STRATEGIC COMMISSIONING BOARD

Day: **Tuesday**
Date: **20 March 2018**
Time: **2.00 pm**
Place: **Lesser Hall 2 - Dukinfield Town Hall**

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Strategic Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 20 February 2018.	1 - 10
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND - MONTH 10 2017/18** To consider the attached report of the Director of Finance.	11 - 28
5.	**QUALITY CONTEXT**	
a)	**QUALITY FRAMEWORK** To consider the attached report of the Director of Safeguarding and Quality.	29 - 54
6.	**COMMISSIONING FOR REFORM**	
a)	**INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP** To consider the attached report of the Interim Director of Commissioning.	55 - 226
b)	**PRIMARY CARE ACCESS SERVICE** To consider the attached report of the Interim Director of Commissioning.	227 - 234
c)	**APPROVAL OF ADULT SOCIAL CARE FEES (EXCLUDING CARE HOMES 2018-19)** To consider the attached report of the Assistant Director (Adult Services).	235 - 252
d)	**CARE HOMES: NEW CONTRACT AND CHANGES OF POLICY** To consider the attached report of the Assistant Director (Adult Services).	253 - 306
e)	**POPULATION HEALTH INVESTMENT FUND** To consider the attached report of the Interim Assistant Director of Population Health.	307 - 334

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.

f) PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF LIFTS 335 - 338

To consider the attached report of the Assistant Director (Adult Services).

7. URGENT ITEMS

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

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on Tuesday 17 April 2017 commencing at 2.00 pm.

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

TAMESIDE AND GLOSSOP
STRATEGIC COMMISSIONING BOARD

20 February 2018

Commenced: 2.00 pm **Terminated: 3.30 pm**

Present: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Steven Pleasant – Tameside MBC Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Councillor Leanne Feeley – Tameside MBC
Councillor Jim Fitzpatrick – Tameside MBC
Councillor David Sweeton – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Dr Alison Lea – NHS Tameside and Glossop CCG
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Dr Vinny Khunger – NHS Tameside and Glossop CCG
Carol Prowse – NHS Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance & Pensions
Gill Gibson – Director of Safeguarding and Quality
Tracey Simpson – Deputy Chief Finance Officer
Alison Lewin – Deputy Director of Transformation
Sarah Dobson – Assistant Director, Policy, Performance & Communications

Apologies: Councillor Jean Wharmby – Derbyshire CC
Councillor Tony Ashton – High Peak BC

27. DECLARATIONS OF INTEREST

There were no declarations of interest submitted by Members of the Strategic Commissioning Board.

28. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 30 January 2018 were approved as a correct record.

29. ONE EQUALITY SCHEME (2018-22)

Consideration was given to a report of the Director of Governance explaining that the One Equality Scheme was the first joint equality scheme of the Tameside and Glossop Strategic Commission (Tameside Council and NHS Tameside and Glossop Clinical Commissioning Group.

The report provided an update on the development of the One Equality Scheme, including the draft for engagement with stakeholders attached to the report as Appendix 1, and its role in helping satisfy obligations under the Specific Duties / Regulations of the Public Sector Equality Duty (Section 149 of the Equality Act 20110) which would not be undertaken jointly as a Strategic Commission.

The report outlined the next steps in terms of engagement with stakeholders and governance leading to formal adoption of the One Equality Scheme by both organisations at The Clinical Commissioning Group Governing Body in May 2018 and Tameside MBC Executive Cabinet in June 2018.

RESOLVED

(i) That the content of the report be noted;

(ii) That the next steps outlined in the report for engagement with stakeholders and governance be agreed.

30. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a jointly prepared report of the consolidated financial position of the economy providing a 2017/18 financial year update on the month 9 financial position at 31 December 2017 and the projected outturn at 31 March 2018. The total Integrated Commissioning Fund was £486m in value. However, it was noted that this was subject to change as new inter authority transfers were actions and allocations amended.

Particular reference was made to details of the summary 2017/18 budgets, net expenditure and forecast outturn of the Integrated Commissioning Fund and Tameside and Glossop Integrated Care NHS Foundation Trust. Supporting details of the forecast outturn variances were explained within Appendix A to the report. Members of the Strategic Commissioning Board noted that there were a number of risks that needed to be managed within the economy during the current financial year, the key risks being:

- Significant budget pressures for the Clinical Commissioning Group relating to Continuing Care related expenditure of £4.3m.
- Children's Services within the Council was managing unprecedented levels of service demand currently projected to result in additional expenditure of £7.8m when compared to the available budget.
- The Integrated Care Foundation Trust was working to a planned deficit of £24.5m for 2017/18 and that efficiencies of £10.4m were required in order to meet this sum.

A summary of the financial position of the Integrated Commissioning Fund broken down by directorate was provided in Table 2 and outlined in more detail at section 2.

In terms of the 2017/18 efficiency plan, the economy had an efficiency sum of £35.1m to deliver of which £24.7m was a requirement of the Strategic Commissioner. Supporting analysis of the delivery against this requirement for the whole economy was provided at Appendix A to the report. It was noted that there was a forecast £4.1m under achievement of this efficiency sum by the end of the financial year, £3.6m of which related to the Strategic Commissioner. It was therefore essential that additional proposals were considered and implemented urgently to address this gap on a recurrent basis thereafter.

The Strategic Commission risk share arrangements in place for 2017/18 were also outlined.

RESOLVED

(i) That the 207/18 financial year update on the month 9 financial position at 31 December 2017 and the projected outturn at 31 March 2018 be noted.

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

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

31. PERFORMANCE REPORT

The Assistant Director Policy, Performance and Communications, outlined the health and care performance update using the new approach agreed in November 2017. The report covered:

- Health & Care Dashboard – including exception reporting for measures which were areas of concern, i.e. performance is declining and/or off target;
- Other intelligence / horizon scanning – including updates on issues raised by Strategic Commissioning Board members from previous reports, any measures that were outside the dashboard but which Strategic Commissioning Board were asked to note, and any other data or performance issues that Strategic Commissioning Board needed to be made aware;
- In-focus – a more detailed review of performance across a number of measures in a thematic area.

The approach and dashboard were aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group. Particular reference was made to the Health & Care Dashboard attached to the report at Appendix 1, and the table below highlighted which measures were for exception reporting and which were on watch.

EXCEPTIONS (areas of concern)	1	A&E 4 hour wait
	4	Diagnostics
	21	Psychosis 2 weeks
ON WATCH (monitored)	2	Delayed Transfer of Care
	39	Direct Payments
	40	Learning Disability
	44	65+ at home 91days

Further detail on the measures for exception reporting was provided in the report and at Appendix 2.

In relation to other intelligence / horizon scanning the Strategic Commissioning Board was asked to note data and performance on the following:

- 'Winter crisis' including A&E and Influenza;
- Impact of cancelled elective activity;
- Digital Health Centre / Community Response Service;
- Moderately / severely frail with personalised care plan; and
- NHS111.

In addition, the thematic focus area was primary care and the headlines were summarised for five key areas which reflected either their current national topical nature or seasonal relevance. It also set out the detail of the performance dashboard used to monitor the 39 practices and future plans and developments to extend and enhance the reporting functionality and presentation of local data to provide a holistic view to practise.

RESOLVED

(i) That the content of the report and in particular those areas of performance currently off track and need for appropriate action to be taken by provider organisations be noted.

(ii) That the ongoing development of the new approach to monitoring and reporting performance across the Tameside and Glossop health and care economy be supported.

32. NEXT STEPS FOR INTERMEDIATE CARE

Reference was made to the Strategic Commissioning Board's consideration of a report on bed based Intermediate Care at its meeting on 30 January 2018 and approval of Option 2 for those patients where it was not possible to deliver rehabilitation and recuperation at home and resulting in the centralisation of the Tameside and Glossop Intermediate Care beds into the Stamford Unit.

This decision was made subject to the implementation of a number of mitigations set out in the report and detailed in the covering letter sent to the Chief Executive of the Tameside and Glossop Integrated Care Foundation Trust.

The letter detailed the agreement to work in partnership to deliver Intermediate Care between the Integrated Care Foundation Trust and Derbyshire County Council. In addition, the letter clearly outlined the intention to drive the development of an investment proposal for supported accommodation on the Shire Hill site in Glossop.

However, the Chair stated that the letter did not articulate the assurances sought by the Board on 30 January 2018 that the Home First offer would be fully established and operational in the Glossop area before any implementation. This was unfortunate as the Board had emphasised that this would assist in building public confidence, ensure consistency and that new care models were understood before changes were implemented. This provision would be best assessed by working with colleagues in Derbyshire County Council and High Peak Borough Council.

RESOLVED

(i) That the content of the letter outlining the next steps of implementation for Intermediate Care in Tameside and Glossop be noted.

(ii) That the agreed next steps for implementation of Intermediate Care in Tameside and Glossop be supported and a progress report presented to the Board in April 2018.

33. HOUSING MANAGEMENT AGREEMENTS SUPPORTED HOUSING SCHEMES

Consideration was given to a report of the Assistant Director (Adult Services) explaining that the Council had previously entered into a number of leases or management agreements with Registered Social Landlords to secure properties where people with disabilities could reside outside a formal care home setting. These were now in need of review.

It was reported that in the Comprehensive Spending Review in November 2015, the Government outlined their plans to extend Local Housing Allowance to social landlords. Local Housing Allowance was a method by which local authorities identified how much housing benefit a claimant was entitled to, that supported them in paying rent / accommodation charge and eligible service charge. The risks of these changes was presented to the Board in February 2017, however, the Government had decided not to implement the proposed reforms across supported housing schemes thus reducing the financial impact originally reported.

