaches and seek assurance that the Trust is taking all necessary measures to minimise the risks of MSA breaches occurring and to manage appropriately when these are unavoidable.

ICFT LAC (Health): The CCG, provider, and LA are continuing to work together to resolve issues with timely notification processes between services and considering how we can improve partnership working. The Improvement Board, whose function is to review the multi agency action plan for the authority since it was allocated an inadequate judgement is overseeing the progress being made to ensure that children and young people who are looked after receive appropriate help and support.

Care Homes:

Balmoral Care Home (Residential): The home received an overall inadequate CQC rating on the 31st August 2017 The main issue causing the CQC concern was the lack of improvement since the last inspection, specifically around medicines management. Following the inspection the Medicines Management Team audited the home and helped to produce an action plan for improvement; the manager has been provided with support. A further full medication audit was undertaken on the 27 September and significant progress was noted. Another medications audit is planned for the 20 December 2017.

A Nursing home remains suspended (since January 2017) following concerns raised from a CQC inspection . A number of issues were identified (poor environment, staff training, staff competencies, leadership, etc.). The home had been in receivership (since October 2016) and has since been sold (back to the former owner). Regular commissioner/provider continue to take place and robust action plan monitoring is in place. A new manager is now in post; some improvements have been noted however the suspension to remain in place. Next commissioner / provider meeting is on the 19/12/17.

A residential home (Glossop) remains on a formal suspension issued by DCC following a safeguarding incident with two agency staff in April 17. The outcome of the police investigation and safeguarding investigation is currently awaited and DCC have taken the decision to suspend new admissions until these are completed. No new admissions have taken place from T&G with the exception of one respite placement which had been a long-standing arrangement and requested the family who had been made aware of issues. On-going monitoring is being undertaken.

NHS England 111 Dashboard.

CCG Level Selected	Time period	Cohort of calls	Distinct Patients
NHS TAMESIDE AND GLOSSOP CCG	Selected 2016/17 Financial Year	43,467	26,106

Ambulance			Other Service			Not Recommended to attend			Unknown / Not Triaged			A&E Dept or UCC		
No. / %	6,395	14.7%	No. / %	25,121	57.8%	No. / %	6,585	15.1%	No. / %	1,990	4.6%	No. / %	3,376	7.8%
No A&E in 24 Hours			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**		
No. / %	1,585	24.8%	No. / %	21,305	84.8%	No. / %	5,912	89.8%	No. / %	1,573	79.0%	No. / %	758	22.5%
A&E in 24 Hours			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**		
No. / %	4,810	75.2%	No. / %	3,816	15.2%	No. / %	673	10.2%	No. / %	417	21.0%	No. / %	2,618	77.5%
Admitted			**Admitted**			**Admitted**			**Admitted**			**Admitted**		
No. / %	1,796	37.3%	No. / %	1,262	33.1%	No. / %	158	23.5%	No. / %	128	30.7%	No. / %	284	10.8%
Not Admitted			**Not Admitted**			**Not Admitted**			**Not Admitted**			**Not Admitted**		
No. / %	3,014	62.7%	No. / %	2,554	66.9%	No. / %	515	76.5%	No. / %	289	69.3%	No. / %	2,334	89.2%

Clicking on any of the cascade boxes will select that Cohort and move to the Cohort tab.
Selecting the Cascade tab will clear all cascade selections on entry.

111

- During 2016/17 there were 43,467 calls to the 111 service.
- 22.5% were sent an ambulance or recommended to attend A&E or urgent care centre.
- The rest were either recommended to attend another service or not.
- 15.2% of the ones that were recommended another service turned up at A&E within 24hrs. With 33% being admitted.
- 10.2% of the ones not recommended any service turned up at A&E within 24hrs. With 23.5% being admitted.

CCG Level Selected	Time period	Cohort of calls	Distinct Patients
NHS TAMESIDE AND GLOSSOP CCG	Selected 2017/18 Financial Year	21,043	14,681

Ambulance			Other Service			Not Recommended to attend			Unknown / Not Triaged			A&E Dept or UCC		
No. / %	3,173	15.1%	No. / %	12,184	57.9%	No. / %	2,979	14.2%	No. / %	793	3.8%	No. / %	1,914	9.1%
No A&E in 24 Hours			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**		
No. / %	747	23.5%	No. / %	10,297	84.5%	No. / %	2,638	88.6%	No. / %	626	78.9%	No. / %	604	31.6%
A&E in 24 Hours			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**		
No. / %	2,426	76.5%	No. / %	1,887	15.5%	No. / %	341	11.4%	No. / %	167	21.1%	No. / %	1,310	68.4%
Admitted			**Admitted**			**Admitted**			**Admitted**			**Admitted**		
No. / %	886	36.5%	No. / %	604	32.0%	No. / %	98	28.7%	No. / %	62	37.1%	No. / %	155	11.8%
Not Admitted			**Not Admitted**			**Not Admitted**			**Not Admitted**			**Not Admitted**		
No. / %	1,540	63.5%	No. / %	1,283	68.0%	No. / %	243	71.3%	No. / %	105	62.9%	No. / %	1,155	88.2%

Clicking on any of the cascade boxes will select that Cohort and move to the Cohort tab.
Selecting the Cascade tab will clear all cascade selections on entry.

111

- Year to date 2017/18 to October there were 21,043 calls to the 111 service.
- 24% were sent and ambulance or recommended to attend A&E or urgent care centre.
- The rest were either recommended to attend another service or not.
- 15.5% of the ones that were recommended another service turned up at A&E within 24hrs. With 32% being admitted.
- 11.4% of the ones not recommended any service turned up at A&E within 24hrs. With 28.7% being admitted.

CCG	Primary Advice Group	A&E within 24 hours	Time period	Cascade cohort of calls	Cascade distinct patients
NHS TAMESIDE AND GLOSSOP CCG	Other Service	A&E Attended	Selected 2017/18 Financial Year	1,887	1,682

Symptom Group

Symptom Group	No.	%
	1,887	
NHS Pathways In House Clinician	304	16.1%
Breathing Problems, Breathlessness or Wheeze	95	5.0%
Vomiting	77	4.1%
Health and Social Information	74	3.9%
Abdominal Pain	71	3.8%
Chest and Upper Back Pain	58	3.1%
Diarrhoea and Vomiting	49	2.6%
Knee or Lower Leg Pain or Swelling	48	2.5%
Lower Back Pain	47	2.5%
Fever	46	2.4%
Diarrhoea	42	2.2%
Skin, Rash	41	2.2%
Pain and/or Frequency Passing Urine	40	2.1%
Predetermined Management Plan	40	2.1%
Vaginal Bleeding, Pregnant	33	1.7%

A&E HRG Treatment Category

HRG	No.	%
	1,887	
Emergency Medicine, Category 2 Investigation with Cate...	815	43.2%
Emergency Medicine, Category 1 Investigation with Cate...	437	23.2%
Emergency Medicine, No Investigation with No Significan...	246	13.0%
Emergency Medicine, Category 2 Investigation with Cate...	148	7.8%

A&E First Diagnosis

Diagnosis	No.	%
	1,887	
No Diagnosis	587	31.1%
Diagnosis not classifiable	368	19.5%
Gastrointestinal conditions	183	9.7%
Respiratory conditions	96	5.1%

111 Clinician Input

Passed to Clinician	No.	%
	1,887	
No	1,459	77.3%
Yes	428	22.7%

A&E Description

A&E Description	No.	%
	1,887	
Type 1 - 24 Hour A&E	1,803	95.5%
Type 3 - Other A&E / Minor Injury	31	1.6%
Type 4 - Walk In Centre	31	1.6%
Type 2 - Single specialty	22	1.2%

Final Disposition

Final Disposition	No.	%
	1,887	
Recommended to contact primary and community care	1,347	71.4%
Recommended to speak to primary and community care	404	21.4%
Recommended to attend other service	93	4.9%
Recommended to dental / pharmacy	43	2.3%

A & E Disposal

A & E Disposal	No.	%
	1,887	
Discharged - follow up treatment to be provided by GP	740	39.2%
Admitted to a Hospital Bed	604	32.0%
Discharged - did not require any follow up treatment	230	12.2%
Referred to other Out-Patient Clinic	93	4.9%

Please note data in this tab is restricted to specific CCG access.

NHS TAMESIDE AND GLOSSOP CCG	Other Service	A&E Attended	Selected 2017/18 Financial Year	1,887	1,682

List of 1,682 distinct Patients

ID	Calls	Att	Adm	Combined
8309206	7	6	391	404
64623	101	93	31	225
44039	11	106	51	168
3043673	2	6	154	162
45245	42	67	31	140
163188	79	22	9	110
91938	75	27	5	107
4014493	89	8	0	97
4059091	71	17	7	95
1018881	24	42	22	88
	5,969	**6,619**	**4,533**	**17,121**

Att / Adm Type

Type	PSTypeDesc	No.
111	111 Call	5,969
AE	Community Dental Service	7
AE	Emergency services	207
AE	General Dental Practitioner	1
AE	General Medical	152
		17,121

HRG

Description	No.
VB08Z Emergency Medicine, Category 2 Investigation with Category 1 Treatment	2778
VB09Z Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment	1376
VB11Z Emergency Medicine, No Investigation with No Significant Treatment	859
VB07Z Emergency Medicine, Category 2 Investigation with Category 2 Treatment	590
LA97A Same Day Dialysis Admission or Attendance, 19	406
	11152

Patient Timeline

NHS TAMESIDE AND GLOSSOP CCG	Other Service	A&E Attended	Selected 2017/18 Financial Year	5	1

List of 1 distinct Patients

ID	Calls	Att	Adm	Combined
64623	101	93	31	225
	101	**93**	**31**	**225**

Clear ID number

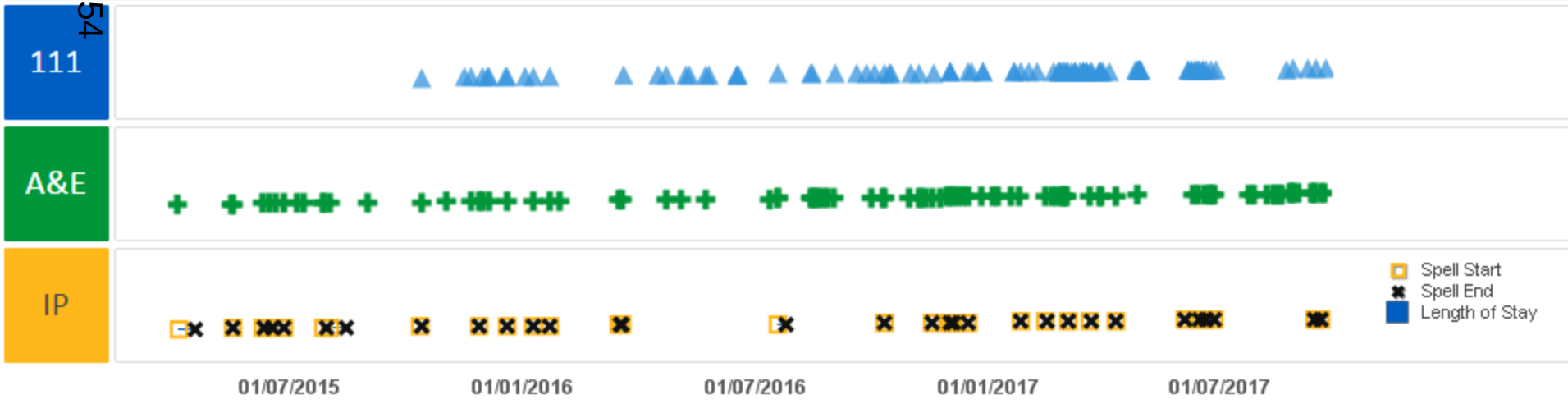
Att / Adm Type

Type	PSTypeDesc	No.
111	111 Call	101
AE	Emergency services	5
AE	Other	2
AE	Self referral	86
IP	Non Elective - Emergency	5
		225

HRG

Description	No.
VB08Z Emergency Medicine, Category 2 Investigation with Category 1 Treatment	40
VB11Z Emergency Medicine, No Investigation with No Significant Treatment	28
VB09Z Emergency Medicine, Category 1 Investigation with Category 1-2 Treatment	17
VB07Z Emergency Medicine, Category 2 Investigation with Category 2 Treatment	6
FB01Z Non-Interventional Acquired Cardiac Conditions	4
	124

Patient Timeline



Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	12 December 2017
Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**2018/19 STRATEGIC COMMISSIONING FUNCTION: COMMISSIONING INTENTIONS**
Report Summary:	A draft letter to providers is set out at **Appendix A** setting out the high level Commissioning Intentions for how Tameside and Glossop Strategic Commission intends to commission services from its providers in 2018/19, in line with the 2017-19 national contract guidance these intentions are to cover the second year of the agreed two year (2017/19) contracting period. More details of specific intentions in terms of activity and financial planning will be shared with provider during the contract negotiation period. The Commissioning Intentions have been put into 4 defined groups 1. Tameside and Glossop Strategic Commission; 2. Tameside and Glossop Financial Context; 3. Specific Commissioning Intentions with no additional funding; 4. Specific Commissioning Intentions – additional support via the Greater Manchester Health and Social Care Partnership. The Commissioning Intentions set out how, due to strong and steady work over the past two years, a single place-based commissioning body has been formed (Tameside and Glossop Strategic Commission) which is made up of Tameside Metropolitan Borough Council and NHS Tameside and Glossop and supports the implementation of a new model of care. The Strategic Commissions commitment is to early intervention, prevention and tackling unacceptable health inequalities are outlined along with the long term commitment to deliver sustainable improvement to healthy life expectancy. We will have an estimated commissioning gap in 2018/19 of £29m which will affect every aspect of our Commissioning Intentions for next year and Section 2 of the intentions provides an over view of what is required by ourselves and our providers in enabling the challenge to be met. Achieving financial sustainability is of utmost importance to provide our economy with future stability and enable the continuation of our transformation journey. We look forward to working alongside providers to identify and support innovate approaches to managing demand in more cost effective ways. The intentions make it clear that we will be unable to support any activity growth or cost increases in 2018/19 and so will be requiring providers to work with us to reduce demand or mitigate this as far as possible. There will be no additional Tameside and Glossop funding for any new services or developments with the exception of those within our transformation plans or guaranteed to provide a rapid return on investment/reduce cost elsewhere in our economy. Any developments with additional ring fenced funding either nationally or via Greater Manchester Health and

Social Care Partnership funds will be supported in full (see detail under Section 4 of the commissioning Intentions).

Specific Commissioning Intentions for 2018/19 that have no additional funding requirements are detailed in Section 3, areas covered in more detail are:

- Aligning health and social care with public sector reform;
- Care Together;
- Outcomes from future public consultations;
- Palliative and End of Life Care;
- Pathway re-designs;
- Frailty;
- Neuro Rehab;
- Stroke;
- Workforce development.

Recommendations:

The Strategic Commissioning Board is asked to approve these 2018/19 Commissioning Intentions so that he Strategic Commission can carry on working with its providers in working towards delivering a stable economy and its long term commitment to delivering sustainable improvement to health life expectancy.

Financial Implications:

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

Budget Allocation (if Investment Decision)	Entire Commissioning budget
CCG or TMBC Budget Allocation	CCG and TMBC where applicable
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	Section 75, In Collaboration Services and Aligned Services
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Not applicable
Additional Comments None.	

Legal Implications:

(Authorised by the Borough Solicitor)

The development of Commissioning Intentions is an annual activity that seeks to ensure commissioners have clear oversight to work towards informing local health activities and to let providers know of the contractual changes that will be implemented in the forthcoming year. Commissioning Intentions are not intended to set out all activity that will be undertaken in a given year but they provide context for commissioning changes, list commissioning changes that improve quality of service or value for money and signal to providers that resources may be changing or new delivery models may be implemented.