Despite the retraction of the Local Housing Allowance cap there were still elements of risk in terms of supported housing provision that needed highlighting in terms of due diligence and the integration agenda. The specific risks related to additional costs incurred, such as meeting fire regulations, voids and rent guarantees with housing providers and the robustness of the agreements that were in place with landlords. It was essential that a management agreement was entered into with Registered Social Landlords to ensure that arrangements were robust going forward and that risk was shared and reduced.

The actual amount of housing benefit paid to tenants to assist with rental costs was £1.6m per annum and this was managed by the housing management function of Adult Services.

In conclusion, it was explained that prior to entering into future management agreements it was essential that senior leaders were aware of the potential risks going forward, particularly in light of the risk share and due diligence process that was required for integration. Housing could have a significant draw on resources particularly when resources were limited and new reforms required increased investment in supported housing schemes to meet requirements.

To mitigate risk, management arrangements had been developed jointly with housing providers and authorisation was being sought to incur expenditure to progress with signing and finalising these arrangements to provide a legal structure to protect all parties within the relationship.

RESOLVED
That the potential risks as detailed in the report be acknowledged and authorisation be given to the expenditure from pooled funding resources if called upon.

34. COMMUNITY RESPONSE SERVICE CHARGING

The Assistant Director (Adult Services) presented a report which sought permission to consult with customers and key stakeholders of the Community Response Service around a number of charging options for the service provided. Out of 3547 current customers 1061 customers currently did not pay for the service and 108 currently paid a reduced rate for the service. These differences had been based on historic decisions and there was a need to ensure that options were explored further regarding these anomalies and available options looked at to address these inconsistencies for financial sustainability moving forward into an integrated organisation. The findings and recommendations from the consultation would be sued to inform a final report and Equality Impact Assessment in June 2018.

It was explained that the Community Response Service supported some of the most vulnerable citizens across the borough with a monitoring and response service through the use of a community alarm, Telecare and Telehealth devices and Digital Health services. This service was a core preventative service supporting vulnerable people to safely maintain independence in the community without the need for more costly interventions.

Four charging options and considerations including benefits, disbenefits and risks were summarised and further information was detailed in the report at Section 6. It was essential that the service reviewed its current practice and charging regime to ensure there was sufficient funding to sustain, develop and grow service operations. The principles of charging were a key component of the in-house service moving equitably to a more financially sustainable service, reducing the reliance on Council funding, to develop a self-financing business unit approach and with the ability to generate additional revenue streams beyond its current remit.

A review of the Community Response Service had commenced in 2017 with the aim of identifying the range of enabling technology being used across Tameside, more intense data gathering, interrogation of intelligence, and exploring with stakeholders new opportunities for the role of technology and the Community Response Service as a whole in the delivery of health and social care services. Current developments were shared to provide context to the overall review as follows:

- Working with Digital Health Care services in the Integrated Care Foundation Trust resulting in a total of 99 people who had avoided A&E and 61 avoided GP appointments.
- Working with the Neighbourhood Teams and the Integrated Urgent Care Team for assessment and triage staff to be able to offer the Community Response Service.
- Project work with Integrated Neighbourhood Teams looking at how information could be shared to identify those who were moderately or severely frail in preparation for more targeted outreach / case finding with GPs.
- Planning sessions with in-house providers from Children and Families Service had commenced to extend service offer to support more families where there were children with special needs, additional needs or young carers.
- With specialist lifting equipment Community Response Service staff had avoided unnecessary ambulance calls when a customer had fallen and closer links formed with colleagues in relation to Falls Programme.
- Discussions at an early stage regarding the potential to work more closely with the North West Ambulance Service and support the service in assisted lifting.

- Process efficiencies had been examined and two significant changes had been made.

The Members of the Board discussed the significant budgetary challenges over the coming years and acknowledged the need to diversify the service delivery market by looking at new and innovative approaches to deliver services whilst reducing cost of provision significantly.

The Board commented favourably on the current developments outlined above and future work of the Community Response Service with providers across the health and social care system identifying where efficiencies could be made and used to contribute to service costs. Greater focus on early action and prevention could make a substantial difference, not only for the service user but potential savings on more costly interventions. An example was highlighted of the Falls Service reducing ambulance calls and the possible associated attendances at A&E which was significantly more costly than those associated with the Community Response Service.

In the light of the comments made by members of the Board and exploration of new opportunities with stakeholders and providers, it was agreed that the decision on the consultation on charging options for the Community Response Service be deferred and the Director of Adult Services would submit a revised proposal to a future meeting of the Board.

RESOLVED
That the decision on the consultation on charging options for the Community Response Service be deferred and the Director of Adult Services to submit a revised proposed to a future meeting of the Board.

35. INTERPRETATION SERVICES

Consideration was given to a report of the Assistant Director (Adult Services) advising that translation services for both verbal and non-verbal languages were provided via a mixture of different arrangements within Tameside and Glossop Integrated Care Foundation Trust and Tameside Council. There was an 'in-house' verbal language interpretation service in the Integrated Care Foundation Trust supplemented by additional purchased telephone interpretation and face to face interpretation and an 'in-house' non-verbal service within the Council supplemented by the use of freelance interpreters for both verbal and non-verbal language interpretation.

It was explained that the service was fragmented and heavily dependent upon business support to organise and manage. The integration of Acute, Primary, Community and Social Care in an Integrated Care Organisation offered the opportunity to rationalise and improve this provision to ensure the needs of the local population were met whilst being more cost effective.

Access to interpretation was essential for the safe care of many residents whose first language was not English and to ensure that the needs of individuals were included and that they were not reliant on family and community members to access services.

The report identified options for providing interpretation services within the Tameside and Glossop health and social care economy and the wider Council so that an appropriate, high quality and best value service could be commissioned to meet these requirements. A joint working group had been formed between the Clinical Commissioning Group, Council and Foundation Trust to produce an implement any approved proposals.

Broadly, there were two commissioning options explained in further detail in the report including advantages / disadvantages:

- **Option 1** – continue to provide services as current with separate health and social care services.

- **Option 2** – commission a single service for the whole of the Integrated Care Organisation which, with a pooled budget, would provide opportunity for some economies in scale but more importantly would offer seamless provision across the multi-speciality teams. Within the single service option there were sub-options:
    - **Option 2a** – continue to provide via a single in house provider and procure a single external provider to provide additional capacity;
    - **Option 2b** – procure a single provider to provide a fully managed service;
    - **Option 2c** – procure a single provider for verbal languages, retain Tameside Interpretation and Communication Service for non-verbal interpretation with additional capacity coming from the procured service.

The procurement approach was outlined and it was proposed that the contract should sit within and procured by the Integrated Care Foundation Trust and this decision had been based upon the advantages of a comprehensive fully managed service across the health and social care economy plus the advantages of maintaining the close links the sensory team had with social care.

The Integrated Care Foundation Trust was predicting a significant recurrent budget reduction of £175,000 on interpretation services if a new model was adopted. This was based partially on a service review within their interpretation service and also an assumption of a large percentage of interpretation moving from face to face to online services. For the Council there might not be the same cashable savings. However, there would be time saved in the administration of current ad hoc services but these were distributed across the Council. A procured service should provide a better rate compared to the current off contract activity and be more efficient from an administrative point of view with improved quality that could be monitored and complying with standing orders.

RESOLVED

(i) That Option 2c be approved as detailed in Section 4 of the report and that Tameside and Glossop Integrated Care Foundation Trust be authorised to procure a single provider for verbal language interpretation and for utilisation by the Council as required.

(ii) That the Council's Tameside Interpretation and Communication Service be retained for non-verbal interpretation with additional capacity provided via the procured service.

36. TAMESIDE CITIZENS ADVICE BUREAU: DIRECT AWARD OF CONTRACT FOR INDEPENDENT SUPPORT AND ADVICE

The Assistant Director (Adult Services) presented a report explaining that the Tameside Citizens Advice Bureau provided free, confidential, impartial and independent support and advice for residents of Tameside. The current funding levels of the Citizens Advice Bureau were not sustainable and the organisation was potentially running at a deficit of £16,766 in 2017/18. In addition to this, funding from the National Lottery was due to come to an end in March 2018 and this would further impact sustainability as this funding continued to core overheads and management hours.

It was reported that the current contract with the Citizens Advice Bureau concluded on 31 March 2018 and a procurement exercise without additional funding and a commitment beyond current budgetary requirements was unlikely to result in the provision of a local organisation that could provide the current levels of service and additional value. A direct award of a contract within initial additional funding was proposed to give time for the organisation to reorganise and bid for additional funding to ensure their sustainability.

Additionally, Tameside Citizens Advice Bureau was embedded within Tameside communities and had extensive experience as a provider of information, support and advice that was free, impartial and confidential. They had a track record of delivering services and had attracted additional funding and services into the Borough. Their approach delivered excellent social value for the

Borough. Direct award of contract would maintain the continuity of a proven and valued organisation that was a key asset in the Borough particularly for vulnerable members of the community.

It was proposed that a waiver to standing orders was granted to allow the direct award of contract to be made to Tameside Citizens Advice Bureau for a period of three years with a year one value of £140,000 and with values for years two and three to be confirmed during the contract subject to budget availability.

For year one this represented an increase in funding of £35,600 on current funding levels. This would enable Tameside Citizens Advice Bureau to:

- Remain solvent and to budget at a break-event rather than the current 2017/18 deficit of £16,766;
- Meet its commitments to other funders in terms of contract monitoring and reporting;
- Restructure to reduce overheads;
- Provide additional investment through the recruitment of a project co-ordinator to seek funding streams and managing bids.

Funding sources for year one only were:

- £78,000 Neighbourhood Services;
- £38,000 Population Health; and
- £24,000 Adult Social Care improved Better Care Fund.

RESOLVED
That a waiver to standing orders be granted to allow the direct award of contract to Tameside Citizens Advice Bureau for a period of three years with a year one value of £140,000 and with values for years two and three to be confirmed during the contract subject to budget availability.

37. TENDER FOR THE PROVISION OF SUPPORTED LIVING FOR ADULTS

Consideration was given to a report of the Assistant Director (Adult Services) that the current contract for the tender for the provision of supported living for adults commenced on 1 June 2014 for a period of 3 years with the option to extend for a period of up to 2 years.

The overarching aims of service delivery were based on recovery and rehabilitation principles that equipped service users with the life skills necessary to move on to more independent living. The service was delivered across two accommodation settings in the Borough supporting 26 tenants. The contract delivered access to support 24 hours a day and 365 days a year.

The current value for this service, 2017/18 was £523,625 representing good value for money when compared to costs for similar services in relation to a recent tender for supported living services.

There was a need for this service in terms of continuing to support a vulnerable group of people subject to section 117 after care, therefore the local authority had a statutory responsibility to provide the service. The service was also essential in supporting individuals with a step down from long term residential placements, the avoidance of future relapses and the need for expensive hospital or residential re-admission.

RESOLVED
That permission be granted to re-tender for the contract for the provision of supported living for adults with mental health needs.

38. TENDER FOR SPECIALIST DEMENTIA CARE HOME WITH NURSING

The Director of Adult Services presented a report advising that there were an estimated 2,691 people in Tameside and Glossop with dementia. As part of the Care Together development Tameside and Glossop were committed to improving the lives of people living with dementia. The overall vision for Tameside and Glossop was linked to the development of rich, specialist support to people living with dementia and their carers at all stages of their pathway. There was a need for a specialist dementia care home with nursing to improve the quality of care closer to home for individuals and their carers.

The specialist dementia care home with nursing would deliver a service to those with advanced, complex dementia requiring specialist support to meet their day to day physical, emotional and behaviour needs and manage the risks associated with this.

It was anticipated that this development would realise savings in costs whilst also delivering an improvement in an individual's experience through maintaining their connections within the locality as well as improving the quality of provision through a robustly commissioned local specialised service.

RESOLVED

(i) That the benefits of commissioning a local specialist dementia home care home be recognised.

(ii) That the plan to tender for a five year contract for 20 beds with a value of £5,200,000, with the option to extend for two or more years in line with the timeframe outlined in the report be agreed.

39. URGENT ITEMS

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

40. DATE OF NEXT MEETING

It was noted that the next meeting of the Strategic Commissioning Board would take place on Tuesday 20 March 2018 commencing at 2.00 pm at Dukinfield Town Hall.

CHAIR

This page is intentionally left blank

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 March 2018

Officer of Strategic Commissioning Board Kathy Roe – Director of Finance – Tameside & Glossop CCG and Tameside MBC

Subject: **TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 JANUARY 2018 AND PROJECTED OUTTURN TO 31 MARCH 2018**

Report Summary:

This is a jointly prepared report of the Tameside & 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 10 financial position (at 31 January 2018) and the projected outturn (at 31 March 2018).

The Tameside and Glossop Care Together Strategic 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:

Strategic Commissioning Board Members are recommended to note:

(i) The 2017/2018 financial year update on the month 10 financial position (at 31 January 2018) and the projected outturn (at 31 March 2018).
(ii) The significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget.
(iii) 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 January 2018 (Month 10 – 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 Strategic 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. INTRODUCTION

1.1 This report aims to provide an update on the financial position of the care together economy as at month 10 in 2017/18 (to 31 January 2018) 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 £487m 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 ones being:

- Significant budget pressures for the CCG relating to Continuing Care related expenditure of £4.2m.

- Children's Services within the Council is managing unprecedented levels of service demand which is currently projected to result in additional expenditure of £7.8m when compared to the available budget.

- The ICFT are working to a planned deficit of £23.7m 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 £5.0m in each of the next two financial years (2017/18 and 2018/19) in support of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) programme 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 £5.0m) in 2017/18 which is a maximum £0.5m contribution from the CCG towards the Council year end position and a maximum of £2.0m 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.

The projected Strategic Commission net funding gap of £7.12m in 2017/18 primarily relates to demand pressures within the Council's Children's Social Care service. This net funding gap within the Council will be resourced via a £0.5m additional contribution to the ICF from the Tameside and Glossop Clinical Commissioning Group as per the terms of the Integrated Commissioning Fund risk share agreement, with the residual balance financed via a combination of Council in year revenue and existing general reserve balances.

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

Organisation	Forecast Position			Forecast Position	
	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Strategic Commission	487,247	494,363	-7,116	-11,219	4,103
ICFT	-23,730	-23,730	0	0	0
Total	**463,517**	**470,633**	**-7,116**	**-11,219**	**4,103**

Table 2 – Risk Share

Risk share contributions transacted in Month 10

Risk Share		**£000's**
CCG Reduction to Risk Share	Continuing Healthcare	3,700
	Mental Health - Individualised Commissioning	500
Sub Total		**4,200**
TMBC Increase to Risk Share	Children's Services	500

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.**

2.3 A summary of the financial position of the ICF, broken down by directorate is provided in **Table 3.**

Table 3 – 2017/18 ICF Financial Position

Service	Forecast Position			Forecast Position	
	Budget	Forecast	Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Acute	203,143	205,376	- 2,233	- 1,990	- 243
Mental Health	29,502	29,698	- 196	- 697	501
Primary Care	82,839	81,647	1,192	1,188	4
Continuing Care	13,623	14,334	- 712	- 4,256	3,544
Community	27,473	27,581	- 108	- 108	- 0
Other	29,385	27,333	2,053	5,862	- 3,809
QIPP	-	-	-	- 3,798	3,798
CCG Running Costs	5,197	5,193	4	-	4
Adult Social Care	44,185	43,659	526	196	330
Children's Social Care	35,192	43,004	- 7,812	- 7,800	- 12
Public Health	16,708	16,538	170	184	- 14
Integrated Commissioning Fund	**487,247**	**494,363**	**- 7,116**	**- 11,219**	**4,103**
CCG Expenditure	391,162	391,162	- 0	- 3,799	3,799
TMBC Net Expenditure	96,085	103,201	- 7,116	- 7,420	304
Integrated Commissioning Fund	**487,247**	**494,363**	**- 7,116**	**- 11,219**	**4,103**
A: Section 75 Services	266,778	266,906	- 128	- 3,748	3,620
B: Aligned Services	187,268	194,770	- 7,502	- 7,754	252
C: In Collaboration Services	33,201	32,687	513	283	230
Integrated Commissioning Fund	**487,247**	**494,363**	**- 7,116**	**- 11,219**	**4,102**

2.4 **Acute** - Against a full year budget of £203.1m, expenditure is forecast to be £205.4m. This represents an overspend of £2.3m. The acute position has deteriorated by £0.2m since month 9, mainly driven by the removal of the Sepsis rebate the CCG was expecting in 2017/18 due to the coding change within HRG4+. Other major movements have been seen in the increase activity for non-contracted activity and in particular high cost cases. The acute cost centre represents 52% of the CCGs overall allocation, of which 34% is contracted with the ICFT. As this is block, there is no risk associated with the ICFT in the reported positon. Other areas within the acute cost centre include NHS associate contracts, independent sector, emergency ambulances and out of area Non-contracted activity. A summary by each sector is provided below with a further breakdown of associate performance by point of delivery:

- Associate provider contracts (over by £2.3m) with the key providers being Manchester Foundation Trust (combined) and the Christie Foundation Trust within medical oncology. Very high cost patients in critical care and emergency admissions are the main causes behind this financial pressure;

- Associate Contracts Performance by Point of Delivery;

  - A&E (£0.2m)
  - Planned Care £0.2m
  - Outpatients (£0.5m)
  - Urgent Care (£1.2m)
  - Excess Bed days (£0.1m)

- Critical Care (£0.6m)
- Other £0.1m

- Independent Sector (over by £0.8m), where activity has grown in real terms, particularly for diagnostic procedures where the independent sector are able to offer treatment with a shorter wait and at lower cost than the ICFT.

- Non Contracted Activity (over by £0.5m), this is an adverse movement of £0.2m in the position this month due to the continued increase in out of area treatment and high cost cases.

2.5 **Mental Health** - Against Core budgets a £0.2m overspend is forecast. This is a £0.5m improvement on the position reported last month due to the CCG's reduced contribution to the ICF risk share being agreed and transacted in month 10. The key drivers remain with high cost individualised commissioning placements, offset by slippage on implementation of new services and a reduced number of patients on step down units at Pennine Care. It is likely that additional slippage will happen on the implementation of business cases that support the five year forward view. However the CCG is working with Providers and GM to ensure the resources are managed accordingly and money is secured for the local economy.

The CCG continues to meet the parity of esteem for mental health which is currently 2.89% at month 10 and on track to meet the Mental Health Investment Standard (MHIS) in 2017/18. A paper went to the strategic commissioning board this month looking at achievement of MHIS in future years and how this links to the five year forward view for mental health.

2.6 **Primary Care** – Currently forecast at £1,2m underspend. This is an overall improvement of £0.004m since last month. Prescribing has seen a favourable movement of £0.2m this month which means the full QIPP expected target of £1.2m has been achieved in full.

Other pressures have emerged this month regarding the level of increased activity within the walk-in centre. The data is currently being verified with Go-To-Doc and commissioners. As there is clear indication this is genuine, we have prudently included an additional £0.2m into the forecast at month 10.