How do proposals align with Health & Wellbeing Strategy?	The Commissioning Intentions are aligned with the Health and Well Being strategy
How do proposals align with Locality Plan?	The Commissioning Intentions have been developed in line with the locality plan and proposed model of care. They are aligned with the transformation fund submission to Greater Manchester.
How do proposals align with the Commissioning Strategy?	The documents are aligned with the commissioning intentions in the Commissioning Strategy.
Public and Patient Implications:	Public and patient implications have been considered for each of the individual intentions included in the document.
Quality Implications:	The appropriate individual Quality Impact Assessments are being / have been undertaken. This document is a compilation of the commissioning activities of the single commission.
How do the proposals help to reduce health inequalities?	The commissioning intentions are in line with the single commission approach to reducing health inequalities.
What are the Equality and Diversity implications?	Equality Impact Assessments have been / will be undertaken on commissioning activities as required. This document is a compilation of the commissioning activities of the single commission, all of which will receive the appropriate individual consideration in terms of equality and diversity implications.
What are the safeguarding implications?	Safeguarding implications of the proposals will be considered and addressed on an individual basis.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information Governance and Privacy Impact Assessments will be undertaken for individual projects rather than for this proposal, including requirements for Privacy Impact Assessments.
Risk Management:	Any risks will be reported and managed via the Clinical Commissioning Group's risk register.
Access to Information :	The background papers relating to this report can be inspected by contacting Jessica Williams (Interim Director of Commissioning): ☎ Telephone: 07985 276263 ☎ e-mail: jessicawilliams1@nhs.net

APPENDIX A

Dear

Tameside & Glossop Commissioning Intentions 2018-19

This letter sets out, in high level terms, how Tameside & Glossop Strategic Commission intends to commission services from providers in 2018-19. In line with the national contract guidance, these commissioning intentions cover the second year of the two year contractual period 1 April 17 – 31 March 2019. Details of specific commissioning intentions, in terms of activity and financial planning, will be shared with appropriate providers during contract negotiation.

1. Tameside & Glossop Strategic Commission

For the past two years, strong and steady work has continued to develop a Strategic Commission made up of Tameside Metropolitan Borough Council and NHS Tameside and Glossop CCG. This has culminated in a single place-based commissioning body which aims to support the implementation of a new model of care, based on our place and which realigns the system to support the development of preventative, local, high quality services.

The Strategic Commission has clear governance arrangements with a Strategic Commissioning Board, clinically led and which has been established as a joint committee of the two organisations with delegated decision-making powers and resources. This creates unifying statutory and collaborative governance arrangements for the first time. The principle roles of the Board are:

- Provide executive leadership for the delivery of the Tameside and Glossop Locality Plan from a commissioning perspective;
- Oversee the management of delegated commissioning functions and pooled budgets;
- Provide effective oversight and assurance of providers and ensure delivery of the commissioned population outcomes;
- Lead the further development of commissioning as part of the statutory and Health and Wellbeing Board governance arrangements.

Tameside and Glossop Strategic Commission is committed to early intervention, prevention and tackling unacceptable health inequalities and these are the bedrock for our strategic commissioning intentions. We have a long term commitment to deliver sustainable improvement to healthy life expectancy.

The Strategic Commissioning Board considers commissioning proposals which are funded from our Integrated Commissioning Fund. This fund is comprised of three elements as set out in the table below:

Budget Allocation Sections	Detail	Governance implications
Section 75	This comprises all services which legislation permits to be held in a pooled fund between NHS bodies and local authorities at a local level	The Strategic Commissioning Board makes decisions on this funding which are binding upon the two statutory partner organisations.
Aligned Services	This comprises services which legislation does not permit to be held within a Section 75 pooled fund.	The Strategic Commissioning Board makes recommendations on the spending of this funding. These recommendations will require formal ratification by the relevant statutory organisation.
In Collaboration Services	This comprises delegated co-commissioned primary care services for which NHS England is accountable and can therefore not be held within a Section 75 or Aligned pooled fund. These specialised services are jointly commissioned with NHS England.	The Strategic Commissioning Board makes recommendations on the spending of this funding. These recommendations will require formal ratification by NHS England and the relevant statutory organisation.

2. Tameside and Glossop Financial Context

2018-19 is likely to be one of the most financially challenged which the Tameside and Glossop economy has yet experienced. Although 2017-18 saw us experiencing one of the most significant challenges in the North West Region, we are optimistic that this challenge will be met this year, albeit with some non-recurrent funding. This however does create additional pressure for 2018-19 and we have an estimated commissioning gap of £29.0m. Our financial situation will affect every aspect of our commissioning intentions for 2018-19.

We are unable to support any activity growth or cost increases in 2018/19 and so will be requiring providers to work with us to reduce demand or mitigate this as far as possible. We will be challenging any activity undertaken which does not adhere to Effective Use of resources (EUR). There will be no additional Tameside and Glossop funding for any new services or developments with the exception of those within our transformation plans or guaranteed to provide a rapid return on investment/reduce cost elsewhere in our economy. Any developments with additional ring fenced funding either nationally or via Greater Manchester Health and Social Care Partnership (GM HSCP) funds will be supported in full (see Section 4).

Achieving financial sustainability is of utmost importance to provide our economy with future stability and enable the continuation of our transformation journey. We look forward to working alongside providers to identify and support innovate approaches to managing demand in more cost effective ways including embracing technology to support self-management. Providers will be required to support the delivery of our model of care, maximise productivity and deliver required population outcomes in the most cost effective way.

3. Specific commissioning intentions for 2018/19 with no additional funding

3.1 Aligning health and social care with wider public sector reform

Due to our current financial position, we are unable to incentivise the following at this stage, but we will be asking providers to recognise and commit to supporting our key 4 local priorities which are aligned to the commitments of our Health and Wellbeing Board:

- Reduction of all aspects of Homelessness
- Reduction in all aspects of Domestic Abuse
- Reducing premature mortality through prevention, assessment, treatment, rehabilitation and care of Coronary Heart Disease and Stroke
- Improving staff satisfaction due to understanding and supporting our vision to deliver an integrated place based approach to improving healthy life expectancy.

We recognise that none of these will be achieved in a single year but wish to signal our intention to improve healthy life expectancy through the achievement of wider public sector outcomes. Ensuring all aspects of health and social care are connected into our wider public sector priorities is part of the vision for Tameside and Glossop and we aim to create an economy wide improvement plan and use intelligence and evidence to these 4 local priorities now and into the future.

Contractual agreements with providers will include a focus on these 4 local priorities as well as those agreed by GM HSCP and national 'Must Do's. Our outcomes framework which will support the measurement and assurance of progress in all these areas is currently in preparation and following further engagement and involvement of key stakeholders, will be confirmed in early Spring 2018.

3.2 Care Together

Care Together is our economy wide change programme to deliver integrated care. This programme aligns political, clinical and managerial leadership and focuses on improving healthy life expectancy, reducing inequality, improving experience of services and improving financial sustainability. The programme has attracted significant GM HSCP transformation funds which will continue to fund commissioned transformational schemes throughout 2018-19.

The Strategic Commission supported the design and development of the Integrated Neighbourhood Model, as agreed by our Care Together Model of Care Steering Group in September 2016. The expectation is that providers, where appropriate, demonstrate delivery towards our agreed set of Integrated Neighbourhood outcomes. This will include the need for Integrated Neighbourhood provision (including services for children) to support the needs of people with all levels of need from prevention through to the very complex.

3.3 Outcomes from Public Consultation

The Strategic Commission will work with providers to implement strategic commissioning decisions arising from public consultations. This includes current consultations focused on intermediate care and urgent care as well as others which may arise in throughout the year. We will ensure adequate quality and outcome measures are designed, agreed and monitored via our established contract monitoring processes. The intermediate care model will include outcomes for home based intermediate care, with clear arrangements for social care delivery in Tameside as well as in Glossop.

3.4 Palliative and End of Life Care

The Strategic Commission will lead work during 2018/19 with a range of providers (NHS, social care and 3rd sector) to set and agree a system-wide strategy and outcomes for palliative and end of life care, meeting the requirements and standards set out in the National Palliative and End of Life Care Partnership's Ambitions for care. A trajectory will be agreed to meet the Greater Manchester average 'Death in Usual Place of Residence' figure (current Tameside and Glossop CCG position 37.1%, Greater Manchester CCG average 42%).

3.5 Pathway Re-design

The NHS Right Care programme identifies 8 priorities for Tameside & Glossop. We have identified 4 as priority programme areas which are;

- Circulation
- Respiratory
- Trauma and Injuries (Falls)

- Musculo Skeletal System (MSK)

The expectation is that providers are committed to, and work with us to ensure delivery of elements of the Right Care improvements and prevent inappropriate activity.

3.6 Frailty
The Strategic Commission, in line with our aspiration to commission across the life course, will develop an integrated approach to the identification and management of Frailty across all settings. We will then work with all providers to ensure the effective adoption of this approach and the delivery of improved outcomes.

3.7 Neuro-Rehabilitation
The commissioners will work with the Greater Manchester Neuro-rehabilitation team to ensure local delivery of services in line with the model agreed at Greater Manchester level.

3.8 Stroke
The commissioner will expect providers to support delivery of the Greater Manchester stroke care model, ensuring patients are directed to the hyper acute providers appropriate, and repatriated to local care within the agreed timescales.

3.8 Workforce Development
There is no doubt that our new models of care will need to embrace different workforce models and potentially new roles, responsibilities and patterns of working. The health service is likely to move towards becoming doctor led but not necessarily doctor delivered. As new professional groups emerge, we will be asking our providers to ensure they can provide high quality learning environments, and where appropriate in multi-disciplinary environments for all professionals.

4. Specific commissioning intentions – additional support via GM HSCP

4.1 Population Health
Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health. We want our providers to acknowledge that population health signals a change in the way health care is accessed, provided and utilized and is a move away from reactive responses to an individual's health needs.

We aim to see a fundamental shift towards outcomes-based, proactive approaches to a given population as well as prevention efforts to reduce disparity and variation in care delivery. We will be working with all our providers and GM HSCP to drive this across GM as well as locally. We will be looking for commitment from providers to the principles of early intervention and prevention with particular focus on:

- Improvement of Healthy Life Expectancy and reduction of premature mortality;
- Focus on the causes of our biggest killers; cancer and heart disease, increasing opportunities and support for positive lifestyle change (tobacco, diet and physical activity);
- Commitment to Early Years and Early Help for our children and families;
- Work and Health;
- Resilient, stronger communities using asset based approaches and social prescribing.

4.2 Primary Care
Our Primary Care delegated commissioning function covers core primary medical services across our 39 practices to ensure provision of services under GMS/PMS/APMS contracts to our registered population. Our plans to meet the national Five Year GP Forward View (5YGPFV) and Greater Manchester strategic vision document; "The Primary Care Contribution, Our Primary Care Strategy 2016-2021" are set out in our Primary Care Investment Agreement (PCIA), submitted to GM HSCP

in August 2017. The Strategic Commission will be working with primary care providers in 2018/19 to address 5 workstream themes:

1. Recruitment of Clinical Pharmacists;
2. GP Resilience;
3. Extended Access;
4. Investment in Online Consultation Systems;
5. Development of Care Navigator and Medical Assistant roles within general practice.

We will also be ensuring we deliver the agreed GM HSCP Primary Care Standards in all areas including access and identify how we can improve alignment of primary care services to the Integrated Neighbourhood model. This may give rise to future commissioning on a neighbourhood basis. In addition, activity will adhere to GMMMG guidance or mutually agreed local variation of this where appropriate.

4.3 Mental Health Commissioning

In 2018/9, we will increase investment and continue our plans to deliver the Five Year Forward View for Mental Health and GM Mental Health Strategy in line with our Care Together developments. This will include aligning all mental health services to the five neighbourhoods and increasing integration of mental health practitioners into the teams.

Our priorities for 2018/9 include:-

- Post-diagnostic support for people living with dementia and their families;
- Mental health acute and crisis care capacity and pathways;
- Reducing waiting times for psychological therapies for people of all ages;
- Parity of esteem for people with a learning disability and/or autism who require support for their mental health;
- Bringing people who are currently out of area back closer to home and reducing the need for out of area placements;
- Peer and community support;
- Multi-agency delivery within the Self-care Education College.

4.3.1 Children and young people's mental health

In 2018/9, we will implement the GM Community CAMHS Service Specification across all community providers. This will specify the expectations of Specialist Community Child and Adolescent Mental Health Services (CAMHS) from all GM Providers. It will describe the role, function and responsibilities of service, implementing Greater Manchester agreement to move away from a CAMHS traditional tiered model of delivery to the more flexible, responsive THRIVE model of care.

4.3.2 SEND

We are committed to delivering the SEND reforms and ensure we effectively meet the needs of children and young people with Special Education Needs and/or Disability (SEND). All partners will need to engage effectively to deliver these reforms, which are expected to be tested in the HMI Ofsted and CQC Local Area Inspection in 2018. We will work with partners to develop a SEND strategy, taking further forward the integration of services, including an all age learning disability service.

4.4 Children & Families

The Strategic Commissioning Board has approved the development and piloting of an Integrated Neighbourhood Children's Team to deliver improved outcomes and efficiencies for children and young people and those who care for them. The Integrated Neighbourhood Children's Team Pilot will facilitate provision of, and access to, bespoke person centred holistic solutions, working to the following principles of place based care:

- Integrated local services ensuring collaborative responses to local need;
- Services that build on assets of the community & intervene early in an emerging problem;
- One team, knowing their area and each other;
- Person centered approach within the context of family & community; and
- Services delivered within the community, close to home from a flexible asset base.

As a result, all providers working with children will be called upon to support this development and delivery in 2018/19.

4.5 Cancer

Tameside and Glossop have collectively approved a locality based response to the GM Cancer Plan. In collaboration with the newly created GM Commissioning Hub, the ongoing review of this plan, the leadership of our Cancer Board, plus representation in a number of provider and commissioner focused GM pathways groups, adherence to and delivery of the GM Cancer Plan in Tameside & Glossop will be assured.

Providers are expected to ensure services are delivered in line with the GM Cancer plan and that all necessary standards and targets are met.

4.6 Healthier Together

Tameside & Glossop is part of the South East Sector of the Healthier Together programme, and will engage with commissioners and providers in the sector on the design and delivery of services in line with this programme.

There is a recurrent financial impact of £7.70m for the South East Sector of the Healthier Together programme of which £3.96m relate to stranded costs at Tameside and Glossop Integrated Care NHS Foundation Trust. This is a significant risk which will need to be addressed as part of the GM HSCP Theme 3 Work Stream. We will be working with GM HSCP and South East Sector to ensure appropriate mitigations.

On behalf of Tameside and Glossop, we are looking forward to working with you in 2018/19 to collectively further the delivery of our vision.

I hope you find our commissioning intentions letter helpful. Please do not hesitate to contact us should you wish to discuss the detail further, and my team and I will be more than happy to assist.

With best wishes.

Yours sincerely,

Jessica Williams
Interim Director of Commissioning

cc. Alan Dow, Chair
Steven Pleasant, Accountable Officer

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 12 December 2017

Officer of Single Commissioning Board Jessica Williams, Interim Director of Commissioning

Subject: **INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**

Report Summary: Tameside and Glossop Single Commission have led the development of a locality strategy for Intermediate Care. The Single Commission were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) in December 2017.

Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, this is an interim report to inform the Strategic Commissioning Board of the consultation progress and process, initial themes and the next steps to ensure a final report to the Strategic Commissioning Board January 2018 meeting.

Recommendations: The Strategic Commissioning Board is advised to consider the attached report, which provides detail on the consultation process and the initial themes arising.

The Strategic Commissioning Board is requested to note that the Equality Impact Assessment is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required.

A further report will be received by the Strategic Commissioning Board in January 2018, to determine the way forward.

Financial Implications:

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

Budget Allocation (if Investment Decision)	Proposed recurrent budget of £8,032k, which represents a saving against current expenditure. £1,983k of non-recurrent transformation funding from GM Health and Social Care Partnership is available to fund transition to the new arrangements.
CCG or TMBC Budget Allocation	CCG
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	Option 2 would deliver £0.7m of recurrent savings compared to budget. Savings released in

Avoidance, Benchmark Comparisons	18/19 would be dependent upon timing of notice to Propco and service transfer dates.

Additional Comments

The finance group have reviewed this business case and support implementation of option 2 (as the option presented through the Clinical Commissioning Group consultation process as the preferred option).

£23.2m of transformation funding has been awarded by GM Health and Social Care Partnership to support transformation of health & social care in Tameside and Glossop. £2m of this non recurrent money has been earmarked for developing a new model for intermediate care and funding double running costs. Receipt of this money is dependent upon attainment of stretching quality and financial targets.

With recurrent savings against budget of £0.7m and savings versus the do nothing scenario of £1.7m, only option 2 will allow us to fully deliver these targets and contribute towards the overall economy gap.

It should be noted that while rental payments are factored into the savings above, the strategic commission in Tameside and Glossop has no control over what happens to the property once notice has been served. Shire Hill is owned by NHS Property Services, a limited company owned by the Department of Health who will determine the future of the site and would take the benefit of any future capital receipt.

Legal Implications:

(Authorised by the Borough Solicitor)

An open and transparent consultation process has been undertaken 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. The level of engagement means that it is appropriate that sufficient time is taken to consider all responses appropriately and any necessary changes/mitigations as a response.

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?

Intermediate care has been identified as a key project for the locality as a component of the Care Together model of integrated care.

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. This work is a critical part of the programme

Recommendations / views of the Professional Reference Group:

The Professional Reference Group supported the model outlined in the paper presented in August 2017 and the recommendation to consult on the 3 options for intermediate care in Tameside and Glossop, with option 2 as the preferred option for the Single Commission and Integrated Care Foundation Trust.

Public and Patient Implications:	This report includes the outcome of a 12 week period of public consultation and engagement with communities in Tameside & Glossop. The report includes a full Equality Impact Assessment.
Quality Implications:	A Quality Impact Assessment is in development and will be completed for presentation to the January 2018 meeting of the Strategic Commissioning Board.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of intermediate care 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 (EIA) will be finalised and will be presented as an appendix to the report to the Strategic Commissioning Board in January 2018. The Strategic Commissioning Board is requested to note that the EIA is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required.
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation, as the provider will be Tameside & Glossop Integrated Care NHS Foundation Trust. The GM Safeguarding Standards are included in the Integrated Care Foundation Trust contract.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements and protocols between the parties sending or receiving the data. Beyond that the commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's Information Governance Working Group will be used as a forum to sense check the data flows and Information Governance requirements relating to this project.
Risk Management:	This programme will be managed via the Care Together Programme Management Office and therefore the risks will be reported and monitored via this process
Access to Information :	**Appendix 1** – Pre consultation engagement information sheet. **Appendix 2** – Consultation questionnaire. **Appendix 3** – Intermediate Care Fact Sheet, Frequently Asked Questions and supporting consultation information. **Appendix 4** – Community engagement contacts. The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Commissioning:  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

1 INTRODUCTION

1.1 Tameside & Glossop Single Commission have led the development of a locality strategy for Intermediate Care. The Single Commission were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) in December 2017.

1.2 In August 2017 the Strategic Commissioning Board agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options have been the subject of public consultation over a 12 week period from 23 August to 15 November 2017. In addition to the public consultation, additional community engagement has taken place through contacting specific groups across Tameside & Glossop.

1.3 Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, this is an interim report to inform the Strategic Commissioning Board of the consultation progress and process, initial themes and the next steps to ensure a final paper to the Strategic Commissioning Board January 2018 meeting.

2 BACKGROUND AND THE INTERMEDIATE CARE OFFER

2.1 The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is set out below. This is the definition which has been used in communication, engagement and consultation work referred to in this report.[1]

What is intermediate care? Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

What are the aims of intermediate care? There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered? Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered? A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

2.2 **Proposed Model of Intermediate Care in Tameside & Glossop:** The proposals for Intermediate Care have been prepared jointly by Tameside and Glossop Integrated Care NHS Foundation Trust and the Single Commission and have been designed to support delivery of the commissioning strategy for Intermediate care services. The strategy document describes the aim to support rehabilitation and recuperation, maximising people's ability to function independently, and enabling them to continue living at home in all but most challenging cases. With a requirement for:

[1] http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/NAIC/NAIC%202017/NAIC2017overview.pdf

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need.
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.
- An ability to care for clients with all levels of dementia, in an appropriate setting.

2.3 **Home First:** One of the key principles within the Tameside and Glossop Care Together approach to integrated care is that wherever it is possible for a person to have their care requirements met within their own place of residence, the system will be responsive to meeting this need in a timely manner. This principle is embodied in this proposal for an intermediate care model. In order to be responsive to people's needs and deliver against this principle Tameside and Glossop Integrated Care Foundation Trust has implemented the "Home First" service model. This model will provide a response to meet an urgent/crisis health and/or social care need. Home first is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting, ensuring people are supported in the environment that is suited to their own care needs and most likely to achieve positive outcomes. This supports the intermediate care aims of:

- Helping people avoid going into hospital unnecessarily;
- Helping people be as independent as possible after a stay in hospital; and
- Preventing people from having to move into a residential home until they really need to.

2.4 The Home First offer will ensure that people are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individuals' intermediate care needs can be managed safely in their own home. In some cases there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place.

2.5 **Community Bed Setting - Overview:** The health and social care economy has commissioned community based beds from a range of sources from across the locality. This includes intermediate care beds, spot beds and an arrangement for discharge to assess beds. In order to improve the community bed offer locally a revised model is being proposed in this report. The key principle of the flexible community bed base model is that support will be delivered through location-based community beds providing general nursing whilst encouraging independence and reablement, alongside in-reach from specialist teams such as therapy services, primary care and mental health. This will ensure individual centred management plans based on care needs that support people's transition back home effectively and ensure a smooth transfer of care, when necessary, to the Integrated Neighbourhood. A flexible community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment, rehabilitation, completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care, and facilitate timely 'discharge to assess' for those people not able to be assessed at home, but who do not require acute hospital based care. When home is not an option for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments);
- Step up capacity to avoid acute admission;
- Intermediate Care Capacity;
- Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehabilitation;

- Specialist assessment and rehabilitation for people with dementia.

The model will provide community beds for individuals with dementia who are at risk of being admitted to hospital or remaining in a hospital bed because they are awaiting assessments. At present there is no local provision to meet this requirement outside of the acute settings meaning that these individuals remain in hospital for longer than is necessary.

2.6 **Current Provision:** Tameside and Glossop Integrated Care Foundation Trust is the provider of all intermediate care beds for Tameside and Glossop as of 1 July 2017, and currently provides community beds from two locations: 64 beds in the Stamford Unit at Darnton House[2], which is a 3-floor 96 bedded purpose-built nursing home adjacent to the Tameside Hospital site (the Trust currently uses two floors, one for intermediate care and one for discharge to assess) and 36 intermediate care beds in Shire Hill Hospital located in Glossop.

2.7 **Options for the delivery of bed based intermediate care:** The Single Commission and Integrated Care Foundation Trust identified 3 options for the delivery of Intermediate Care beds. All options were considered alongside the ongoing development and delivery of the Care Together model of care, in particular the Home First model, Integrated Neighbourhoods, the Intermediate / Specialist Community Based Services, and acute hospital based elements of intermediate care.

2.8 On 22 August 2017 the Tameside and Glossop Single Commissioning Board agreed to consult on 3 options for the delivery of Intermediate Care beds, for a period of 12 weeks, commencing 23 August and ending on 15 November 2017. The full set of papers presented to the Single Commissioning Board on 22 August is available on the Clinical Commissioning Group website http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board. A summary of the options is outlined below.

2.9 **Option 1: Maintain Current Arrangements** - Delivery of bed based intermediate care from the Stamford Unit at Darnton House (32 beds) and Shire Hill in Glossop (36 beds).

2.10 **Option 2: Use of available 96 bedded unit** - Transfer of all bed-based intermediate care to a single location in the Stamford Unit at Darnton House.

2.11 **Option 3: Stimulation of the Local Market to Develop Single / Multi Site -** Engagement with local providers to develop capacity within existing care homes, or the development of capacity in new homes. Whilst the benefits of a larger scheme would not be realised, it is possible that in the longer term, once the Integrated Neighbourhoods and Home First models have fully embedded, that there could be a benefit to developing capacity at a neighbourhood level. The maturity of the wider economy may mean that fewer community beds are required, and that services could be developed at a neighbourhood level to meet need.

2.12 **Preferred option:** The Single Commissioning Board approved the proposal that the Single Commission with the Integrated Care Foundation Trust enter into formal consultation based on the 3 options outlined above, stating the case for the preferred option as option 2. The

[2] Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1st July 2016 with the CQC the location of The Stamford Unit at Darnton House. This was to provide a community in-patient facility as part its intermediate care services. Services in the Stamford Unit at Darnton House are accessed via agreed Trust patient pathways and it operates as community wards for medically stable patients who are having their discharge planned and enabled. They form part of services provided by the Trust as a provider of commissioned Acute and Community services for the population of Tameside and Glossop within the Integrated Care Foundation Trust.

information presented to the Single Commissioning Board on 22 August to support the decision is outlined in the table below.

Option 1	The view of the Single Commission and Integrated Care Foundation Trust is that this is not a sustainable model going forwards. The economy is not functioning to its optimum: people are in acute beds that do not need to be, they are in these beds for longer than they need to be, and they are unable to access the services they require at the time they need them. The current arrangements are fragmented – beds are delivered across 2 sites – Shire Hill and the Stamford Unit at Darnton House. At present staff are working from a number of bases, with the expectation that community and neighbourhood staff travel across the locality, diluting the capacity and time that could be inputted with individuals to maximise the potential for returning home promptly. This option does not deliver the vision of a single location for bed based intermediate care.
Option 2	Patient Environment - The Stamford Unit is 100% en-suite single room accommodation with significant communal space on each of the three wards which has been demonstrated to encourage social interaction and independence. Additionally one floor of the Stamford Unit in the Darnton Building has been designed as dementia friendly with access to outside space and wandering routes, which will enable the Trust to provide community beds for patients with Dementia. Accessibility – the Stamford Unit is located in a central location and is co-located close to the Tameside Hospital site and therefore has strong public transport links, ample parking and is accessible for patients and relatives. Additionally, access and short journey times for health care professionals and support services into Darnton Building will enable development of in-reach into the unit as proposed in the model. Recruitment and Retention – recruitment and retention of nursing and support staff at the Shire Hill hospital site is an ongoing risk due to the remote location at the edge of the conurbation Single location – option 2 supports the delivery of bed based intermediate care from a single location to enable the flexible use of community beds to support the Home First model and enable the approaches to Discharge to Assess and Intermediate Care to be flexed depending on the demands in the system at any point in time. Whilst the aim of the home first model is to use the community beds flexibly to meet the demand at any point in time, the notional intermediate care bed figure proposed is 64 beds. Tameside and Glossop Integrated Care NHS Foundation Trust registered from 1 July 2016 with the Care Quality Commission the location of The Stamford Unit at Darnton House. This option meets the national definition of 'intermediate care' from a combination of home and bed-based services and is in line with the recommendations of the Contingency Planning Team report from 2015.
Option 3	This option relies on their being the engagement from providers to invest locally in increasing capacity. Should this be available there would be a lead in time to any new building, which would again require a short term solution until additional bed capacity is developed. There are a number of providers who have indicated their interest in working on developments with the Single Commission so this is something that is possible to negotiate. While the current capacity has been estimated, it is difficult to commit at this time to the capacity that may be required in the economy in 2-3 years' time, which is the information a provider would need in order for providers to invest in new capacity.

3 CASE FOR CHANGE

3.1 A number of factors and service reviews have led to the identification of Intermediate Care as a priority for the Tameside and Glossop locality and the development of the model outlined in this paper and the consultation approved by the Single Commissioning Board on 22 August. This section outlines the case for change presented to the Single Commissioning Board to inform their decision.

3.2 **Intermediate Care – Halfway Home:** The Department of Health's 2009 intermediate care guidance, *Halfway Home*[3] defined intermediate care as follows: *Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.* The initial guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The *Halfway Home* guidance clearly set intermediate care as an integrated part of a continuum or pathway of services, linking:

- health promotion;
- housing;
- low level support services in the community;
- early intervention and preventative services;
- social care;
- primary care;
- community health services;
- support for carers;
- acute hospital care.

The local intermediate care offer described in this paper embraces the philosophy of the Halfway Home guidance, with a focus on delivering care and the required wrap-around support to maximise independence.

3.3 **National Audit of Intermediate Care 2015:** The results of the National Audit of Intermediate Care (NAIC) from 2015 (based on 2013-14 data from providers and commissioners across the locality) identified the following in relation to the Tameside and Glossop intermediate care model (summary / selection of key indicators):

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3 http://webarchive.nationalarchives.gov.uk/20130124050747/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

- An above average investment in intermediate care per 100,000 weighted population (4th highest of the 47 localities which participated);
- Above average beds commissioned per 100,000 weighted population (12th highest);
- Above average investment in bed based care compared with national average (£3.9m against a national average of £2.3m);
- A positive response was provided to 6 of the 13 quality standards;
- A negative response to the commissioning of integrated home and bed based intermediate care services.

The analysis of this report led to the early identification of Intermediate Care as a priority for the developing Care Together programme. A number of developments have taken place, informed in part by this review, which are included in the current model of intermediate care. The National Audit of Intermediate Care is taking place in 2017. The Single Commission and Integrated Care Foundation Trust have participated in the audit to support the ongoing review of the locality's intermediate care system. The Greater Manchester Health and Social Care Partnership has supported the National Audit of Intermediate Care 2017, and have stated a requirement that all 10 localities in Greater Manchester participate.

3.4 **Tameside & Glossop NHS Foundation Trust Contingency Planning Team (CPT) Final Report September 2015[4]:** Price Waterhouse Cooper were appointed by Monitor (the body established to authorise, monitor and regulate NHS Foundation Trusts) to carry out a review of the Tameside and Glossop locality. A report was produced which states that improving the way services are currently delivered, through an innovative, more joined-up approach across Tameside and Glossop, will improve the care patients receive and put Tameside NHS Foundation Trust back on to a sound clinical and financial footing. The Contingency Planning Team worked with a range of stakeholders across the locality to develop proposals for a model of care which included a new Urgent Integrated Care Service. Intermediate Care is described as a key element of the Urgent Integrated Care Service (now developed and implemented as Integrated Urgent Care Team and Home First). One of the features included in the Contingency Planning Team report is that the Urgent Integrated Care Service would be increasingly delivered in people's own homes.

3.5 **Tameside & Glossop Care Together Programme Model of Care:** The Tameside & Glossop Care Together model of care has been developed in response to the Contingency Planning Team report outlined in the section above. The analysis carried out by the Contingency Planning Team, and other reports detailed in this paper, suggest that the current community bed base offer within the intermediate care service is not fit for purpose. The current service does not provide an adequate step up facility and does not offer any capacity for people with dementia or delirium following an acute episode. People remain in an acute bed for significantly longer than necessary, with poorer outcomes. It is expected that the remodelled service will offer improved quality for individuals, resulting in better outcomes and increased chances of returning home. The model described in this report would form a key element of the 'Home First' offer. A priority of the Care Together programme is to support people at home, whenever possible and safe to do so, or in a community bed where home is not appropriate, to avoid unnecessary hospital attendances, admissions and to ensure safe and prompt discharges. Where an admission has been appropriate, a prompt and safe discharge may require a short placement in a community bed for rehabilitation, reablement, recuperation or to facilitate discharge to assess.

3.6 **'Step-Up' facilities:** The level of demand for step beds to avoid admissions is not fully understood, as the decision to admit is usually related to a clinical need, but an alternative option may significantly reduce such admissions. Reviews undertaken in the past by the Emergency Care Intensive Support Team (ECIST) and the Greater Manchester Utilisation

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461261/Final_CPT_report.pdf

Management unit[5] have highlighted an issue with people being in an acute bed when a step up to a nursing bed may have been more suitable and enabled a more accurate assessment of on-going need.

3.7 For people with dementia or delirium, time for recuperation and assessment out of hospital will lead to not only better outcomes but a reduction in length of stay in hospital and reduced risk of premature admission to long term care. Undertaking assessment of people with dementia within an acute hospital setting often leads to inaccurate assumptions being made about their safety to return home, resulting in extended length of stay and increased risk of a permanent residential admission. Intermediate care beds which are staffed to support people with dementia, operating as part of the community bed offer described in this report will enable the assessment and subsequent rehabilitation to be undertaken in a more appropriate location.

3.8 A point prevalence exercise conducted by the Utilisation Management unit in November 2012 at Tameside Hospital (then Tameside Hospital NHS Foundation Trust) showed that 43 out of 272 could have been supported in a community bed-based facility and of these five only had a social need with a further eight having a social and therapy need. Thirteen people needed a level of mental health support with or without other therapeutic and nursing needs. The remaining seventeen required a level of health support.

3.9 The utilisation benchmarking analysis of acute and community beds undertaken in December 2015 identified from a cohort of 133 at Tameside that 68 individuals' needs could be better managed in an alternative care setting. Of these 6 could have been in the current community bed-base facility and a further 30 could have been supported in a more flexible bed-base, 19 with mental health support, 4 with nursing support, 4 with social support and two with stroke rehabilitation support.

3.10 The development of intermediate care services with the appropriate level of home and bed based care supports one of the key priorities identified as part of the Care Together programme – frailty – by reducing length of stay for some of the most vulnerable people and by offering an integrated, wrap around support package. We know that 20% of admissions of older people into hospital are inappropriate (National Audit of Intermediate Care 2015) and that 10 days spent in hospital leads to the equivalent of an additional 10 years ageing in the muscles of people aged over 80 (Giles et al 2004) so it is important that people are supported in a service that offers a therapeutic and reabling environment.