2.7 **Continuing Care** – Against Core budgets we are reporting a £0.7m overspend. This is a £3.5m improvement on the position reported last month due to CCG's reduced contribution to the ICF risk share being agreed and transacted in month 10.

Growth in individualised packages of care remains the CCGs biggest financial risk. From the reported £6.0m financial pressure, £4.2m reduced contribution to the risk share has been used to mitigate some of this risk in month 10.

The financial recovery plan was updated and presented to the finance and QIPP group in January. A significant amount of work is underway to look at service redesign with the ICFT around Fast Track patients and moving away from spot purchasing to block contracts for individualised commissioning packages across both CCG and Local Authority.

There is now a clear and established process for accessing the Dowry fund as part of the transforming care strategy. The CCG has submitted its claims for 3 cases at the end of January and waiting on the outcome. To mitigate some of the risk associated with this, the CCG is only assuming 50% back at this stage.

2.8 **Community** - The majority of spend within this directorate is within the block contract for the ICFT. There is an adverse variance of £0.09m that relates to VAT on the wheelchairs

contract. The position includes this as the worst case scenario as there are still ongoing discussions with the Inland Revenue about a reclaim of this tax.

2.9 **Other** – This directorate includes Better Care Fund (BCF), estates, transformation funding and reserves. BCF and transformation funding are both on track to spend in line with plan. There is some risk around estates as we have still not received accurate schedules from Propco. The BCF forecast spend has increased in month 10 by £0.5m. This is for the additional risk share contribution that was transacted in month from the CCG to Local Authority to support financial pressures within children services.

The underspend within the directorate relates to reserves where we have budget to offset the overspend reported elsewhere and ensure the CCG meets financial control totals.

2.10 **QIPP** – Against an annual savings target of £23.9m, all £23.9m has been fully banked in month 10.

The CCG's reported net risk last month was £2.0m. The post mitigation risk reported to NHSE this month is zero.

2.11 **CCG Running Costs** – On track to remain within running cost allocation and have now delivered £1.2m QIPP savings against a target of £1.1m. This has now been fully banked for 2017/18.

2.12 **Adult Social Care –** Increase of £0.2m 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 throughout the year).

Employee related spend is forecast to be £0.4m 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.

There has been an increase in Homecare hours delivered throughout December 2017 and January 2018, this has resulted in a forecast expenditure increase of £0.2m
Nursing bed capacity in Care Homes remains stretched with vacancy levels of approximately 5% (28 beds) across the borough.

2.13 **Children's Services** – Pressure of £7.8m due to increased expenditure on children's placements and social workers as a result of the increased demand being experienced in this area and in line with OFSTED recommendations.

The number of Looked After Children has increased from 519 at April 2017 to 590 in January 2018. The current budget allocation will finance approximately 450 placements, assuming average weekly unit costs for placements.

Forecast expenditure on employee related costs forecast to be £1.4m 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 and Assistant Director of Children's Services.

2.14 **Public Health –** Consistent with the position reported in previous months.

3. 2017/18 EFFICIENCY PLAN

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

3.2 **Appendix 1** provides supporting analysis of the delivery against this requirement for the whole economy. It is worth noting that there is a forecast £0.4m under achievement of this efficiency sum by the end of the financial year. It is worth noting that there was a gap of £3.6m reported last month of which has since been resolved through the risk share contribution that has been transacted non-recurrently in month 10.

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

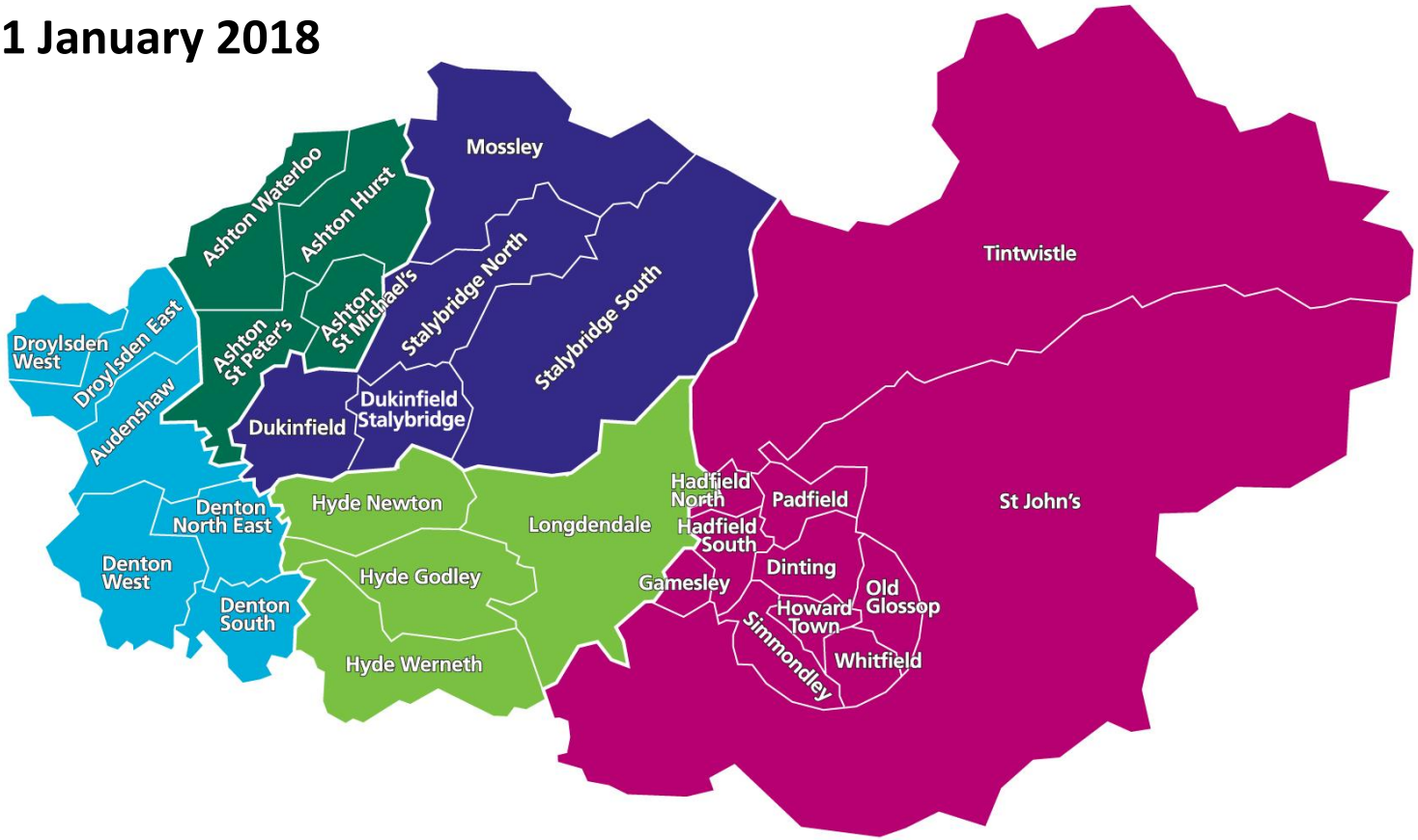
This page is intentionally left blank

TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

financial monitoring statements

Period Ending 31 January 2018
Month 10



Kathy Roe
Claire Yarwood

NHS Tameside and Glossop Clinical Commissioning Group
Tameside Metropolitan Borough
NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Integrated Care Together Economy Financial Position

In 2017/18 the Care Together economy still has a £7,116k financial gap

How do we close this gap?

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
Strategic Commission	403,297	409,232	-5,934	487,247	494,363	-7,116	-11,219	4,103
ICFT	-20,321	-21,013	-693	-23,730	-23,730	0	0	0
Total	**382,976**	**388,219**	**-6,627**	**463,517**	**470,633**	**-7,116**	**-11,219**	**4,103**

- Following transaction of the Integrated Commissioning Fund risk share, the Strategic Commission funding position has improved by £4,103k this month to show a gap of £7,116k. This gap relates primarily pressures within Children's Social Care as explained within the Executive Summary. This net funding gap within the Council will be resourced via a £500k contribution from the CCG into the ICF risk share agreement, with the residual balance financed via a combination of Council in year revenue and existing general reserve balances. We continue to report that we will meet our financial control totals.

- The ICFT are working to a planned deficit of £23,730k for 2017/18, which is an improvement of £619k since last month). Trust efficiencies of £10,397k are required in order to meet this control total. (The trust has seen an improvement towards this of £135k since month 9)

- The Integrated Commissioning Fund has now received the extra non-recurrent contributions from the risk share agreement ensuring a balanced position is now achieved.

- While the financial gap is a large figure, it is important to appreciate this within the context of the total budget:

Economy Wide Highlights

- The full £23,900k QIPP target has now been achieved this month which reduces the CCGs post mitigations risk for 2017/18 to zero.

- Risk Share contributions transacted
  > £3,700k – Continuing Care
  > £500k – MH Non-CHC
  > **£4,200k Sub Total**
  > £500k Children's Services

- CHC/MH Non-CHC and Neuro Rehab is forecast to overspend by £2,188k. This is a reduction of £4,200k from last month due to the risk share contribution highlighted above. This doesn't change the underlying position that there is a £6,388k cost pressure in this area.

- £7,812k projected overspend on Children's Services predominantly driven by out of area placements. £500k from the risk share contribution has been transacted in month 10.