3.11 Current Management of the Urgent Care system: the locality operates a process whereby patient flow and delivery of key access requirements across the urgent care system are routinely monitored. One area which is included within this is the use of the intermediate care system. The current offer is used almost exclusively as step down resource, with little access to the beds for step up support, creating increased pressure on the economy when trying to support people in crisis in the community. This often results in unnecessary hospital admissions that result in significant pressure and cost to the wider economy, and reduces the long term prognosis, particularly for older people. There are also times when although the system is under pressure, there are vacancies in the intermediate care beds, as bed based intermediate care is not what is required for the patients in the system.

4 STRATEGY DEVELOPMENT AND ENGAGEMENT

4.1 The commissioner Intermediate Care strategy outlines national guidance, local expectations of intermediate care, and the action taken over the past 2 years as part of the Care Together programme to refine the Tameside and Glossop locality model. This document outlines the expectations from the Single Commission for the delivery of intermediate care at home

[5] Greater Manchester Utilisation Management Unit: Clinically led analytics service https://www.gmahsn.org/utilisation-management

wherever possible, therefore requiring a clear model of community based care and an appropriate level of bed based intermediate care.

4.2 The Single Commission have reviewed the outputs from previous consultation and engagement on intermediate care and the wider Care Together model to inform the model of Intermediate Care. This includes information extracted from the engagement events facilitated by Action Together and the Glossop Volunteer Centre, and information from Care Together engagement events facilitated by the NHS Benchmark Consulting team during 2014/15.

4.3 A number of engagement activities took place during 2014-2016, through which 602 local people were involved in Care Together and the specific work streams. Action Together, Glossop Volunteer Centre and High Peak Community Voluntary Service used a range of asset based techniques and engaged with a range of other voluntary, community and faith organisations. The methodology used included:

- Focus groups to reach a number service users with who have protected characteristics. 32 sessions where undertaken (15 in Tameside, 18 in Glossop). 330 people were involved.
- Large events which focused on developing a shared understanding of the concepts of Care Together and the development of solutions and aspirations for delivery. There were specific group events (such as the faith sector) and then Neighbourhood based events. Over 100 key community connectors where involved in the neighbourhood based events.
- 1:1 interviews with service users who had experience of the Home First and Discharge to Access Services. In addition, 8 members of staff were also interviewed.

Intermediate care crosses several of the work streams. Key messages from these engagement activities which relate to intermediate care and are addressed by the model described in this paper are:

- We experience health and social care that is disjointed and delivered in silos, and we would welcome more joined up services.
- People strongly support the work being done to co-ordinate and join up services and the importance of multi-agency working […] people want to be treated as individuals not in a one size fits all approach or just by their condition and continuity of care also matters.
- Transport and travel to and from services, including voluntary sector support, is one of the biggest issues and influences how people experience and use services. Community based support is seen as a positive solution to address this.

Comments received which were specific to inpatient (bed-based) intermediate care include:

- Surrounding patients by what they have at home so they are confident to return home i.e. home equipment used not industrial.
- Socialising is an important aspect to recovery. The main socialising happens in the dining room, they help each other. They have a purpose to get up and go to it therefore gets people moving and getting stronger walking, therefore become more independent to go home and stay there.
- Social rehab – helps with stand and transfer (people being stronger on their feet) making cups of teas, talking to people.
- People are able to socialise and make new friends – particularly around shared dining.
- There was a strong feeling that having a similar, medically led, set-up in the community would prevent A&E attendance, and provide a bridge between hospital and home.
- Staff understanding and being aware of individual's needs (not treating everyone the same, with the same routine) especially with rehabilitation.

- A co-ordinated approach to the care – caring together.
- Facilities that are homely to help build confidence that they can cope at home.

4.4 Events were held in May 2014, under the Care Together banner, which were attended by 66 members of staff from across health, social care, independent sector and the 3rd sector. All staff were either providers of intermediate care services, or worked in services forming part of the pathways using the intermediate care services. The objective of the events was to engage staff in sessions which were intended to:

- Achieve a shared understanding of the current pathway for patients requiring the support of intermediate care and associated admission avoidance schemes.
- Identify and prioritise the key issues to be addressed within the project scope regarding the review of intermediate care services and admission avoidance schemes.

In the sessions staff identified a range of issues relating to the delivery of care, including:

- Gap in the system with no 'step up' pathway into intermediate care which means patients are admitted to hospital, and community teams can't refer to the inpatient intermediate care units.
- Patients stay in hospital whilst they are assessed.
- Lack of consistency across the intermediate care units.

The pathway which was produced in the first of these sessions illustrated a system with multiple points of entry and 'hand offs'. The output from these sessions was a business case which illustrated a model of integrated admission avoidance and intermediate care which has informed the current delivery of services described in this report, and which continues to inform the ongoing development of intermediate care services.

4.5 The Commissioning Directorate of the Single Commission have undertaken pre-consultation engagement conversations across the locality with the public and staff. The purpose of these sessions was to understand the views of staff and the public on the current system of intermediate care, and the proposed strategic direction and outcomes we expect to see from the model of intermediate care commissioned. Engagement has taken place with staff, the Patient Neighbourhood Groups, and with a range of stakeholders in the community via Glossop Volunteer Centre and Action Together. Attached at **Appendix 1** is the information which was shared with the groups to inform the discussions.

4.6 The session with staff currently working in the intermediate care system in June 2017 identified the following issues:

- Intermediate care services need to operate in a way which is 'goal driven' and with a clear end point.
- Patients with palliative care needs should not be excluded.
- Intermediate care needs to focus on the physical needs of the individual but also taken into consideration and be able to support the wider emotional needs, including people with mental health needs.
- The environment in which intermediate care is delivered needs to be conducive to interaction with the individual and provide this physical space to enable this.
- The 'step up' offer and admission avoidance element of intermediate care needs to be expanded, with the appropriate level of medical support.

4.7 The 5 Patient Neighbourhood Groups were engaged in the pre-consultation engagement. The general response to the proposed model and outcomes was positive and supportive. Comments received from the groups include:

- Services which patients could have in their own homes either in an attempt to keep them out of hospital, or return home quicker, should be publicised more in; order to make patients and their families/carers aware of these, and how to access them.
- The proposed model of intermediate care covers all elements required - we particularly discussed the use of 'step up' beds and those present felt that GPs should be able to use more step up beds rather than admitting to secondary care.
- Welcome the inclusion of dementia patients within the new model.
- Request that the commissioner considers the position of users of intermediate care in relation to support available at home – consider information to show whether users of services live alone and whether this is taken into consideration when determining an appropriate care plan.

4.8 At the request of the Single Commission, Action Together arranged 7 sessions to discuss the intermediate care proposals. Comments included the need to support people to be independent, but also safe; the model covers the very practical elements of supporting people to live independently but there needs to be a focus on emotional wellbeing, mental health, dementia, as issues that may have an adverse effect on people living independently; the need for a system which doesn't allow people to 'slip through the net'.

4.9 Glossop Volunteer Centre held 9 sessions with a range of stakeholders from the Glossop Neighbourhood to present the intermediate care strategy and proposed outcomes. The response to the proposed offer of intermediate care in people's homes was positive, with assurance requested regarding the need for good communication with patients, practical support, and ongoing monitoring to ensure people are safe. The need for 'bed based' care was acknowledged and supported, but with a preference expressed by a significant proportion of those involved for home based care where possible. The proposed aims and outcomes for intermediate care in Tameside and Glossop were supported unanimously, with the proposed addition of an outcome or aim relating to 'person centred care' and the need to acknowledge support for people once the period of intermediate care has been completed.

5 CONSULTATION PROCESS

Pre-Consultation Engagement

5.1 The report presented to the Single Commissioning Board on 22 August included details of pre-consultation engagement activities, now summarised in section 4 of this report.

Consultation Process

5.2 The Single Commissioning Board approved the proposal that the Intermediate Care service model proposals included options which could lead to a significant change in service delivery and therefore should be subject to a period of formal consultation. This consultation needed to offer local people the opportunity to comment on the proposals and options developed and considered by the Single Commissioning Board and Integrated Care Foundation Trust. The consultation was on the following 3 options:

- **Option 1:** Maintain current status.
- **Option 2:** Use of available 96 bed facility and co-location of all intermediate and community beds as 'flexible bed base' model (Stamford Unit, Darnton House).
- **Option 3:** Stimulation of the market to develop a single / multi-location base.

5.3 The consultation ran from 23 August 2017 to 15 November 2017.

5.4 The online consultation closed on Wednesday 15 November. Paper copies of the questionnaire were accepted until 5pm on Friday 17 November 2017.

5.5 The consultation was hosted on the CCG website in the form of a standard questionnaire (http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation) with an

introduction to explain the reason for the changes followed by a series of questions. A free format text box was included to allow people the opportunity to provide any comments, views and suggestions they wish to be taken into account. A copy of the questionnaire used is attached at **Appendix 2.**

5.6 In addition to the online consultation, paper copies were made available in all 39 GP surgeries across Tameside & Glossop and made available at all public meetings and meetings with community groups. Paper copies were provided to Tameside and Glossop Integrated Care NHS Foundation Trust for sharing with service users. Copies were also made available in all libraries in Tameside and the High Peak area (Glossop, Hadfield and Gamesley). Pre-paid envelopes were also provided for responses to be returned. Each questionnaire returned was given a 'unique reference number' and inputted to the online consultation system, with the reference number included in the response.

5.7 Posters advertising the consultation were produced and distributed across the locality, including to all GP surgeries. Copies of the posters are included at **Appendix 3.**

5.8 A 'Fact Sheet' was developed by the Single Commission and the Integrated Care Foundation Trust which was posted on the Clinical Commissioning Group website consultation page. This sheet was updated throughout the consultation process to reflect questions raised through the public meetings and other community engagement processes undertaken. This Fact Sheet is included at **Appendix 3**.

5.9 A 'Frequently Asked Questions' section of the consultation page on the CCG website was in place from the start of the consultation process, and was expanded throughout the 12 weeks' consultation to include questions raised through the meetings undertaken during the 12 weeks. A copy of the FAQ is attached at **Appendix 3**.

5.10 Four public meetings were held during the period of the consultation. Two were held in the Glossop neighbourhood, one in Droylsden (Tameside) and one in Ashton (Tameside). A report on each of the public meetings can be seen in section 6 of this report. All 4 meetings were filmed and the full recording of the meetings posted on the Clinical Commissioning Group consultation website The recorded attendance figures for each meeting can be seen below:

Meeting Date and Location	Number of Attendees
21st September 2017, Bradbury House, Glossop	92
11th October, Age UK, Ashton-under-Lyne	12
17th October, Guardsman Tony Downes House Droylsden	4
1st November, Glossopdale Community College, Glossop	205

Planning, assuring and delivering service change for patients

5.11 In October 2015 NHS England published an update to the good practice guide for commissioners on the NHS England assurance process for major service change and reconfiguration. The guidance states that 'NHS England's role in reconfiguration is to support commissioners and their local partners to develop clear, evidence based proposals for service reconfiguration, and to undertake assurance as mandated by the Government.[6]

5.12 The guidance includes four tests of service reconfiguration, with an expectation that the proposal satisfies the four tests. The four tests are:

- Strong public and patient engagement
- Consistency with current and prospective need for patient choice
- Clear, clinical evidence base
- Support for proposals from commissioners

[6] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

5.13 There are also four key themes outlined in the guidance for service reconfiguration. These are:

- **Preparation and planning**: planned and managed approach from the start which establishes clear roles, a shared approach between organisations, and builds alignment on the case for change
- **Evidence**: ensure proposals are underpinned by clear clinical evidence and align with clinical guidance and best practice
- **Leadership and clinical involvement**: Clinicians should determine and drive the case for change
- **Involvement of patients and the public**: Critical that patients and the public are involved throughout the development, planning and decision making

5.14 The NHS guidance has been taken into consideration when establishing and running the consultation process described in this paper.

Promotion and Communications

5.15 The Intermediate Care consultation has been promoted extensively since 23 August 2017. In addition to the page on the Clinical Commissioning Group website (http://www.tamesideandglossopccg.org/get-involved/intermediate-care-consultation) the consultation has been shared and promoted in a number of ways, as summarised in the table below.

A webpage hosting the consultation on NHS Tameside and Glossop Clinical Commissioning Group website which includes a copy of the full report presented at Single Commissioning Board, a booklet outlining key information relating to the proposed options, a key factsheet, frequently asked questions and a link to the consultation itself
An email announcing the launch of the consultation was sent on 23 August 2017 to all MPs, Elected Members for both Tameside and High Peak (Glossop), GPs across Tameside & Glossop, Patient Neighbourhood Groups, Patient Participation Groups, Voluntary, Community & Faith Sector umbrella organisations (e.g. Action Together, The Bureau, High Peak CVS, Healthwatch Tameside and Healthwatch Derbyshire) and to over 90 community groups across Tameside & Glossop
Posters have been provided to all GP surgeries across Tameside & Glossop promoting the consultation
Proactive social media messaging on the social media pages of NHS Tameside & Glossop CCG, Tameside Council and T&G ICFT (Twitter, Facebook or Instagram).
Proactive social media messaging specifically advertising the 4 public meetings
A press release from the CCG – this was also included on the Tameside Council and Care Together websites http://www.tamesideandglossopccg.org/news/intermediate-care-review
A link included on Tameside Council's Big Conversation webpage
A link included on Tameside Council's Big Conversation online community which has 249 members
Item in the Chief Executive's Brief for all TMBC and CCG staff, which also includes pension fund and Elected members, all GPs, Practice Nurses and Practice Managers, CCG Board, ECG Board and Mark Tweedie
Item in NHS T&G CCG monthly update which is distributed to GPs, practice managers, practice nurses and all Single Commissioning Function staff
Paper copies of the survey have also been provided to all GP practices across Tameside & Glossop; Tameside & Glossop Integrated Care NHS Foundation Trust to enable consultation with patients at both Shire Hill and those on the Tameside Hospital site who may want to provide their views via a paper survey; all libraries in Tameside and the High

Peak area (Glossop, Hadfield and Gamesley). Paper copies have also been provided to voluntary and community sector organisations upon request; specifically Healthwatch Tameside and The Bureau (Glossop) to date.
Statement from Alan Dow, Chair NHS CCG, sent to the Glossop Chronicle to address concerns from residents who had contacted the paper. 30 August.
Half page feature from Karen James and Steven Pleasant on Intermediate Care and encouraging to take part in the consultation. Tameside Reporter 31 August.
Included on the Information Ambassadors E-Newsletter on 1 September.
Alan Dow, Chair of NHS Tameside & Glossop CCG, provided a radio interview on 7 September to High Peak Radio. This was broadcast at 10:30 and 15:30 on 8 September.
A letter from Alan Dow, Chair NHS CCG, regarding the consultation included in The Reporter (14 September)
Half page advertisements promoting the consultation included in The Tameside Reporter and Glossop Chronicle on 14 September
Further item on Intermediate Care in Chief Executive's Brief on 15 September.
Paper copies of the consultation were available at Tameside & Glossop Integrated Care NHS Foundation Trust's Open Day on Sunday 17 September
Email sent to All GPs encouraging them to place the link to the consultation on their websites and social media pages where they have them.
Social media assets/messages emailed to internal and external comms contacts for use on their channels
Information and the link to the consultation included in Tameside Council's monthly E-News email newsletter for September.
Half page advertisements promoting the public events published in the Tameside Reporter and Glossop Chronicle.
Public meetings have taken place in Glossop on Thursday 21 September, Ashton on Wednesday 11 October, Droylsden on Tuesday 17 October, Glossop on 1st November.
The Glossop Chronicle and Tameside Reporter were invited on a tour of the Intermediate Care facilities on Thursday 21 September.

5.16 In addition to the information included in the section above, and sharing of the information from the Clinical Commissioning Group/Tameside MBC social media accounts by partner organisations and local stakeholders, the consultation received media coverage from:

- ITV Granada Reports
- BBC North West News
- Tameside Reporter and Glossop Chronicle
- Tameside Reporter online – 29 August 2017[7]
- Glossop Chronicle online – 16 September 2017[8]
- Glossop chronicle online – 28 September 2017[9]

Response Rates

5.17 In total, 1,358 responses were received to the online questionnaire hosted on the CCG website.

[7] https://tamesidereporter.com/2017/08/tameside-and-glossop-intermediate-care-consultation-launched/

[8] https://glossopchronicle.com/2017/09/public-meeting-over-shire-hill-hospital-announced/

[9] https://glossopchronicle.com/2017/09/shire-hill-hospital-is-a-godsend/

5.18 Over 1,750 paper questionnaires were issued and **153** returned to the CCG using the pre-paid envelopes provided. These **153** returned paper responses are included in the total number of responses quoted above.