- £2,233k projected overspend on acute, driven by increased activity (mainly emergency admissions) at providers other than the ICFT

- Risk Attached to delivery of Trust Efficiency Plan (TEP)

- Medical agency spend creating particular pressures

Tameside Integrated Care Foundation Trust Financial Position

High level financial overview

	Month 10			Year to Date			Forecast Outturn
	Plan	Actual	Variance	Plan	Actual	Variance	Plan
	£000	£000	£000	£000	£000	£000	£000
Normalised Surplus/(Deficit)	(1,435)	(1,641)	(206)	(20,321)	(21,013)	(693)	(23,730)
Capital Expenditure	661	421	(240)	4,664	1,962	(2,702)	4,664
Cash and Equivalents	1,190	1,861	671				
Trust Efficiency Savings	1,261	852	(409)	7,903	7,697	(206)	10,397
Use of Resources Metric	3	3	0	3	3	0	3

- YTD Net position is £21,000k deficit, c. £700k over the proposed deficit.
- Internal management forecast at Month 10 is c£23,700k deficit
- Trust Efficiency Programme is c. £200k behind the year to date (YTD) target
- Cash is £600k above the planned balance

Key risks and highlights

Key Risks – I&E

- **Control Total -** The Trust has agreed with NHSI that it will deliver it's planned deficit. As the Trust did not sign up to the NHSI control total, there will be no access to STF or capital monies for A&E Streaming and from the Digital fund.
- **Medical Staffing -** The level of medical agency expenditure is providing a financial pressure for the Trust
- **Unfunded Beds -** The Trust has a number of escalated beds that are unfunded.
- **Activity levels -** Income on smaller clinical contracts is falling, but no corresponding reduction in costs.
- **TEP -** Failure to deliver the Trusts efficiency target.
- **Expenditure on A&E and General Medicine** is significantly over budget reflecting pressure in non-elective activity.

Key Risks – Balance Sheet/Other

- **Loans -** At the end of 2016/17, the Trust had loan liability of £54,800k. It is anticipated that this will increase to £78,100k in 2017/18. The Trust will be required to repay part of this liability in 2018 and a further loan may be required to service this repayment.
- **Cash -** The January month end cash balance was £600k above the expected the £1,200k plan.
- **Winter Tranche 1 & 2** – The forecast assumes the receipt of Tranche 1 monies of £618k which will reduce the Trusts Planned deficit to £23,700k. The Tranche 2 monies of £725k will be used to support winter schemes and will be expended during Quarter 4
- **Agency Cap -** The NHSI requirement is for the Trust to reduce medical agency expenditure by £1,200k. Currently the Trust is forecasting to achieve the Agency cap by c. £200k, Total Forecast spend at Month 10 is £11,300k

Overall Risk Rating - Medium Pressure/High Risk Improvement/Low risk

Tameside and Glossop Strategic Commissioner Financial Position

- Forecast overspend of £7,116k is driven by significant pressures in children's services.

- Following the transaction of the ICF risk share the overall position has improved by £4,102k since M9.
  - In line with the terms of the agreement the council have contributed £4,200k into the risk share in relation to pressures in individualised commissioning (£3,700k to individualised commissioning patients & £500k for individualised commissioning team Mental Health placements).
  - The CCG has contributed £500k into the ICFT risk share pool in response to pressures in Children's Services (which may not be obvious to see in the high level table below as the benefit has been used to refund council reserves where the original budget increase came from).

- Both organisations are currently reporting that statutory duties and financial control totals will be met. The CCG is reporting that the QIPP target has been fully achieved, with post mitigation risks of zero.

	YTD Position			Forecast Position			Forecast Position	
£000's	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	168,494	169,943	-1,449	203,143	205,376	-2,233	-1,990	-243
Mental Health	24,587	24,733	-146	29,502	29,698	-196	-697	501
Primary Care	69,112	67,928	1,185	82,839	81,647	1,192	1,188	4
Continuing Care	11,347	11,108	239	13,623	14,334	-712	-4,256	3,544
Community	23,004	22,988	16	27,473	27,581	-108	-108	-0
Other	20,652	22,071	-1,419	29,385	27,333	2,053	5,862	-3,809
QIPP	-	-	-	-	-	-	-3,798	3,798
CCG Running Costs	4,589	3,020	1,570	5,197	5,193	4	-	4
Adult Social Care	38,870	38,432	438	44,185	43,659	526	196	330
Children's services	28,096	34,606	-6,510	35,192	43,004	-7,812	-7,800	-12
Public Health	14,545	14,403	142	16,708	16,538	170	184	-14
Integrated Commissioning Fund	**403,297**	**409,232**	**-5,934**	**487,247**	**494,363**	**-7,116**	**-11,219**	**4,103**
CCG Expenditure	321,786	321,791	-4	391,162	391,162	-0	-3,799	3,799
TMBC Expenditure	81,511	87,441	-5,930	96,085	103,201	-7,116	-7,420	304
Integrated Commissioning Fund	**403,297**	**409,232**	**-5,934**	**487,247**	**494,363**	**-7,116**	**-11,219**	**4,103**
A: Section 75 Services	222,169	221,673	496	266,778	266,906	-128	-3,748	3,620
B: Aligned Services	153,532	160,382	-6,850	187,268	194,770	-7,502	-7,754	252
C: In Collaboration Services	27,597	27,177	420	33,201	32,687	513	283	230
Integrated Commissioning Fund	**403,297**	**409,232**	**-5,934**	**487,247**	**494,363**	**-7,116**	**-11,219**	**4,102**

Better Care Fund

- The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.
- 2017/18 Better Care Fund contributions for both Tameside and Derbyshire have now been agreed. As detailed in the table below the Tameside BCF for 2017/18 is £24,093k. In Derbyshire the fund is valued at £101,283k.
- Contributions from T&G CCG are £15,597k and £2,252k respectively. Meaning the CCG is investing £17,849k in BCF in total.
- An expenditure plan that meets all requirements is in place and funds are now being spent in line with the approved plan. Actuals are expected to come in equal to budget, with neither an under or overspend forecast.
- The CCG is spending £5,085k from the BCF pot, reducing the net contribution down to £12,764k.
- There is expected to be an element of slippage on the 2017-18 i-BCF allocation, this is acceptable within the guidance from the Department for Communities and Local Government (DCLG). An updated investment profile will be shared once finalised. The Q3 i-BCF submission was made to DCLG in mid-January, this indicated that all performance targets and metrics were being met in line with the agreed plan.

2017/18 BCF Funding (£000's)	Tameside			Derbyshire			Total CCG Position
	Council	CCG	Total	Council	CCG	Total	
T&G CCG Contribution	0	15,597	15,597	0	2,252	2,252	17,849
Centrally Funded Grants (DFG)	2,153	0	2,153	5,966	0	5,966	0
iBCF	6,343	0	6,343	19,612	0	19,612	0
Other Sources of funding (other CCGs)	0	0	0	73,454	0	73,454	0
Total BCF Funding 2017/18	**8,496**	**15,597**	**24,093**	**99,031**	**2,252**	**101,283**	**17,849**

2017/18 BCF Expenditure (£000's)	Tameside			Derbyshire			Total CCG Position
	Council	CCG	Total	Council	CCG	Total	
Integrated Neighbourhoods	3,265	3,027	6,292	0	456	456	3,483
Integrated Urgent Care	2,375	1,602	3,977	0	0	0	1,602
Maintaining and Enhancing Services	11,671	0	11,671	0	0	0	0
Disabled Facilities Grant	2,153	0	2,153	5,966	0	5,966	0
Other	0	0	0	94,840	0	94,840	0
Total BCF Expenditure	**19,464**	**4,629**	**24,093**	**100,806**	**456**	**101,262**	**5,085**

Net CCG contribution	**12,764**
Tameside	10,968
Derbyshire	1,796

Integrated Commissioning Fund Risks

Continuing Care — A

- Growth in individualised packages of care remains the CCGs biggest financial risk. From the reported £6,000k financial pressure, £4,200k has been used from the risk share to mitigate some of this risk in month 10.
- The financial recovery plan was updated and presented to the finance and QIPP group in January. A significant amount of work is underway to look at service redesign with the ICFT around Fast Track patients and moving away from spot purchasing to block contracts for individualised commissioning packages across both CCG and LA.
- There is now a clear and established process for accessing the Dowry fund as part of the transforming care strategy. The CCG has submitted its claims for 3 cases at the end of January and waiting on the outcome. To mitigate some of the risk associated with this, the CCG is only assuming 50% back at this stage.

Children's Services — R

- Pressure of £7,812k due to increased investment required in children's placements and social workers as a result of the increased demand being experienced in this area and in line with OFSTED recommendations. As part of the risk share contribution, £500k has been transacted in month 10 from the CCG to support the pressures in Children's.
- The number of Looked After Children has increased from 519 at April 2017 to 590 in January 2018.
- The current budget allocation will finance approximately 450 placements

QIPP — G

- Against an annual savings target of £23,900k, all £23,900k has been fully banked in month 10.
- The reported net risk last month was £2,000k. Our net post mitigation risk reported to NHSE this month is zero.

Acute services — A

- Demand Management for emergency services at the associate providers remains a key risk for the CCG. The acute position has adversely moved by £200k this month, rising to £2,300k forecast overspend. This is summarised below identifying the key drivers by point of delivery.

• A&E	(£200k)
• Planned Care	£200k
• Outpatients	(£500k)
• Urgent Care	(£1,200k)
• Excess Bed days	(£100k)
• Critical Care	(£600k)
• Other	£100k

Mental Health: — A

- Heightened levels of out of area placements at premium prices due to shortage of MH beds locally are a significant driver of overspend
- Cost pressures to deliver requirement of Five Year Forward View present a significant medium term risk to financial position of Strategic Commissioner (though slippage in implementation of schemes in 17/18 has improved the in year position slightly).
- Sustainability of local MH providers and potential requirement of additional commissioner contributions is also a risk.

Adult Social Care — A

- While an in year underspend of £526k is currently being forecast, there is significant medium term risk in this area as a result of:
  - increased demand for social care services to support improvement in DTOCs and as a result of demographic growth
  - financial pressure from living wage legislation and care home market

Financial Gap and Efficiency Position

- In order to deliver financial control totals, an economy wide savings target of £35,070k was set for 2017/18. This is made of £10,397k Trust Efficiency Plan (TEP) savings at the ICFT and £24,673k across the strategic commissioner (made up of £23,900k CCG QIPP and £773k of planned council savings).
- The table below details progress against this target. In total, savings of £34,675k are expected, which is an improvement of £3,722k from M9, but still leaves a shortfall of £395k within the ICFT. This is however an improvement of £135k since last month at the ICFT. The £3,700k comes from transacting the risk share contribution this month into the ICF resource to contribute towards the CHC / MH-Non CHC individualised commissioning and children's.
- The ICFT still have £2,305k savings to deliver in final 2 months of the year. Deep dives are underway to confirm delivery of outstanding schemes.
- For the commissioner, the full £23,900k QIPP target has now been achieved in full at month 10. The council remains on track to deliver the full target of £773k with only £129k still to find in the next 2 months.

Key Headlines:

- £32,241k of actual savings delivered in first 10 months of year.
- This represents an over-achievement against plan of £6,831k due to the profiling.
- Final projected economy savings are £395k lower than target.
- This represents a £3,722k improvement against the position reported at M9 due to the transacted risk share contribution.
- More work is required to bring forward new schemes addressing the short fall.
- £19,505k (59%) of expected savings are due to be delivered on a recurrent basis.

£000's	YTD Position			Annual	Risk Rated Forecast Position				Expected	Variance
	Target	Delivered	Variance	Target	Posted	Low	Medium	High	Savings	
ICFT	**7,903**	**7,697**	**- 206**	**10,397**	**8,900**	**1,092**	**10**	**809**	**10,002**	**- 395**
Technical Target	1,036	1,655	619	1,243	1,701	62	-	-	1,763	520
Divisional Target - Corporate	825	1,276	451	1,020	1,392	-	4	23	1,396	375
Pharmacy	296	409	113	392	448	77	-	17	525	133
Divisional Target - Surgery	529	572	43	640	700	-	3	-	704	64
Transformation Schemes	101	130	29	121	130	40	-	-	170	49
Workforce Efficiency	600	355	- 245	1,000	453	547	-	216	1,000	0
Estates	342	473	131	557	508	13	3	4	524	- 34
Paperlite	104	3	- 101	125	8	5	-	-	14	- 111
Divisional Target - Medicine	665	562	- 104	803	646	46	-	33	691	- 112
Medical Staffing	536	359	- 177	716	474	44	-	122	518	- 198
Nursing	809	555	- 254	975	568	137	-	-	705	- 270
Demand Management	1,383	1,029	- 354	1,732	1,417	8	-	337	1,425	- 306
Procurement	677	320	- 358	1,073	454	113	-	58	567	- 506
Strategic Commissioner	**17,507**	**24,544**	**7,037**	**24,673**	**24,544**	**71**	**58**	**-**	**24,673**	**- 0**
Technical Target	1,635	10,611	8,976	1,875	10,611	-	-	-	10,611	8,736
Primary Care	1,688	2,279	592	1,748	2,279	-	-	-	2,279	532
Single Commissioning	931	1,221	290	1,137	1,221	-	-	-	1,221	84
Neighbourhoods	781	781	-	781	781	-	-	-	781	-
Acute Services - Elective	586	586	-	1,116	586	-	-	-	586	- 530
Other	724	724	-	1,324	724	-	-	-	724	- 600
Effective Use of Resources	1,250	815	- 435	1,500	815	-	-	-	815	- 685
Mental Health	294	296	2	994	296	-	-	-	296	- 698
GP Prescribing	2,013	1,185	- 828	2,516	1,185	-	-	-	1,185	- 1,331
Back Office Functions	437	562	125	2,024	562	-	-	-	562	- 1,463
Demand Management	6,525	4,840	- 1,685	8,885	4,840	-	-	-	4,840	- 4,045
Adult Social Care	280	280	-	336	280	10	46	-	336	-
Public Health	364	364	-	437	364	61	12	-	437	-
Total Economy Position	**25,410**	**32,241**	**6,831**	**35,070**	**33,444**	**1,163**	**68**	**809**	**34,675**	**- 395**

This page is intentionally left blank

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	20 March 2018
Officer of Single Commissioning Board	Gill Gibson, Director of Safeguarding and Quality
Subject:	**COMMISSIONING FOR QUALITY FRAMEWORK**
Report Summary:	Quality is the central principle of our health and social care service. It is what matters most to people and what motivates and unites the workforce. In Tameside and Glossop Public Health, Social Care and the Clinical Commissioning Group (CCG) have come together as a Single Commissioning Function, combining commissioning teams and budgets. With this arrangement comes a commitment and responsibility for securing continued high quality services for its local population. This document sets out a **Commitment to Quality** from the leaders of Tameside & Glossop Single Commissioning Function. This framework provides a mechanism for overseeing quality across health and social care. The framework complies with the nationally agreed definition of quality and the Greater Manchester Health and Social Care Partnership Quality Improvement Framework. The framework ensures quality is embedded at all stages of the commissioning cycle, from strategic planning, to procurement assurance and supporting service improvement. The Framework is appended to the Terms of Reference for the Quality and Performance Assurance Group which will be reviewed in 12 months' time.
Recommendations:	The Strategic Commissioning Board is requested to: Endorse the Commissioning for Quality Framework and the Terms of Reference for the Quality and Performance Assurance Group.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The Commissioning for Quality Framework is presented for information and as such does not have any direct and immediate financial implications.
Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account, understanding where best to focus resources and oversight. This document provides the framework and focus for quality assurance. Statutory duties of a CCG are discharged under the NHS Act 2006 and the Health and Social Care Act 2012: - • To promote the NHS Constitution. • To exercise functions effectively, efficiently and economically. • To exercise functions with a view to securing continuous

	improvement in the quality of services provided. • To assist and support the NHS Commissioning Board in discharging its duty to a secure continuous improvement in the quality of primary medical services.
How do proposals align with Health & Wellbeing Strategy?	The Commissioning for Quality Framework underpins the H&W strategy and will help strengthened joint working by providing a strategic framework to commissioning for quality across the health and care economy.
How do proposals align with Locality Plan?	Quality assurance of the SCF commissioned services underpins the delivery of the locality plan.
Public and Patient Implications: **And Quality Implications**	This document sets out a commitment to quality from the leaders of Tameside & Glossop Strategic Commission Function .It provides a mechanism for overseeing quality across health and social care. The framework ensures quality is embedded at all stages of the commissioning cycle, from strategic planning, to procurement assurance and supporting service improvements and quality outcomes for patient and the public and that services are responsive, person-centred and well led.
How do the proposals help to reduce health inequalities? **What are the Equality and Diversity implications?**	The framework complies with the nationally agreed definition of quality (National Quality Board) and the Greater Manchester Health and Social Care Partnership Quality Improvement Framework. It ensures commissioning for quality provides a mechanism to ensure services are equitable for all and that inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.
What are the safeguarding implications?	Safeguarding is implicit within the definitions of commissioning for quality.
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:	No current risks identified. Application of this framework will support the SCF to understand and monitor risk, in terms of quality and patient safety, across commissioned services.
Access to Information :	The background papers relating to this report can be inspected by contacting Gill Gibson, Director of Quality and Safeguarding: Telephone: 0161 342 5611 e-mail: gill.gibson@nhs.net

Tameside and Glossop Strategic Commission

Quality Framework

2017-2021

Introduction

The quality of health and social care services is under scrutiny like never before. The government and public rightly expects those responsible for commissioning services, ensure those services provide the highest standards of care. The public need to be assured that services they use are safe, effective and provide a positive experience.

The Health and social care economy is facing the combined challenge of rising demand, increased cost, advancing science, changing expectations and tough economic circumstances. Meeting these challenges whilst maintaining and improving quality will not be easy, but is essential for the sustainability of our health and social care economy. *"Quality without efficiency is unsustainable, but efficiency without quality would be unthinkable"*. To meet these challenges, we need to become a health and social care economy focused on continual learning and improvement.

Quality is the central principle of our health and social care service. It is what matters most to people and what motivates and unites the workforce.

In Tameside and Glossop Public Health, Social Care and the Clinical Commissioning Group (CCG) have come together as a Strategic Commission, combining commissioning teams and budgets. With this arrangement comes a commitment and responsibility for securing continued high quality services for its local population.

This document sets out a **Commitment to Quality** from the leaders of Tameside & Glossop Strategic Commission Function .This framework provides a mechanism for overseeing quality across health and social care. The framework complies with the nationally agreed definition of quality and the Greater Manchester Health and Social Care Partnership Quality Improvement Framework. The framework ensures quality is embedded at all stages of the commissioning cycle, from strategic planning, to procurement assurance and supporting service improvement.

This framework should be read in conjunction with:

- Annual Quality Report
- Primary Care Quality Standards
- Annual Safeguarding Report
- Sustainability and Transformation Plan
- NHS Shared Planning Guidance 2017 – 2019
- National Quality Board – Shared Commitment to Quality.

National Context

This quality Framework ensures the strategic commission takes into account its responsibilities for The NHS Outcomes Framework · The five domains of the NHS Outcomes Framework are covered by three dimensions against which the quality and safety of services should be measured; they are Effectiveness, Patient Experience and Safety.