5.19 A full and detailed analysis of the responses to the questionnaire is currently being undertaken and will be produced for the January SCB report.

5.20 Once the full analysis has been undertaken we will be ensuring there is an external validation of the consultation process and analysis.

6 COMMUNITY AND WIDER FEEDBACK

Community and Patient Engagement

6.1 In addition to the consultation hosted on the Clinical Commissioning Group website, and the public meetings, 105 community and patient groups were contacted by the Clinical Commissioning Group directly by letter or email to inform them of the consultation and invite them to be involved. A full list of the groups contacted to inform them of the consultation, and inviting them to participate, is attached at **Appendix 4.**

6.2 On 23 August emails were sent to the community groups identified in **Appendix 4** to confirm the launch of the consultation and invite their involvement. The same email message was sent to a number of stakeholders across Tameside and Glossop, representing statutory and 3rd sector organisations and patient groups.

6.3 Throughout the consultation the Clinical Commissioning Group (through the Care Together Programme Management Office) has maintained a log of all engagement activities undertaken, and all contact with community and patient groups / individuals.

6.4 Action Together and The Bureau (Glossop's Voluntary and Community Network) provided support to the Clinical Commissioning Group in this consultation programme by ensuring that the web link for the consultation documents and online form for residents to have their say was publicised on their websites and social media pages, and that the Clinical Commissioning Group had information on local groups to optimise the community engagement.

6.5 The consultation was presented to a number of Local Authority fora and meetings, as listed in the table below, across the Tameside (Tameside Metropolitan Borough Council) and Glossop (Derbyshire County Council) neighbourhoods.

Executive Board - Tameside Council	14 September 2017	Dukinfield Town Hall
Executive Board - Tameside Council	18th October 2017	Dukinfield Town Hall
Tameside Integrated Care and Wellbeing Scrutiny Panel	14 September 2017	Dukinfield Town Hall
Scrutiny - Derbyshire - Health	18 September 2017	County Hall Matlock
Health and Wellbeing Board – Tameside	21 September 2017	Dukinfield Town Hall
Health and Wellbeing Board – Derbyshire	30 August 2017	Committee Room 1, County Hall, Matlock
Health and Wellbeing Board – Derbyshire	5 October 2017	Committee Room 1, County Hall, Matlock
Community Select Committee (High Peak)	4 October 2017	Café Area, Pavilion Gardens, Buxton.

Dukinfield Town Council	7 September 2017	Lesser Hall 2 - Dukinfield Town Hall
Audenshaw Town Council	12 September 2017	Ryecroft Hall, Audenshaw
Mossley Town Council	20 September 2017	George Lawton Hall, Mossley
Droylsden Town Council	14 September 2017	Guardsman Tony Downes House, Droylsden
Longdendale Town Council	19 September 2017	Hattersley Hub, Hattersley
Stalybridge Town Council	20 September 2017	Stalybridge Civic Hall,
Ashton Town Council	26 September 2017	Tameside Age UK Ashton-under-Lyne,
Denton Town Council	5 October 2017	Denton Town Hall, Denton
High Peak and Derbyshire Councillor Briefing	25 September 2017	Municipal Buildings, Glossop
Joint Trade Union Meeting	13 September 2017	Silver Springs ICFT
Briefing with the Leader of High Peak Borough Council	14 September 2017	Committee Room in the Municipal Buildings, Glossop.

6.6 The consultation was presented to formal meetings of a range of stakeholders, as outlined in the table below:

NHS Tameside and Glossop Clinical Commissioning Group Part A Governing Body meeting	27 September 2017	Dukinfield Town Hall
ICFT Board of Directors Meeting	28 September 2017	Silver Springs, ICFT
GP TARGET session (CCG General Practice engagement and education)	21 September 2017	Curzon Ashton Football, Ashton Under Lyne
Tameside & Glossop GP Practice Managers	19 September 2017	Stamford Park Pavillion
Tameside & Glossop Practice Nurse Forum	4 September 2017	Ashton Primary Care Centre
Ashton Neighbourhood meeting	6 September 2017	Ashton Primary Care Centre.
Glossop Neighbourhood meeting	31 August 2017	Lambgates Health Centre
Hyde Neighbourhood meeting	1 September 2017	Thornley House Hyde
Stalybridge/Mossley Neighbourhood meeting	12 September 2017	Millbrook Practice
Denton Neighbourhood meeting	5 September 2017	Churchgate Surgery

6.7 The consultation was presented to meetings of a number of community and patient groups who responded to the initial invitation to engage, and the offer for Clinical Commissioning Group representatives to attend their meetings. This information is summarised in the table below.

Joint meeting with The Bureau, Healthwatch Derbyshire and High Peak CVS.	7 September 2017	The Bureau, Glossop,
Patient Neighbourhood Group-Glossop	12 September 2017	Lambgates Medical Practice, Wesley Street, Hadfield, SK13 1DJ
Patient Neighbourhood Group – Hyde	13 September 2017	Brooke Surgery Hyde
Patient Neighbourhood Group - Ashton	15 September 2017	Ashton Primary Care Centre
Patient Neighbourhood Group - Dukinfield/ Stalybridge/Mossley	27 September 2017	Millbrook Medical Centre
Glossop Action for Local Older People (GALOP)	3 October 2017	Bradbury House, Glossop
St Mary's Friendship Group In Hyde	24 October 2017	St Mary's Church Hall, Hyde
Age UK Tameside	9 November 2017	Age UK Tameside, Ashton Under Lyne

6.8 A summary of the issues raised in the meetings referred to above is included here. A number of groups and organisations have submitted comments and shared views on the proposals as follows:

- Transport concern over travel time and lack of public transport for those without a car.
- Cost of Public Transport to see loved ones.
- Carer's travel of carers using Intermediate Care.
- Staff and how this affects them.
- Concerns about standard of care in The Stamford Unit.
- Glossop has different needs to Tameside, and should have a different offer.
- Lack of validity of consultation process and consultation literature.
- Ownership of Shire Hill and what will happen to the land should Shire Hill close.
- Glossop is losing another asset.
- Concern of standards of private care homes and the cost.

Positive comments:

- Expressions of understanding of the reasons for the preferred option.

- Support for idea that the intermediate care offer for people in Tameside and Glossop would be clear and would be set out in the discussions regarding people's discharge from hospital care.
- Positive report for care received in the Stamford Unit and for location and facilities.

Tameside & Glossop Integrated Care NHS Foundation Trust

6.9 Tameside and Glossop Integrated Care Foundation Trust were a partner in the consultation process; attending and presenting at all public meetings, providing response to questions received during the consultation process, and providing information to include in the consultation materials hosted on the Clinical Commissioning Group website.

6.10 The Integrated Care Foundation Trust Medical Director, Mr Brendan Ryan, has confirmed his clinical support for the preferred option – Option 2.

Customercare Enquiries

6.11 All enquiries for the Clinical Commissioning Group and Tameside Metropolitan Borough Council, in the form of Freedom of Information requests (FOIs), complaints, MP enquiries / correspondence and general comments, are received and dealt with by the Executive Support team in the Governance, Resources and Pensions directorate.

6.12 During the period of the consultation, the Clinical Commissioning Group have received Freedom of Information Requests (FOIs), complaints and MP enquiries relating to the consultation and intermediate care. All have been acknowledged, and where required, answers provided. Details of these can be seen below.

Enquiry Type & Date	Summary of request	Summary of response
FOI	Request for confirmation of the cost to the commissioner of developing the proposals presented to the Single Commissioning Board on 22 August 2017	A number of officers of the CCG and Local Authority, working with colleagues across Tameside & Glossop (including our clinical leaders) have developed proposals for the model of intermediate care. The paper presented to the Single Commissioning Board on 22nd August was the culmination of a programme of work spanning a number of years, as summarised in section 5 of the document. This work was to support the development of the Care Together model of care. It is not possible to specify exactly how much time and therefore proportion of a number of individuals' salaries has been used in developing this proposal, as this is not the only area of work for officers and managers
MP	Request for further information on the expansion of community services in the Glossop neighbourhood	Response provided with details of plans for the Glossop Integrated Neighbourhood and contact details for the ICFT's Operational Manager leading this work
Complaint	Request for paper copies of the questionnaire	50 copies sent to the complainant as requested
Query / Concern	Views expressed regarding the intermediate care proposals	Response requested submission of the views expressed via the formal consultation process, to ensure views included

Query / Concern	Query regarding potential technical issues with the online consultation	Link checked, and response to confirm there were no technical issues, but to ask for further contact if the issue continued and further support or paper copies required

6.13 During the consultation, the Clinical Commissioning Group received comments from a number of community and patient representatives / members of the public. This contact was made outside the meetings referred to above, and the public meetings. A record was kept of all contact made and the responses provided. In total 60 items of correspondence were received from 45 people. A summary of the issues raised is included in the table below.

Comments	**Response**
Requests were made for public meetings to take place in the Glossop area for residents to meet with senior staff involved in this consultation to gain a greater understanding of the consultation options.	Four Public Meetings were held in both Tameside and Glossop and were held on: 21st September 2017, Bradbury House, Glossop 11th October, Age UK, Ashton-under-Lyne 17th October, Guardsman Tony Downes House Droylsden 1st November, Glossopdale Community College, Glossop
Concerns regarding travel times from Glossop to the Stamford Unit.	Basemap TRACC software has been used to calculate travel times to both Shire Hill and Stamford Unit on the site of Tameside Hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) at both peak and off peak time periods. The software covers all major public transport options including bus, train and tram. TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times. A full assessment of public transport and drive time accessibility has been undertaken as part of our Equality Impact Assessment.
Requests were made for more paper copies of the consultation document to be sent to some GP surgeries in Tameside and Glossop to replenish the copies that were originally sent to every GP surgery in Tameside and Glossop.	All GP surgeries in Glossop received a phone call to check for adequate copies of the paper consultation document. Those needing additional copies were then sent some via the post.
Additional information was requested regarding Home Care Services.	Information was distributed regarding Home Care Service, Urgent Care Service and Emergency Response Teams.

Partnership Engagement Network Conference

6.14 Tameside Council, Tameside and Glossop Clinical Commissioning Group and Tameside and Glossop Integrated Care NHS Foundation Trust have established a Partnership Engagement Network. This will create the framework for the organisations to work in partnership with the public, stakeholders, partners and organisations in the voluntary, community and faith sectors. This structure will involve a wide range of partners and stakeholders and ensure that they are able to play an active role in developing the approaches that we take in the delivery and commissioning of services.

6.15 A key element of Partnership Engagement Network will be a twice yearly conference made up of around 100 representatives from stakeholder organisations and representatives of

groups that represent the public. Best practice and learning will be shared at the conference, and it will be an opportunity for relationships to be built across the multi-agency partnership. The first of these conferences took place on Friday 13 October 2017 at Hyde Town Hall. The conference consisted of introductory talks followed by a series of workshop sessions. The event included a workshop on the Intermediate Care consultation, providing an opportunity to engage with members of the local community.

6.16 This conference was attended by over 60 people from a range of groups across Tameside & Glossop, who all were offered the opportunity to participate in the workshop on the Intermediate Care proposals.

6.17 A summary of the notes from the 2 workshop sessions held at the event on 13th October is included in the table below:

Shire Hill Building
It was highlighted that rationally, option 2 is the best option for quality of care, but emotional ties to the Shire Hill building make rationality difficult. It was mentioned that Shire Hill is not being lost, but that simply the intermediate care beds may be moving.
Glossop residents are sceptical about the future of the Shire Hill building. They are worried it will be turned into housing. *Community services and physiotherapy will all remain in the Glossop Health Neighbourhood. It is not the CCG's decision as to what could happen to the building as it is owned by NHS England.*

Stamford Unit
The Stamford Unit is better for dementia which is a growing issue. It has more specialist staff who struggle getting to Glossop. This means there would be significant financial gains in going with option two, but also a far better quality of care.
Patients from Glossop who receive intermediate care in the Stamford Unit will receive better care. The issue was raised about those who may struggle to see their families, but a Glossop volunteer raised that The Bureau already drive people to and from Shire Hill and the Stamford Unit, and this service would continue.

Home Based Care
It was raised that the full utility of beds depends upon good housing stock. What forward planning is done to help people at home? *Discharge to assess carries out assessments to see what the home environment is like.*
Action Together have been part of the Home First consultation and the ticket home system ensures every patient has a safe and easy journey from hospital to home by ensuring small questions (do you have your house keys? Is there milk in the fridge? Is your gas and electricity on?) are answered by the team to ensure people can get home quicker and their quality of care is improved.
The need to ensure that Home First, Ticket Home, and Intermediate Care work together and ensure the patient is involved in their own journey was raised as important. *One of the advantages of having a Single Commissioning Function is that managers from health, finance, housing and transport can now all have these conversations more easily.*
The plans for home base care are located within the development of integrated neighbourhoods.

Public Meetings

6.18 During the consultation period, four public meetings were held. The details of the meetings and the number of people attending each are included in the table below:

Meeting Date and Location	Number of Attendees
21 September 2017, Bradbury House, Glossop	92
11 October, Age UK, Ashton-under-Lyne	12
17 October, Guardsman Tony Downes House Droylsden	4
1 November, Glossopdale Community College, Glossop	205

6.19 The public meetings were all recorded and the links to the videos uploaded onto the consultation page on the Clinical Commissioning Group website, so that people unable to attend were able to view the events.

6.20 Key points and issues raised at the meetings were captured and are included in the summaries below:

Thursday 21 September 2017, Bradbury Community House, Glossop

- T&G ICFT is difficult to reach via car and public transport from Glossop, Gamesley, Hadfield due to traffic, for visitors and staff who live in Glossop
- In other parts of the country hospitals can be much further away from residents than T&G ICFT is from Glossop
- Some views were that traffic is always bad; other that sometimes traffic is bad, not always
- Glossop is continually having medical (and other) services cut, stop cutting and invest in Glossop
- Is Option 2 predicated on the need to make the already arranged lease of the Stamford Unit financially viable? Why is rent being paid on two buildings
- T&G CCG is biased towards Tameside and against Glossop, they do not recognise that Glossop is different and part of Derbyshire
- The clinical reputation of T&G ICFT is not good
- Population of Glossop is expanding, particularly aging population
- Are the Stamford Unit facilities as good as Shire Hill's when infection prevention is considered, when socialisation of patients is considered, when extra physiotherapy facilities are considered, when the level of urban/rural pollution is considered
- What is the future of the Shire Hill building if the Intermediate Care facilities are closed down?
- Issues with the consultation process/document: the style of the consultation documents are too biased, the consultation process itself is a waste of money that can be used on patients, the consultation is a waste of time as the decision has already been made

Wednesday 11 October, Age UK Tameside, Ashton-under-Lyne

- Currently, are Tameside residents being sent to Shire Hill despite the Stamford Unit being closer
- Will charges be involved in any of the proposed options
- With option 3, would patients have a choice of the location of their care
- Lease signed with healthcare provider by ICFT is the reason for Shire Hill Intermediate Care being closed, the decision has already been made, and the consultation is biased towards this decision
- Shire Hill patients, from Glossop and Tameside, find Shire Hill to be a great location and conducive to recovery, closing Shire Hill and moving Intermediate Care to the Stamford Unit exclusively would be detrimental to the health and wellbeing of Intermediate Care users
- Traveling to Tameside from Glossop is difficult, by car but especially by public transport
- Housebuilding is taking place in Glossop and population is increasing
- Medical services are leaving Shire Hill, dentists, etc. the closure of Intermediate Care at Shire Hill is part of this but also exacerbates the process
- Enough resources to look after people in their own homes as part of care in the

community
- What will happen to staff who currently work at Shire Hill?
- Is the Stamford Unit fit for purpose, is it the best environment for Intermediate Care, i.e. falls, atmosphere etc.