The NHS Constitution, which sets out rights for patients, public and staff and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

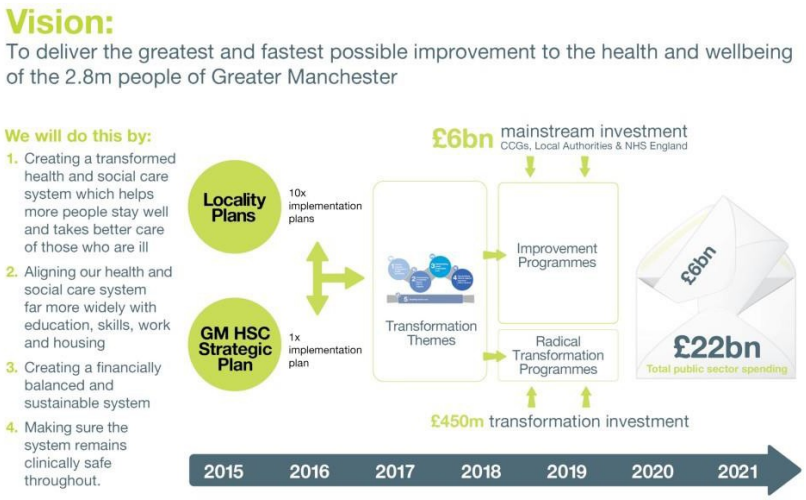
The Five Year Forward View, General Practice Forward View and the Sustainability and Transformation Plans (STPs) driven by the "triple aim" principles of (1) improving the health and wellbeing of the whole population; (2) better quality for all patients, through care and redesign; and (3) better value for taxpayers in a financially sustainable system. The CCG element of The Strategic Commission is monitored by Greater Manchester Health and Social Care partnership through the CCG Improvement and assessment Framework ensuring the CCG is meeting its duties to meet the National directives discussed above.

- This framework embraces the principles of the NHS England Right Care programme,
- the value that the patient derives from their own care and treatment
- the value the whole population derives from the investment in their healthcare

Local Context

The **Greater Manchester Health and Social Care Partnership** is the body made up of the 37 NHS organisations and councils in the city region, which is overseeing devolution and taking charge of the
£6bn health and social care budget. Governed by the Health and Social Care Partnership Board, which meets in public each month, the Partnership comprises the 37 local authority and NHS organisations in Greater Manchester, plus representatives from primary care, NHS England, the community and voluntary sectors, Healthwatch, Greater Manchester Police and the Greater Manchester Fire and Rescue Service.

The Strategic Plan: Taking Charge of our Health and Social Care in Greater Manchester, was launched in December 2015. It is aligned to ten Locality Plans setting out ambitions in each of GM's boroughs and created by the CCG, Local Authority and providers. It also summarises how the £450m Transformation Fund (the fund which will allow us to make the transformational changes needed in health and social care so we can deliver our objectives) will contribute to the mainstream improvement programme across GM, and our ambition to ultimately take charge of the £22bn public sector budget.



Care Together is Tameside and Glossop's locality plan outlining the future of health and social care for our population. These plans put Tameside and Glossop at the forefront of a new era in health and social care integration.

Under the Care Together Programme NHS Tameside and Glossop Clinical Commissioning Group (T&G CCG), Tameside Metropolitan Borough Council (TMBC), and Tameside and Glossop Integrated Care NHS Foundation Trust (T&G IC) are working together to develop, introduce and operate an integrated system of health and social care in Tameside and Glossop.

At its heart, Care Together is the development of care that is closer to home and involves the development of local care teams, Care Together is very much about how the people of Tameside and Glossop, along with GPs, the local Council, care providers, hospital, community services and

charities can work effectively together to deliver improved health and social care services, placing the person at the centre of the care that is required.

What is Quality?

A single shared view of quality - High-quality, person-centred care for all, now and into the future

The NHS Five Year Forward View confirms a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system. This definition builds on its existing definition of quality, the areas which matter most to people who use services:

Quality for people who use services

- **Safety**: people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **Effectiveness**: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Positive experience**:
    - **Caring**: staff involve and treat people with compassion, dignity and respect.
    - **Responsive and person-centred**: services respond to people's needs and choices and enable them to be equal partners in their care.

Quality for those providing services:

We know that to provide high-quality care, we need high performing providers and commissioners working together and in partnership with, and for, local people and communities, that:

- Are **well-led**: they are open and collaborate internally and externally and are committed to learning and improvement.
- **Use resources sustainably**: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.
- Are **equitable for all**: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

The Care Quality Commission's (CQC) inspection approach for providers of care embeds this shared view of quality using the 5 domains as the framework for assessing the quality of services commissioned by the Single Commission Function:

Seven steps to improve quality

These seven steps set out what all of us need to do together to maintain and improve the quality of care that people experience. We have strong foundations to build on but there is also much more for all of us to do if we are to close the care and quality gap.

Quality Framework

There are two other national drivers for high-quality care; the NHS Constitution (2013) and the NHS Outcomes Framework (2014).

The NHS Constitution (2013) sets out what patients, the public and staff can expect from the NHS and what the NHS expects from them in return. It contains a set of core quality principles that CCGs seek to apply.

- The patient and the public comes first – not the needs of any organisation
- Quality is everybody's business – from the ward to the board; from the supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers
- If we (health and care professionals, staff as well as patients and the wider public) have concerns we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and staffs tell us about the quality of care; and if concerns are raised, we listen and 'go and look'

The NHS Outcomes Framework (2014) sets out the national outcomes that all providers of NHS funded care should be working towards. Indicators in the NHS Outcomes Framework (2014) are grouped around five domains, which set out the high level national outcomes that the NHS should be aiming to improve. The domains are:-

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Ensuring that patients receive high quality care involves a complex set of interconnected roles, responsibilities and relationships between CCG, Local Authority, Public Health, professionals, provider organisations, other commissioners, systems and professional regulators and other national bodies and frameworks. Key drivers in quality include:-

CCG Improvement and Assessment Framework

The CCG Improvement and Assessment Framework has been developed with four domains and will focus on six clinical priorities – Mental health, dementia, Learning disabilities, Cancer, Diabetes and maternity. It has been designed as a dynamic tool to enable CCGs to focus on the emerging opportunities facing the NHS in future years such patient safety and patient and public engagement.

The four domains are:

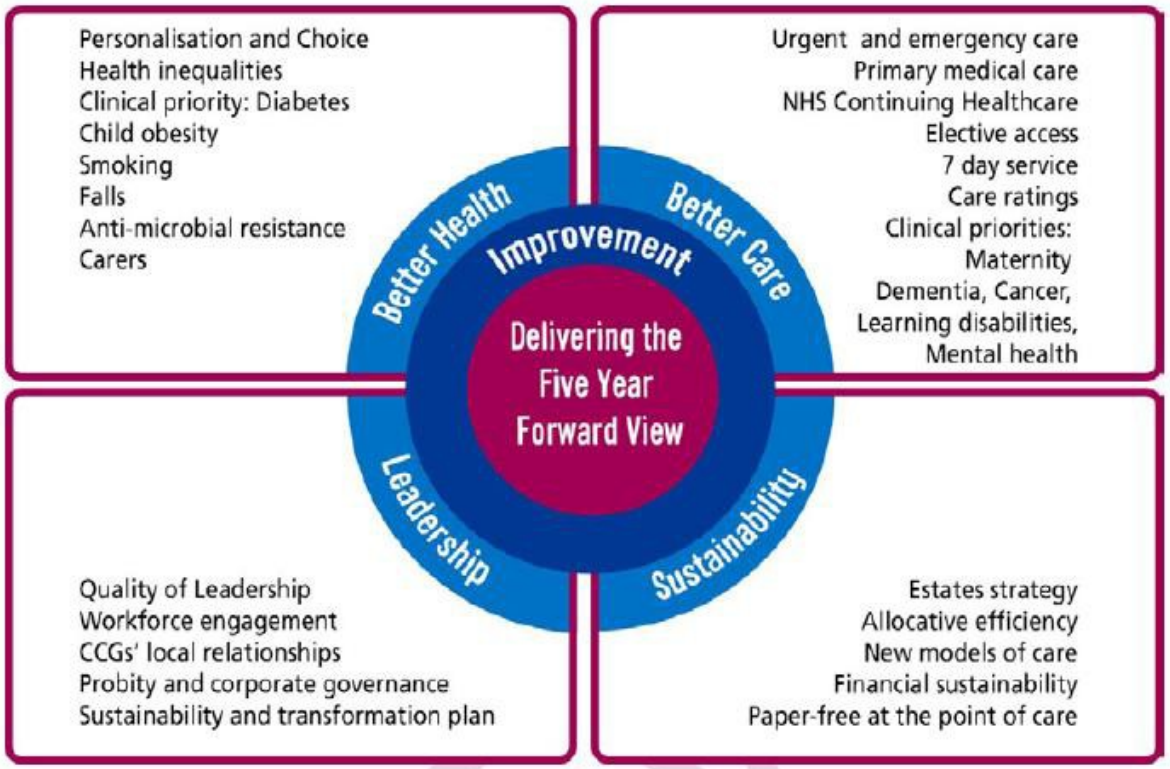
• Better Health: how well the CCG is contributing towards improving the health and wellbeing of its population and how it is affecting the demand curve from our population

• Better Care: focussing on care redesign, performance of constitutional standards and a range of outcomes

• Sustainability: Financial balance and securing good value for patients and the public from our commissioning activity

• Leadership: The quality of leadership, the quality of our plans, how it works with partners and governance arrangements in place to ensure probity

This framework is summarised in the diagram below:


Personalisation and Choice
Health inequalities
Clinical priority: Diabetes
Child obesity
Smoking
Falls
Anti-microbial resistance
Carers
Urgent and emergency care
Primary medical care
NHS Continuing Healthcare
Elective access
7 day service
Care ratings
Clinical priorities:
Maternity
Dementia, Cancer,
Learning disabilities,
Mental health
Better Health
Improvement
Better Care
Delivering the
Five Year
Forward View
Leadership
Sustainability
Quality of Leadership
Workforce engagement
CCGs' local relationships
Probity and corporate governance
Sustainability and transformation plan
Estates strategy
Allocative efficiency
New models of care
Financial sustainability
Paper-free at the point of care

The CCG will use this framework to focus on its areas of delivery; this framework specifically focuses on the 'Better health' and 'Better care' aspects of delivery and commissioning, however we recognise that quality requires 'leadership' and 'sustainability' and these two aspects are 'enablers' for delivery.