Tuesday 17 October 2017, Guardsman Tony Downes House Droylsden

- Concern over lack of Derbyshire County Council Involvement in the whole process
- Question regarding decrease in number of beds
- Concern from Glossop residents over a difference of care and provision in Tameside and Glossop
- Question regarding user specialist hospitals across Greater Manchester, and will there be a re-design that includes Tameside Hospital
- What will happen to the land that Shire Hill is built on?
- Concerns over consultation process and validity of the literature used for consultation
- Concern about travel time for Glossop based staff should option two be implemented
- Assurance asked from the Panel to make sure that Glossop residents don't receive 'a second rate service'
- Concern about Transport times from Glossop to the Stamford Unit

Wednesday 1 November 2017, Glossopdale School, Glossop

- Transitioning from care into the home and it shouldn't be an hour and a half journey away.
- Concern regarding the validity of the App used for Transport times.
- Suggestion that better communication and partnership working is needed with Derbyshire County Council to put things in place after the outcome of the consultation.
- Issues with the validity of Statistics and data due to being skewed in favour of option two.
- Concern over transport and access if proposed Mottram Bypass is to be implemented.
- Concerns that George Street is being underutilised and has very little public parking.
- Queries regarding the former Darnton Building.
- Queries regarding the number of Intermediate Care beds at the Stamford Unit.
- Concerns regarding re-admission rates from home and transporting patients back to the hospital.
- Concerns about carers and family members having to make long and expensive journeys to see loved ones.
- The ownership of Shire Hill and concerns over future plans of the land if Shire Hill were to close.

6.21 The issues above have been included in the section 5 of this report, which identifies the key themes of the responses to this consultation, and the commissioner response.

Public Petition - Glossop

6.22 In addition to the comments received via the online questionnaire and the methods outlined above, a public petition was created by Glossop Residents and the 'Save our Shire Hill' campaign. This petition was presented by Ruth George MP to the Houses of Parliament.

7 CONSULTATION RESPONSES BY THEME

7.1 Responses to questions 4 – 7 of the questionnaire are being classified by theme, based on commonly mentioned issues and concerns.

7.2 The summary of the community and wider engagement carried out to support the consultation process identifies a number of issues raised and comments made during the discussions with representatives of the Clinical Commissioning Group.

7.3 This section of the report identifies the key themes from issues raised in response to the questionnaire, at public meetings, and through the wider community engagement, and provides a commissioner response to each issue. From the initial analysis of the survey responses, we reflected key themes in the tables below. Further details will be provided in the report presented to the Strategic Commissioning Board in January 2018, following a more detailed analysis and independent review of the consultation process and responses.

7.4 The table below summarises the high level themes identified from the initial analysis of the consultation responses.

CONSULTATION FEEDBACK THEME	DETAIL
TRANSPORT	• Public transport availability • Parking • Journey times (car and public transport)
SHIRE HILL	• Site • Staff
PATIENT CARE	• Safety • Quality of services (Shire Hill, Stamford Unit / T&GICFT, home based, other potential providers) • Staffing issues • Future capacity
GLOSSOP PROVISION	• Intermediate care in the neighbourhood • Community provision • George Street site – Glossop Primary Care Centre
PASTORAL CARE	• Proximity of intermediate care beds to patients' family and carers • Connection with communities
AFFORDABILITY	• Funding of future intermediate care model
CONSULTATION PROCESS	

8 EQUALITY IMPACT ASSESSMENT

8.1 To ensure compliance with the public sector equality duty (section 149 of the Equality Act 2010) public bodies, in the exercise of their functions, must pay 'due regard' to the need to eliminate discrimination, victimisation and harassment; advance equality of opportunity; and foster good relations.

8.2 The Equality Act 2010[10] makes certain types of discrimination unlawful on the grounds of:

- Age;
- Being or becoming a transsexual person;
- Being married or in a civil partnership;
- Being pregnant or on maternity leave;
- Disability;
- Race including colour, nationality, ethnic or national origin;
- Religion, belief or lack of religion/belief;
- Sex;
- Sexual orientation;

These are called 'protected characteristics'.

[10] https://www.gov.uk/guidance/equality-act-2010-guidance#overview

8.3 Tameside and Glossop Clinical Commissioning Group have an additional 4 locally determined protected characteristic group:

- Carers;
- Mental health;
- Military veterans;
- Breastfeeding.

8.4 A copy of the initial EIA presented to the Single Commissioning Board in August 2017 can be seen within the Single Commissioning Board papers from August 22 2017 http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board

8.5 A full Equality Impact Assessment (EIA) will be finalised to support this report and will be presented as an appendix to the report to the SCB in January 2018. SCB are requested to note that the Equality Impact Assessment is a work in progress and will be developed further to ensure it responds to issues raised within the consultation and explores whether additional mitigations will be required.

9 CONCLUSIONS

9.1 In August 2017 the Single Commissioning Board agreed the outline of a model of Intermediate Care for Tameside and Glossop and approved a proposal to carry out a formal consultation on 3 options for the bed based element of Intermediate Care services.

9.2 Extensive consultation has been undertaken over a period of 12 weeks. The initial themes from this are included in this report.

9.3 The Single Commission are confident that the four key themes set out in the NHS England October 2015 guidance on major service change and reconfiguration (see section 5 of this report) have been met as follows.

9.4 **Preparation and planning:** The development of the model for intermediate care – home and bed based – has been a key workstream for the Care Together programme, therefore ensuring a locality based approach between organisations, and ensuring engagement with / involvement of key stakeholders in the delivery of health & social care in Tameside & Glossop. The Clinical Commissioning Group, Tameside Metropolitan Borough Council (Single Commission) and Tameside and Glossop Integrated Care Foundation Trust have led a planned and managed approach to the development of the model and the subsequent consultation process, ensuring engagement with all key partners, the public, and patients.

9.5 **Evidence:** the 'case for change' information included in this report indicates that proposals for intermediate care have been developed based on clear clinical evidence and that they align with clinical guidelines and best practice.

9.6 **Leadership and clinical involvement**: The case for change for the intermediate care model, including the bed-based service model, has been driven by the Care Together programme, with the Integrated Care NHS Foundation Trust, the Local Authority and the Clinical Commissioning Group as key partners in the programme. This has involved working with a wide range of health and social care providers and community organisations / 3rd sector partners. The consultation and engagement work which has been undertaken between 23 August and 15 November has been under the leadership of the Clinical Commissioning Group Chair supported by the Chief Executive of the Integrated Care NHS Foundation Trust, with a significant level of input from local clinicians as document in sections 5 and 6 of this report.

9.7 **Involvement of patients and the public:** The consultation process outlined in sections 5 and 6 provide details of an extensive public and patient engagement in the consultation. Public meetings have been held, in addition to extensive publication and promotion of the consultation to encourage engagement and involvement. Meetings with a wide range of community / 3rd sector groups have taken place as part of the consultation process. The Strategic Commissioning Board meetings, where decisions are taken in relation to commissioning proposals, are public meetings.

9.8 It is recognised that to complement the Intermediate Care bed based services, the community intermediate care and Neighbourhood offers will continue to be developed and implemented, led by the Care Together Programme Board.

9.9 The impact of the proposed model is being fully evaluated and along with the outcome of the consultation will form a comprehensive Equality Impact Assessment which will be presented with the report to Strategic Commissioning Board in January 2018.

9.10 An independent assessment of the consultation process, including the analysis of the results, will be undertaken ahead of the presentation to a full report with recommendations to the January Strategic Commissioning Board.

10 RECOMMENDATIONS

10.1 The recommendations are as presented on the front sheet of this report.

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Appendix 1

Intermediate Care in Tameside & Glossop

The CCG are leading a review of Intermediate Care services in Tameside & Glossop and are seeking advice from patient and public representatives.

The work done so far has been informed to a significant degree by the engagement activities led by our 3rd sector through Action Together and Glossop Volunteer Centre. Comments made through the engagement work to support Care Together have been used to develop the current Strategy which informs the model we commission from Tameside & Glossop Integrated Care Foundation Trust, and the developments which have taken place over the past 18 months. The reports from the sessions have been analysed and any information which relates to intermediate care has been taken and used in the development of the full strategy presented to the CCG/Single Commission committees.

We are seeking further comments on our plans for Intermediate Care.

What is Intermediate Care?

The definition of Intermediate Care included in the National Audit of Intermediate Care 2017 (developed with the assistance of the Plain English Campaign) is as follows.

What is intermediate care?

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system –community services, hospitals, GPs and social care.

What are the aims of intermediate care?

There are three main aims of intermediate care and they are to:

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered?

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

Intermediate care services are currently delivered to the population of Tameside & Glossop CCG by the Integrated Care Foundation Trust as community, hospital and bed-based intermediate care services (the latter at Darnton House and Shire Hill), and by Tameside Metropolitan Borough and Derbyshire County Councils.

Question:	The section below is a summary of the model we intend to commission / deliver in Tameside and Glossop. We would appreciate your comments on whether this is the right model, and any additional suggestions you may have.

Model of Intermediate Care

Intermediate care services provide a crucial role in helping people to avoid going into hospital unnecessarily, helping people to be as independent as possible after a stay in hospital, and preventing people from having to move into a residential or care home until they really need to.

The overall aim of the intermediate care services is to support the rehabilitation and recuperation of patients maximising the patients' ability to function, to enable them to continue living at home in all but most challenging cases.

This should include home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) provided by an integrated team providing both health and social care input based on individual need. The model should also include community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

The delivery model for intermediate care, including the assessment processes, must have the ability to care for clients with all levels of dementia, in an appropriate setting.

The further development of a model for Tameside & Glossop will take account of the outputs from previous audits and reviews, and the learning from the developments which have taken place during 2016-17.

Question:	The section below is a summary of the outcomes we want to achieve from our Intermediate Care model. We would appreciate your comments on whether these are the right outcomes, and any additional suggestions you may have.

Proposed Outcomes

The further development of this Intermediate Care strategy will include the proposal and agreement of a set of system-wide outcome measures to assess the impact on:

- Maximising independence
- Preventing unnecessary hospital admissions
- Preventing unnecessary admissions to long term residential care
- Following hospital admissions, optimising discharges to usual place of residence

Appendix 2

Review of Intermediate Care provision in Tameside & Glossop
(Options for the delivery of bed based Intermediate Care)

NHS Tameside and Glossop Clinical Commissioning Group (CCG) are committed to ensuring the best possible health care is provided for residents in Tameside and Glossop. However we face significant challenges in providing quality services that meet the needs of a growing older population and the increasing number of people with long-term health conditions that need care. In order to meet the health care needs of our population for the future and within the budgets available, the CCG and its partners have reviewed ways to deliver our services. This consultation focuses on how we continue providing a high quality, responsive and accessible Intermediate Care service in Tameside and Glossop in light of increased demand

1. Have you ever used Intermediate Care services in Tameside & Glossop? (Please tick one box only)

☐ Yes (Go to Q2) ☐ No (Go to Q4)

2. When did you last use Intermediate Care services in Tameside & Glossop? (Please tick one box only)

☐ Within the last month

☐ Within the last six months

☐ Within the last year

☐ Within the last two years

☐ More than two years ago

3. Which Intermediate Care facility / services have you previously used? (Please tick all that apply)

☐ Shire Hill

☐ Stamford Unit (on the site of Tameside Hospital)

☐ Grange View

☐ Community services / Reablement e.g. you received treatment from a nurse / physiotherapist etc in your own home

☐ Other (please state)

4. Intermediate Care helps people avoid going into hospital unnecessarily and supports people to come out of hospital as quickly as possible. It helps people stay in their own homes and to keep their independence for as long as possible. The Intermediate Care offer across Tameside & Glossop will include a home-based service, which will give a more intensive amount of care in people's own home. This will be provided by a joint team of social care (carers and social workers) and health professionals (nurses and therapists).

What are your thoughts on a home based Intermediate Care service being provided across Tameside & Glossop? (Please write your comments in the box below)

5. There are three options in our model for how bed based Intermediate Care services could be delivered across Tameside & Glossop in the future. Please tell us what each of these options would mean for you if they were implemented? (Please write your comments in the box below each option)

You can access further information about the Intermediate Care service and each option in our information document available at www.tamesideandglossopccg.org/intermediatecare

Option 1: Maintain current arrangements

This option maintains the number of beds provided at the Stamford Unit (32) within the Tameside Hospital site and maintains the current community beds provided at Shire Hill in Glossop (36 beds). There is also access to 32 'discharge to assess' beds at the Stamford Unit.

- The facilities available at each of the two locations are different and provide differing levels of care, due in part to the location of and facilities available in the buildings.
- This option requires staff to work from a number of locations, with the expectation that community and neighbourhood staff travel across the area reducing the amount of time that can be spent with individuals to help them return home quickly.
- It is our view that this is not a sustainable model for the future.
- Between April 2015 and May 2017; 847 service users stayed at Shire Hill only 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of Stamford Unit.

- Between March 2015 and May 2017; 1,279 service users stayed at Stamford Unit and 96% of them lived with 5 miles of it.
- In the off-peak period, during weekdays, 80% of residents in Tameside and Glossop can reach the Stamford Unit by public transport within 45 minutes, compared to 24% travelling to Shire Hill.

Option 2: All bed-based intermediate care in a single location at the Stamford Unit.

This is our preferred option. All bed-based Intermediate Care would be provided at a single location in the Stamford Unit run by Tameside Hospital on their site in Ashton. The hospital is rated Good by the Care Quality Commission (CQC). The provision of Intermediate Care beds at Shire Hill in Glossop would cease.

- This option provides 64 Intermediate Care beds in the Stamford Unit, Ashton
- If we located all the Intermediate Care beds along with the 'discharge to assess' beds in the Stamford Unit, we would have a dedicated building of 96 beds which could be used flexibly to accommodate daily patient need.
- 27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.
- The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space on each of the three wards. This encourages social interaction and independence and provides space to support rehabilitation and patients' exercises.
- One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia.
- The Stamford Unit is located in a central location in Ashton close to Tameside Hospital. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives.
- Additionally easy access and short journey times for health care professionals and support staff between the Stamford Unit and main hospital will reduce staff travelling time, increase specialist support to all intermediate care beds and enable the development of services in the unit.

Option 3: Develop a scheme of bed based Intermediate Care within local private care homes

This option would require us to work with private care home providers to develop capacity within existing care homes or invest locally in increasing capacity to host bed based Intermediate Care. This option would mean that Intermediate Care beds are not located in one single location but spread out across the area where capacity can be found. This option requires care home providers to be willing to invest in increasing bed spaces and if new care homes were required, a short term solution would be required whilst capacity in the system is built.

6. If you have an alternative option on how the Intermediate Care service could be delivered across Tameside & Glossop in the future please tell us in the box below, Please explain the benefits this alternative option will bring and any financial considerations.

7. Do you have any other comments you would like to make about Intermediate Care services in Tameside & Glossop? (Please write in the box below)

About You

8. Please tick the box that best describes your interest in this issue? (Please tick one box only)

- ☐ A user or previous user of Intermediate Care services in Tameside & Glossop
- ☐ A family member or carer of someone who has used or is using Intermediate Care services in Tameside & Glossop
- ☐ A member of the public
- ☐ An employee of Tameside Council
- ☐ An employee of NHS Tameside & Glossop Clinical Commissioning Group
- ☐ An employee of Tameside & Glossop Integrated Care NHS Foundation Trust
- ☐ An employee of Derbyshire County Council or High Peak Borough Council
- ☐ A community or voluntary group
- ☐ A partner organisation
- ☐ A business / private organisation
- ☐ Other (please specify)

9. What is your home postcode? (Please state)

10. What best describes your gender? (Please tick one box only)

- ☐ Female
- ☐ Male
- ☐ Prefer to self-describe
- ☐ Prefer not to say

11. What is your age? (Please state)

12. Which ethnic group do you consider yourself to belong to? (Please tick one box only)

White

- ☐ English / Welsh / Scottish / Northern Irish / British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (Please specify)

Mixed / Multiple Ethnic Groups

- ☐ White and Black Caribbean
- ☐ White and Asian
- ☐ White and Black African
- ☐ Any other Mixed / Multiple ethnic background (Please specify)

Black / African / Caribbean / Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black / African / Caribbean background (Please specify)

Asian / Asian British

- ☐ Indian
- ☐ Bangladeshi
- ☐ Pakistani
- ☐ Chinese
- ☐ Any other Asian background (Please specify)

Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group (Please specify)

13. What is your religion? (Please tick one box only)

- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ No religion
- ☐ Any other religion, please state

14. What is your sexual orientation? (Please tick one box only)

- ☐ Heterosexual / Straight
- ☐ Gay man
- ☐ Gay woman / lesbian
- ☐ Prefer not to say
- ☐ Prefer to self-describe

15. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

- ☐ Yes, limited a lot
- ☐ Yes, limited a little
- ☐ No

16. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

- ☐ Yes, 1-19 hours a week
- ☐ Yes, 20-49 hours a week
- ☐ Yes, 50+ hours a week
- ☐ No

17. Are you a member or ex-member of the armed forces? (Please tick one box only)

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

18. What is your marital status? (Please tick one box only)

- ☐ Single
- ☐ Married / Civil Partnership
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to say

FACT SHEET

REVIEW OF INTERMEDIATE CARE PROVISION IN TAMESIDE AND GLOSSOP

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)

1. Intermediate Care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of health and social care – community services, hospitals, GPs and social care.

2. Intermediate Care helps people avoid going into hospital unnecessarily, helps people be as independent as possible after a stay in hospital, and prevents people from having to move into a residential home until they really need to.

3. Intermediate Care services are provided by a variety of different professionals, from nurses and therapists to social workers. The person or team providing care will depend on the individual's needs at that time.

4. We deliver Intermediate Care in two main ways. Home First – a range of services which support people in their own home or at a location in their local community. Intermediate Care beds – beds for people coming out of hospital requiring a package of care which cannot be provided at home, or for people who need a short stay away from home for extra support to prevent them needing admission to hospital.

5. In Tameside and Glossop we have invested heavily in recent years in Home First services. We now need to look at the Intermediate Care beds to ensure they are fit for purpose, provide quality care and are affordable. Our plans for Intermediate Care beds are the focus of this consultation.

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

6 When developing our plans we have listened to the public and patients. Over the last two years we've sought your views on how Intermediate Care should be provided.

- **You said** – care should be provided at home first and then via Intermediate Care beds if needed
- **You said** – intermediate care beds should be used to avoid admittance to hospital where appropriate, as well as being used following discharge from hospital.

7 We currently provide 68 Intermediate Care beds across two sites – the Stamford Unit in Ashton next to Tameside Hospital and Shire Hill in Glossop. Both are managed by Tameside Hospital, now called Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

8 Our preferred option is to provide all Intermediate Care beds in one central location at the Stamford Unit in Ashton run by the ICFT, which is rated as Good by the Care Quality Commission (CQC).

9 Our preferred option is to provide 64 beds with the flexibility to use further beds in the Stamford Unit if required, depending on the daily requirement for beds.

10 We're continuing to grow and develop our Home First services which will reduce the need for Intermediate Care beds and avoid unnecessary admissions to hospital, supporting more people to stay at or return to their home.

11 847 people have stayed in Intermediate Care beds at Shire Hill in Glossop over the last two years. 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of the Stamford Unit in Ashton.

12 80% of residents in Tameside and Glossop can reach the Stamford Unit in 45 minutes by public transport compared to only 24% travelling to Shire Hill (weekdays, off-peak)

13 The Stamford Unit offers single room en-suite accommodation, communal space for social interaction, is close to wider services at Tameside Hospital and is modern and up-to-date.

14 One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide Intermediate Care beds for patients with dementia.

15 Have your say on the options for delivering bed based Intermediate Care by completing the online survey at **www.tamesideandglossopccg.org/get-involved/intermediatecare.** You can pick up a paper copy from your local GP or email **TGCCG.communications@nhs.net.**

16 27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSALS AT WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

FREQUENTLY ASKED QUESTIONS

REVIEW OF INTERMEDIATE CARE PROVISION IN TAMESIDE AND GLOSSOP

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)

Q1 Will your decision result in a reduction in the number of Intermediate Care beds across Tameside & Glossop?

A The following table outlines the number of beds currently provided and the number of beds under each option:

	Stamford Unit, Ashton	Shire Hill, Glossop	Private Care Home Providers
Current Provision	32	36	0
Option 1	32	36	0
Option 2	64	0	0
Option 3	32	0	Up to 32

Q2 Why is your preferred option to have all bed-based intermediate care in a single location at Stamford Unit?

A The Stamford Unit is located in a central location in Ashton on the Tameside Hospital site. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives. Additionally it will provide easy access and short journey times for health care professionals and support services between the Stamford Unit and main hospital increasing staff contact time with patients, reducing staff travelling time, increasing specialist support if required which ultimately could reduce the need for any patients to be readmitted into a hospital bed.

The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space. This encourages social interaction and independence.

One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia. If we located all the intermediate Care beds along with 'discharge to assess' beds in the Stamford Unit, we would have a dedicated building of 96 beds which could be used flexibly to accomodate patient needs.

27% of patients from Shire Hill were readmitted back to the hospital as their condition required greater clinical support which cannot be provided at Shire Hill, but is more accessible from the Stamford site. One central location will reduce transfers which fragments the care pathway and creates a poor experience for the patient themselves and their families.

Q3 If 64 of the 96 beds at Stamford Unit are expected to be used for Intermediate Care, what will the other 32 beds be used for?

A The additional 32 beds at the Stamford Unit will primarily be used as discharge to assess beds. However, we have the flexibility to use some of these beds for Intermediate Care if the need arises, due to changes in demand.

Q4 If Intermediate Care beds are transferred to a single location in the Stamford Unit (as per Option 2 of the consultation), what will happen to patients currently based at Shire Hill?

A Intermediate Care services from bed based facilities are usually only delivered for a maximum of 6 weeks. This is not a 'long stay' option. If the location for delivery of bed based services should change as a result of this consultation, the process will be managed very carefully to minimise the number of people who have to be transferred / moved.

Q5 What will happen to the Shire Hill building if Option 2 of the consultation is implemented? Are there any other services provided from here in addition to intermediate care?

A If following the consultation process a decision is made to move the Intermediate Care bed service at Shire Hill, further work would be undertaken to determine future viability of the Shire Hill site. There is a group already working on the review of buildings across the whole of Tameside & Glossop who are aware of this proposal and will provide support on the future use of Shire Hill should the decision be made to relocate the bed based Intermediate Care service to the Stamford Unit.

Q6 Who owns the buildings where Intermediate Care beds are currently provided in Tameside & Glossop?

A The Stamford Unit (Ashton) is owned by L&M who lease the building to Tameside & Glossop Integrated Care NHS Foundation Trust. Shire Hill (Glossop) is owned by NHS Property Services.

Q7 Who will be providing the care for patients?

A Under Options 1 and 2 all care will be provided by staff from Tameside Hospital (Tameside & Glossop Integrated Care NHS Foundation Trust). Under Option 3, some care could be provided by the staff employed by the care home in which the beds are based, but the specialist Intermediate Care will be delivered by staff from Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT), who would travel to the appropriate site (care home) to do so.

Q8 If you relocate the bed based Intermediate Care service as per Option 2 of the consultation, some people may have to travel further to the Stamford Unit site. How can I get there?

A Stamford Unit is situated on the ICFT site (Tameside Hospital) and is accessible via various modes of transport including public transport. A full assessment of public transport and drive time accessibility has been undertaken as part of the Equality Impact Assessment.

Analysis shows that:

- 847 people have stayed in intermediate care beds at Shire Hill in Glossop over the last two years. 40% of them lived within 5 miles of it. 84% of them lived within 5 miles of the Stamford Unit in Ashton.
- 80% of residents in Tameside and Glossop can reach the Stamford Unit in 45 minutes by public transport compared to only 24% travelling to Shire Hill (weekdays, off-peak)

Q9 I believe there have previously been concerns about the quality of services provided at Darnton House (the site on which Stamford Unit now sits). Is this still the case?

A No, since July 2016 the Stamford Unit has been run by the ICFT (Tameside Hospital) which is rated 'Good' by the Care Quality Commission (CQC).

Q10 Is this just about closing services?

A No, we are looking to balance affordability of services with quality and accessibility. We believe our preferred option provides the best care in a modern and patient friendly environment in an accessible, central location.

Q11 If the Intermediate Care beds are transferred to a single location in the Stamford Unit (as per Option 2 of the consultation), what will happen to the other community services currently delivered from Shire Hill?

A Dedicated services provided to Glossop residents such as Physiotherapy and Occupational Therapy will still be delivered in Glossop.

Q12 Is this consultation just about saving money?

A No, this consultation aims to ensure that we have a high quality Intermediate Care which provides effective outcomes, accessibility and affordability so there is a sustainable service for future years. This is about doing what is right for all local people - this is a service for patients across the whole of Tameside and Glossop and has to consider and balance the needs of all. In Tameside and Glossop we have invested heavily in recent years in Home First services. We now need to look at the Intermediate Care beds (the focus of this consultation) to ensure they are fit for purpose, provide quality care, balance accessibility for all and are affordable.

Q13 Will I get the same level of service that I do now?

A Under our preferred option we believe the level of service will improve.

The Stamford Unit is able to provide single room accommodation, each with their own en-suite facilities along with significant communal space. This encourages social interaction and independence.

One floor of the Stamford Unit has been designed to be dementia friendly with access to outside space and wandering routes, which will enable us to provide intermediate care and 'discharge to assess' beds in a unit which is able to support patients with dementia.

The Stamford Unit is located in a central location in Ashton on the Tameside Hospital site. The site has good public transport links, parking facilities, is well known and is easily accessible for patients and relatives. Additionally it will provide easy access and short journey times for health care professionals and support services between the Stamford Unit and the main hospital as required.

A full Quality Impact Assessment has been completed as part of this process.

Q14 Why can't you leave things as they are?

A Tameside and Glossop Clinical Commissioning Group (CCG) are committed to ensuring the best possible health care is provided for residents in Tameside and Glossop. However we face significant challenges in providing quality services that meet the needs of a growing older population and the increasing number of people with long-term health conditions that need care. In order to meet the health care needs of our population for the future and within the budgets available, the CCG and its partners have reviewed ways to deliver our services. We believe that there is a better way of delivering the Intermediate Care service, which is more affordable and will result in better service for patients. We feel that maintaining services as they are currently does not provide this.

Q15 How will my views to the consultation help you make a decision?

A Your views are very important to us in making a decision on how Intermediate Care services will be delivered across Tameside & Glossop in future. The consultation will run for 12 weeks from 23 August 2017 until 15 November 2017. Once the consultation closes, the CCG will analyse all the responses received by the closing date. This feedback from residents, along with a range of other factors including legal and financial considerations, will be taken into account when preparing a final proposal on which option should be implemented.

Q16 How have you calculated how long it takes for people to travel to the locations where Intermediate Care is provided in Tameside & Glossop (i.e. Shire Hill and Stamford Unit on the site of Tameside hospital)?

A A Basemap's TRACC software was used to calculate travel times to both Shire Hill and Stamford Unit on the site of Tameside hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) using public transport at both peak and off peak time periods. This covers all major public transport options across Tameside and Glossop including bus, train and tram.

TRACC was also used to calculate drive times at both peak and off peak time periods, and walk times.

Full details of this public transport, drive time and walk time analysis (including maps) is included in the Equality Impact Assessment.

Q17 Will employees be at risk of redundancy as a result of the outcome of the consultation?

A If a decision is taken to move Intermediate Care beds from Shire Hill formal consultation will commence with staff. We do not expected that there will be any compulsory redundancies for employees irrespective of which option is decided upon and implemented.

Q18 When will the final decision be made?

A It is proposed that a report will be taken to Single Commissioning Board with our recommendations in December 2017. This report will be available on the CCG's website at **www.tamesideandglossopccg.org**

Q19 What about infection control? I've been told that the Stamford Unit does not meet infection control requirements.

A Both the Stamford Unit and Shire Hill meet all the required infection prevention standards appropriate for the services they provide.

Q20 Is the bed-based element of the Intermediate Care service suitable for bariatric weight patients?

A Both the Stamford Unit and Shire Hill will be able to accommodate bariatric patients.

Q21 Who can be cared for in the Intermediate Care beds included in this consultation?

A The intermediate care beds commissioned by NHS Tameside & Glossop Clinical Commissioning Group at the Stamford Unit and Shire Hill are for patients registered with Tameside & Glossop GP surgeries. Patients usually start their care at the Tameside & Glossop Integrated Care NHS Foundation Trust (Tameside General Hospital). However they can also be transferred in where their acute hospital based care may have been delivered elsewhere (e.g. Manchester Royal Infirmary, Stepping Hill Hospital) and they require a period of Intermediate Care before going home. Although, this group of patients is quite small.

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REVIEW OF INTERMEDIATE CARE PROVISION IN TAMESIDE AND GLOSSOP

(OPTIONS FOR THE DELIVERY OF BED BASED INTERMEDIATE CARE)

23 AUGUST – 15 NOVEMBER 2017

Intermediate Care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital.

Your views are important to us in making a decision on how Intermediate Care services will be delivered across Tameside and Glossop.

OUR PROPOSAL IS BASED ON THE BELOW

OPTION 1	OPTION 2 (PREFFERED)	OPTION 3
MAINTAIN CURRENT ARRANGEMENTS	**ALL BED BASED INTERMEDIATE CARE IN A SINGLE LOCATION AT THE STAMFORD UNIT**	**DEVELOP A SCHEME OF BED BASED INTERMEDIATE CARE WITHIN LOCAL PRIVATE CARE HOMES**
• 32 Intermediate Care beds in the Stamford Unit, Ashton. • 36 Intermediate Care beds at Shire Hill in Glossop.	• 64 Intermediate Care beds in the Stamford Unit, Ashton. • Access to the 'discharge to assess' beds at the Stamford Unit meaning a total of 96 beds which could be used flexibly.	• 32 Intermediate Care beds at the Stamford Unit, Ashton. • Up to 32 Intermediate Care beds provided by private care home providers.
• Requires staff to work across locations, reducing time spent with patients. • Facilities available at each site are different and therefore provide differing levels of care. • Not a sustainable model long term.	• One central location, which is easily accessible for patients and staff with good transport links, and removes the need to transfer patients between sites • Access for all Intermediate Care and 'discharge to assess' bed patients with dementia, to the dementia friendly facilities at the Stamford Unit.	• Intermediate Care beds would be spread out across the area where capacity can be found.

Have YOUR say

FIND OUT MORE AND HAVE YOUR SAY ON THE PROPOSAL AT:

WWW.TAMESIDEANDGLOSSOPCCG.ORG/INTERMEDIATECARE

OR PICK UP A PAPER COPY FROM YOUR LOCAL GP

NHS Tameside and Glossop Clinical Commissioning Group

Tameside and Glossop Caretogether Single Commissioning Function

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Appendix 4

Tameside & Glossop Clinical Commissioning Group Intermediate Care Consultation

COMMUNITY AND WIDER ENGAGEMENT: COMMUNITY GROUPS

Access Glossop	Fitoverfifty	Mencap
Action Together	Foodbanks	MIND TOG
Adullam Homes	Glossop Arts project	MS Society
Age Concern Glossop	Glossopdale Furniture Project	National Childbirth Trust Glossop and District
Age UK	Glossop Sure Start Children's	New Life Church Ashton
Age UK Derby & Derbyshire	Glossopdale Street Pastors	Newsdisk
Alzheimer's Association	Glossopdale VIP Group	Outreach Glossop
Amber Trust	Glossopdale Women's Institute	Over 50s Computer Group
Anthony Seddon Centre	Grafton Centre	Over 75s Project
Bare Necessities	Greystones	Padfield Residents Society
Be Well	G52	Parish Church of All Saints Glossop
Blythe House	Healthwatch Derbyshire	Parkinsons Equipment
Branching Out Glossop	Healthwatch Tameside	Patient Advice & Liaison Service
Bridges	High Peak Community Group	Peak Active Sport
CAP Money Course	High Peak Community Safety Partnership	Peak Film Society
Cascade Baby Bundles	High Peak CVS	People First
Central Methodist Church Hyde	High Peak Disability Sport	Probation service Public Health
Change Grow Live	High Peak Fibromyalgia& ME CFC Support Group	Reuben's Retreat
Church of the Nazarene	High Peak Foodbank	Samaritans Buxton
Citizens Advice Bureau	High Peak Learning Disabilities Team	SSAFA
Countryside Volunteers	High Peak MS Support Local Contact	St Charles RC Church
Cranberries	High Peak Night stop	St Marys RC Church
Crossroads	High Peak Prostate Cancer Support Group	Stockport Cerebral Palsy Society
Deaf & Hearing Support	High Peak ROKPA	Stroke Association
Dementia Friendly Glossop	Home Start High Peak	Tameside & Glossop MIND
Derbyshire Alcohol Advice Service	Hyde Bangladeshi Welfare Association	Tameside & Glossop NHS Trust
Derbyshire Carers	Hyde Community Action	Tameside & Glossop Stroke Information & Support Group
Do Sport UK	Infinity Initiatives	Tameside African Refugee Association
Elim Church	Jericho Café	Tameside Carers Association
Enable Housing Association	Khush Amdid	Tameside Sight
Europia	Life you Choose	TASCA
Fairplay	Making Space	The Helping Hand Hyde

Dementia Action Alliance	Trinity Church Audenshaw	Whitfield Parish
Tameside and Glossop Dementia Action Alliance	Volunteer Centre	West African Development
Tameside Armed Service Community (TASC)	Volunteer Centre Glossop and District	Write From the Heart
Tameside Fibromyalgia & ME/CFS Support Group	Timeswap Time Bank	Youth Forum

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 12 December 2017

Officer of Strategic Commissioning Board Gideon Smith, Consultant in Public Health Medicine

Subject: **COMMUNITY HEALTH CHECKS CONTRACT EXTENSION**

Report Summary:

The NHS Health Check is a national programme of systematic prevention that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease.

The overall aim of this Community Health Checks Service is to provide the community element of an integrated NHS Health Checks Programme to people in various community settings across Tameside that will improve health outcomes and the quality of life of the Tameside eligible population.

The Be Well Tameside Service contract forms part of the Tameside and Glossop CCG contract with Pennine Care which is due for review and renewal from April 2019. An extension to the current Community Health Checks Programme contract to March 2019 will enable an incorporation of this contract into the Wellbeing Service contract.

The NHS Health Checks Programme is a priority as outlined in the GM Devolution Public Health Programme and is a mandated service within the Public Health Grant. A contract extension for 2017/18 was requested to enable there to be time for the GM strategic direction on the 'Find and Treat' programme, which includes NHS Health Checks. To date the GM strategic direction for NHS Health Checks has not been finalised, but options currently being discussed are consistent with the current local service model.

Recommendations:

That Strategic Commissioning Board approve the extension of the Community Health Checks Programme contract for 12 months until 31 March 2019 to enable the alignment to the commissioning intentions of the Greater Manchester Partnership.

Financial Implications:

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

Budget Allocation (if Investment Decision)	£95,900
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	SCB

Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	Future health service demand avoidance.

Additional Comments

The proposed further one year extension to the existing contract will allow additional time to assess the future neighbourhood model that is planned to be in place from 1 April 2019 in line with Greater Manchester proposals and the new locality Wellbeing Service contract.

Section 3.1 of the report states that the existing contract is on target to deliver the outcomes within the contract specification. Performance is not therefore deemed to be an issue.

Members should note that this contract has been extended on two previous occasions as explained in section 1.3. It would no longer be cost effective to retender the contract due to the service provision intentions from April 2019.

However this may now have been an option to consider at the time of the initial extension request in June 2016 as it may have realised potential savings on the annual contract value.

Legal Implications:

(Authorised by the Borough Solicitor)

In the circumstances it would not be cost effective to retender the contract at this time given the intention to allow retendering aligned to the commissioning intentions of the Greater Manchester Partnership. There are apparently no issues with the performance of the contract which is reported to be operating well and delivering against agreed objectives.

How do proposals align with Health & Wellbeing Strategy?

The service supports the Health and Wellbeing Strategy vision supporting the domains of working well and living well and addresses health inequalities by contributing to achieving the Health and Wellbeing Board 'Turning the Curve on Blood Pressure' aspiration to increase the percentage of people with hypertension known to their GP.

How do proposals align with Locality Plan?

The Service will sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from the rise in obesity and sedentary living, and reduce the gap between Tameside and England.

How do proposals align with the Commissioning Strategy?

The overall aim of this service is to provide the community element of an integrated NHS Health Checks Programme to people in various community settings across Tameside that will improve health outcomes and the quality of life of the Tameside eligible population. This will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability. This service continues to fulfil this aim and is targeting those most at risk.

Recommendations / views of the Professional Reference Group:	This paper has not been received by the Health and Care Advisory Group.
Public and Patient Implications:	In November 2015 the current provider team was successful in winning the 'Best Impact on Patient Experience' Award at the National Heart UK Health Check Awards. The service aims to enable and support self-care.
Quality Implications:	The Community Health Check service has been subject to routine quarterly performance management and monitoring. All the performance data is available if required.
How do the proposals help to reduce health inequalities?	The service contributes to achieving local outcomes to: • Reduce CVD mortality in Tameside at a rate faster than the national average. • Make a significant contribution towards reducing health inequalities within the Borough (including socio-economic, ethnic and gender inequalities) by improving the identification and management of people in disadvantaged communities.
What are the Equality and Diversity implications?	The Community Health Check service targets vulnerable and hard to reach populations to increase the overall take-up of NHS Health Checks in the Borough in order to improve health outcomes and the quality of life of the Tameside eligible population.
What are the safeguarding implications?	None.
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. BACKGROUND

1.1 The NHS Health Check is a national programme of systematic prevention that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease. It is aimed at people aged 40-74 who have not been previously diagnosed with one of these conditions (including hypertension) and consists of a face to face individual risk assessment followed by risk management advice and interventions.

1.2 Local NHS Health Checks have been delivered through a General Practice (GP) Local Enhanced Service (LES) since the start of the programme in 2010. This involves GPs sending invites to eligible patients on their practice list inviting them to attend.

1.3 In June 2014, following a competitive tender, a two year contract to provide NHS Community Health Checks was awarded to Pennine Care Foundation Trust. The contract included the option, subject to agreement between the parties, to extend for up to a further one year. Following a report to the Single Commissioning Board in June 2016 the option to extend the contract for 12 months was exercised and the contract was extended until 30 June 2017, and further extension to 31 March 2018 was agreed in February 2017. The contract includes a three month no fault termination clause. The contract commenced on 1 July 2014 and has an annual value of £95,900.

1.4 The Community Health Check service targets vulnerable and hard to reach populations to increase the overall take-up of NHS Health Checks in the Borough in order to improve health outcomes and the quality of life of the Tameside eligible population. The programme will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability.

2. GM CONTEXT

2.1 The NHS Health Checks Programme is a priority as outlined in the GM Devolution Public Health Programme and is a mandated service within the Public Health Grant. Each Council within GM currently commissions a local programme, and local leads meet together regularly with Public Health England NW to review practice and performance, implementation of new guidance and strategic direction.

2.2 The contract extension for 2017/18 was requested to enable there to be time for the GM strategic direction on the 'Find and Treat' programme, which includes NHS Health Checks, to inform the implementation of the local Neighbourhood model of care, so that any revisions of the Community NHS Health Checks programme could be included in the specification for subsequent retendering.

2.3 To date the GM strategic direction for NHS Health Checks has not been finalised, but options currently being discussed are consistent with the current local service model.

3. LOCAL CONTEXT

3.1 The contract is working effectively with Pennine Care NHS Foundation Trust achieving objectives set out in the agreed service specification. The Community Health Check service has been subject to routine quarterly performance management and monitoring. The service has proved to be very successful in reaching the target demographic and increasing the take-up of health checks. The service is on target to deliver 2261 health checks and mini MOT's as required for 2017/18. The proposal for the continued delivery of the Service will complement the delivery of health checks within primary care and ensure that targets are met.

3.2 Following the review of services to develop a comprehensive local Wellness offer to support lifestyle change, including access by hard to reach groups, the Community Health Checks programme forms a key part of the Be Well Tameside Service as part of the Neighbourhood model of care within the Care Together programme.

3.3 The Community Health Checks service made an important contribution to the achievement of the CCG Quality Premium target in 2016/17, delivering 19% of the total activity in the year. The service was able develop direct support to practices who could send invitations but had limited capacity to provide the checks.

3.4 The Be Well Tameside Service contract forms part of the CCG contract with Pennine Care which is due for review and renewal from April 2019. An extension to the current Community Health Checks Programme contract to March 2019 will enable an incorporation of this contract into the Wellbeing Service contract.

4. PROPOSAL

4.1 The overall aim of this service is to provide the community element of an integrated NHS Health Checks Programme to people in various community settings across Tameside that will improve health outcomes and the quality of life of the Tameside eligible population. This will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability. This service continues to fulfil this aim and is targeting those most at risk.

4.2 The Service will sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from the rise in obesity and sedentary living, and reduce the gap between Tameside and England.

4.3 Tameside and Glossop face a very significant challenge to reduce premature deaths from cardiovascular disease. NHS Health Checks identify early vascular disease, particularly cardiovascular disease, and provide a cost-effective approach to enabling behaviour change and access to follow up and treatment that reduces risk of future illness.

4.4 The contact is subject to regular efficiency review, and required activity has been increased from 2000 in 2016/17 to 2261 for 2017/18. A fuller review that takes into account the GM strategic direction for NHS Health Checks, national guidance and experience, as well as local learning from the Community Health Checks Service and Primary Care Quality Premium, will be undertaken in the context of the planned incorporation into the Wellbeing Service contract.

5 RECOMMENDATIONS

5.1 As detailed on the cover of this report.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	12 December 2017
Reporting Member / Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**EXTENDED ACCESS SERVICE AND OUT OF HOURS – CONTRACT VARIATIONS TO EXTEND**

Report Summary:

The Extended Access Service (EAS) has been in place as a pilot contract since 1 December 2015 and has been extended once during this period. The contract is provided by Orbit, GP Federation in partnership with GTD (GoToDoc). The previous extension was for 12 months to bring the contract end date to 30 November 2017. The service delivers access to general practice services for all patients across Tameside and Glossop, offering pre-bookable appointments for same day and routine access.

The Extended Access Service contract is now due for renewal and this paper requests approval to further extend the existing contract to the 30 September 2018.

Clinical Commissioning Group records show that the Out of Hours (OOH) contract has been in place since (at least) 2011. The current contract period is due to end on the 31 March 2018 and this paper requests approval to further extend the existing contract to 30 September 2018 to align the contract end date to that of the Extended Access Service.

The rationales for the extensions are that Extended Access Service and Out of Hours are fundamental elements of our Urgent Care plans for the future. These plans are currently being widely consulted on across Tameside and Glossop and our future commissioning requirements will only be clarified once the outcome of the consultation is known, anticipated at the end of February 2018.

Recommendations:

The Strategic Commissioning Board is asked to:

1. Approve the request to extend the Extended Access Service contract to 30 September 2018.
2. Approve the request to further extend the existing Out of Hours contract to 30 September 2018 to align the contract end date to that of the Extended Access Service.
3. Note that a detailed report will be received in January 2018 to outline the procurement process for these services and the relative benefits and risks to consider in making this decision.

Financial Implications:

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

Budget Allocation (if Investment Decision)	£807k annual cost of Extended Access Service and £1,774k cost of Out of Hours is consistent with the CCG's current recurrent budget.

CCG or TMBC Budget Allocation	CCG
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	Short term extension would be cost neutral.
Additional Comments The finance group have reviewed this business case. Recurrent budget to cover a short term extension of contracts is already in place. Extension of the contract allows time to ensure that the long term solution for urgent care is properly aligned to strategic intent and to assess contribution to the closing the economy financial gap.	

Legal Implications:

(Authorised by the Borough Solicitor)

In the circumstances it would not be cost effective to retender the contract at this time given the ongoing consultation exercise. Given the date of the request there is insufficient time to go out to tender in any event as the contract is technically expired already.

There are stated to be no reported issues with the performance of the contracts which are reported to be operating well and delivering against agreed objectives.

To mitigate the risk of challenge it would be advisable to advertise the intention to procure a replacement service via the issue of a prior information notice published in accordance with the Public Contracts Regulations 2015. Bidders are less likely to challenge the extension of a contract where there is a further procurement exercise envisaged.

How do proposals align with Health & Wellbeing Strategy?

Improving access for the whole population to access primary and urgent care services is a key outcome of this workstream.

How do proposals align with Locality Plan?

Integrated place-based system working with cooperation between providers, with key commissioning outcomes including economic benefit, resilience and improving access.

How do proposals align with the Commissioning Strategy?

Urgent Care proposal currently out to consultation sets out the detailed plans for how Urgent Care will be accessed and delivered in the future. Extended Access and Out of Hours are key components of this overall model of delivery,

	therefore future contracting will be key to enabling integrated working between providers and to align systems which will see direct improvements to care for patients.
Recommendations / views of the Health and Care Advisory Group:	This report has not been presented to the Health and Care Advisory Group.
Public and Patient Implications:	None – no change to current service provision.
Quality Implications:	None – no change to current service provision.
How do the proposals help to reduce health inequalities?	None – no change to current service provision.
What are the Equality and Diversity implications?	None – no change to current service provision.
What are the safeguarding implications?	Retaining current provision of access to primary care for registered and unregistered patients, whilst the Urgent Care consultation takes place and any subsequent commissioning actions are carried out in line with governance and due process.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	N/A
Risk Management:	A further detailed paper will be presented to the Strategic Commissioning Board in January 2018 to set out the procurement options for these services. The requested contract extensions will allow sufficient time for an informed decision and action to be taken regarding the future commissioning of these services, whilst we also await the outcome of the UC consultation that is due to run to the 26 January 2018.
Access to Information :	The background papers relating to this report can be inspected by contacting Janna Rigby, Head of Primary Care:  Telephone: 07342 056001  e-mail: janna.rigby@nhs.net

1. BACKGROUND

Extended Access Service

1.1 The Extended Access Service (EAS) has been in place as a pilot contract since 1 December 2015 and has been extended once during this period. The contract is provided by Orbit, GP Federation in partnership with GTD (GoToDoc). The previous extension was for 12 months to bring the contract end date to 30 November 2017.

1.2 The service delivers access to general practice services for all patients across Tameside and Glossop, offering pre-bookable appointments for same day and routine access.

1.3 The original contract had a fixed period of 12 months to the 30 November 2016. In November 2016, Primary Care Committee noted that an extension had been agreed for a further 12 months while due to the Greater Manchester evaluation not taking place until March 2017. During the extension period plans were developed around urgent primary care, of which the Extended Access Service is an element.

1.4 During that period much work has been done to report progress of the proposal for a future Urgent Care model. A full 12 week consultation began on the 1 November 2017 and will run until the 26 January 2017. The outcome of the consultation will determine the future model of delivery of Extended Access, Out of Hours, Alternative to Transfer services. Commissioning in advance of the consultation would therefore not be ideal.

1.5 The contract term has been managed as follows:

1/12/2015 – 30/11/16	Initial contract period
1/12/16 – 30/11/17	12 month extension
1/12/17 – 30/9/18	10 month extension (requested)

1.6 The Extended Access Service contract is now due for renewal and this paper, based on the reasons stated above requests approval to further extend the existing contract to the 30 September 2018.

1.7 As noted above, the contract has been extended previously and to date this action has not received challenge from the market. It is therefore proposed that a further 10 month extension is granted, along with the rationale provided.

Out-of-Hours

1.8 Clinical Commissioning Group records show that the current Out of Hours (OOH) contract has been in place since 2010. The contract is provided by GoToDoc. The contract term has been managed as follows:

1/4/2010 – 31/3/15	Initial contract period
1/4/15 – 31/3/16	12 month extension
1/4/16 – 31/3/17	12 month extension (current)
1/4/17 – 30/9/17	3 month extension (requested)

1.9 The current contract period is due to end on the 31 March 2018 and this paper requests approval to further extend the existing contract to 30 September 2018 to align the contract end date to that of the Extended Access Service. This will tie in with the plans to align each of the services within the future model of delivery of extended access, Out of Hours and Alternative to Transfer services as part of the wider Urgent Care system. Commissioning in advance of the consultation would therefore not be ideal.

1.10 As noted above, the contract has been extended previously and to date this action has not received challenge from the market. It is therefore proposed that a further 3 month extension is granted, along with the rationale provided.

2. RATIONALE

2.1 The rationale for the extensions are that the Extended Access Service and Out of Hours are fundamental elements of our Urgent Care plans for the future. These plans are currently being widely consulted on across Tameside and Glossop and our future commissioning requirements will only be clarified once the outcome of the consultation is known, anticipated at the end of February 2018.

2.2 In order to ensure continued provision of the Extended Access and Out of Hours Services especially over the challenging winter months, an extension is proposed for the existing contract holders. This will allow sufficient time to understand the outcome of the consultation, run an effective procurement process for the new service and enable a new provider to take on the contract should this be appropriate.

2.3 The extension for the Extended Access Service would be for 10 months, from 1 December 2017 to 30 September 2018 and six months for the Out of Hours, from 31 March 2018 to 30 September 2018. It is not expected that any further extensions will be offered on these contracts.

3. SUMMARY OF THE EXTENSIONS

	Extended Access Service	**Out of Hours Service**
Provider	Orbit (GP Federation) and GoToDoc	GoToDoc
Extension period	1/12/17 – 30/9/18	31/3/18 – 30/9/18
Annual contract value	£807,000	£1,774,000

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

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