Right Care Programme:

During the past 12 months we have been working hard to secure improvements in a variety of areas where we know that greater health gain can be achieved for local residents. We have used the analysis from the Right Care programme to further understand where there are opportunities to improve outcomes for patients and deliver better value for money.

Tameside and Glossop Strategic Commission are taking forward the Right Care approach through new programmes to ensure that it becomes embedded in commissioning work streams. We will be focusing on key priority areas, namely respiratory, circulation, musculoskeletal, orthopaedic trauma and injury from falls, mental health, cancer, gastro intestinal and endocrine.

Commissioning intentions

Each year CCGs are required to articulate a key set of commissioning priorities, these priorities will be focused on ensuring that the residents of Tameside and Glossop continue to have access to essential health services, we also take the opportunity to review areas where we feel additional impetus is required in order to be able to address areas of health concern, for example cancer or heart disease.

Our commissioning priorities are called 'commissioning intentions', our commissioning intentions focus on key system wide priority areas of homelessness, domestic violence, chronic heart disease and staff culture to support transformation programme.

Quality Premiums

The Quality Premium (QP) scheme is about financially rewarding clinical commissioning groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services. There are five National Measures and one local measure selected from the suite of Right Care indicators.

National Indicators:	Early Cancer Diagnosis
	GP Access and Experience
	Continuing Healthcare
	Mental Health - Equity of Access and outcomes in to IAPT services
	Bloodstream Infections
Local Indicator	Increase reported to estimated prevalence of COPD.

The SCF has a whole system approach to maximise achievement in the quality premium scheme. A lead commissioner is assigned to each Quality Premium measure who, supported by Business Intelligence function, provide a quarterly update on the position of achieving the target and any mitigating actions being taken where Quality Premiums are not on target. The Quality and Safeguarding Directorate hold quarterly meetings with lead commissioners, Business Intelligence, finance and providers to monitor progress against Quality Premium scheme.

Evidence Based Decision Making Framework

To assist the strategic commission in making robust evidence based decisions along the commissioning cycle a number of requirements need to be met. **The Evidence Based Decision Making Framework** summarises those requirements and the support available to contract and commissioning managers to ensure they discharge their obligation to provide robust and evidential reports to decision makers in the areas of:

- Equality and diversity
- Quality and risk
- Consultation & engagement (including on-going patient participation)

Briefing sessions have been provided to commissioners across the Strategic Commission to support how they evidence any anticipated impact on quality and patient safety through commissioning decisions; support will continue to be provided by the quality team to support robust evidenced based decision making.

CQUINs

The Strategic Commission ensures CQUINs are offered to commissioned providers in line with the National Guidance. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. Performance of CQUINs is monitored via the provider Quality Contract meetings. National indicators have a focus on: -

• Improving the outcomes and experience of patients with mental health needs
• Enabling GPs to have better access to consultants to determine the best course of action for their patients and make it easier for GPs to access appointments for their patients
• Provider collaboration to support patients in hospitals to get back home in a safe and timely manner
• Patients accessing advice and referral to services to prevent ill health related to tobacco and alcohol
• Community services placing a greater emphasis on wound care leading to better patient and system outcomes
• Empowering staff to help patients take more control of their own existing long term conditions
• Supporting patients to move through the urgent care services in a way that meets their clinical needs.

Quality Initiatives

NHS Five Year Forward View (2014) states that health service must invest in preventative health strategies and work closer with social care partners in order to meet the needs of the population. The SCF has worked in partnership with the ICFT to develop two local quality initiatives which aim:

1. Standardise and improve infection prevention and control practice amongst non-acute care providers – in particular reaching out to care homes and care homes with nursing.

2. Standardise and improve wound care prevention and management amongst healthcare workers in the community (residential staff, care homes with nursing staff and home care workers)

Quality Expectations

All contracts specify the outcomes and quality standards, planned monitoring arrangements and penalties where these apply. Where a risk to quality is identified, the CCG will escalate as appropriate and will use appropriate commissioning and contractual levers to bring about improvements.

Securing and improving quality cannot be achieved by the Strategic Commission in isolation. We recognise that our patients' journey cut across primary, secondary and specialist care, health and social care, with services commissioned and delivered by multiple organisations and professions both within and outside the NHS. We appreciate the commitment of our partners to work with us in improving quality. We will continue to support and collaborate with provider organisations to improve the quality of services provided, whilst holding them to account for standards of service delivery.

The Quality and Safeguarding team produce a quarterly Quality Assurance report for all commissioned services and a monthly Quality and Safeguarding exception report. The team also provides a bi monthly report to GM Health and Social Care Partnership highlight and quality and patients safety areas of concern.

Provider Monitoring

The Strategic Commission has established contract monitoring processes in place to routinely monitor the quality and performance of our lead commissioned providers; these meetings take place on a routine basis.

There are existing mechanisms within the CCG / Strategic Commission to escalate any risk where a provider is not making satisfactory progress to improve quality and / or performance as expected by implementing existing contracting levers and also via escalation to GM Health and Social Care Partnership as appropriate.

Where the Strategic Commission acts as an Associate Commissioner we have mechanisms in place whereby the lead commissioning organisation notify the Strategic Commission of any quality / performance concerns; this would be managed via their own internal contract monitoring mechanisms and escalation to GM Partnership where appropriate.

There is a quality assurance framework for primary care which details how to provide the CCG Governing Body / Strategic Commission Board with assurance as to the quality of primary care. It has three levels of escalation from routine monitoring at level 1 to escalation to the Primary Care Committee at level three.

In order to deliver on this framework the quality team aim to further develop their existing quality assurance mechanisms to ensure quality assurance across the whole health and social care economy is available to SCB and GB (see local priorities).

ICFT Contract Management Framework

The Contract Management Framework brings together the quality and outcome elements of the ICFT contract providing a framework to monitor assurance against each of the areas within it, seeking such assurance from existing groups / structures where appropriate. The framework provides the Director level Contract Management Group with robust assurance on the detailed monitoring of the contract, ensuring the required links are made with financial and activity monitoring and will set the programme of work / agenda for a Contract Quality & Performance Assurance Group.

Provider Quality Visits

The Strategic Commission ensures that they see at first hand the quality of care being provided to patients and service users. We will visit provider organisations to observe care delivery, the environment that it is being provided in and to speak to patients, relatives and staff regarding their experiences of receiving or providing care. The Strategic Commission will provide feedback to the provider on their observations and also reflect the findings and outcomes of the visits in Strategic Commission Quality reports.

Visits take place with the prior agreement and notification of the provider, unless there are significant concerns relating to standards of quality and safety whereupon an unannounced visit may be appropriate.

Research and Development:

The Strategic Commission seeks assurance that providers are effectively using research activity and research methodologies to contribute to achieving its duty to improve health care for the patients in Tameside and Glossop, based on sound clinical evidence.

Patient Experience:

The Strategic Commission draws on a range of patient experience to help monitor the quality of commissioned services including Patient Opinion stories, complaints, Healthwatch, Equality and Diversity group, serious incidents, national patient experience survey, Friends and Family Test and quality visits.

Safeguarding:

The Strategic Commission is committed to ensure that the risks of abuse and neglect to adults, children and young people are minimised and that children and young people achieve their optimal life chances. T&G SCF achieve this by providing support to all of its commissioned services around their safeguarding responsibilities and ensuring robust

safeguarding systems, training, policies and procedures are in place that facilitates effective multi-agency working. It also contributes to the multi-agency partnerships for safeguarding via the Local Safeguarding Children's Board and Safeguarding Adults Board.

Equality and Diversity:

The Strategic Commission needs to be assured that the services it commissions on behalf of its local populations are equitable for all: that they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. The mechanism for seeking this assurance is via information from providers to fulfil the EDHR (Equality, Diversity and Human Rights) element of the contract; the utilisation of this for informing commissioning and quality assurance is an area for development.

Quality Accounts

Large providers of NHS care are required to publish a Quality Account each year. The account must contain a retrospective review of performance of key quality initiatives and priorities and set out the quality priorities for the forthcoming year. Providers are also required to outline the clinical audits that they have taken part in or have undertaken independently. The account will be available publicly however before it is published CCGs must be given the opportunity to comment on providers' quality accounts. Providers must include the comments from the CCG in their entirety, in the final publication of the account. Accounts will be monitored through the relevant quality groups to ensure that they are an accurate account of quality and that progress against the identified priorities is being made

T&G SCF will provide comments on the Quality Account for the providers where they act as lead commissioner. Comments will be signed off by Director of Quality and Safeguarding and Chief Executive. Providers will be monitored for performance and progress against the clinical priorities through the quality contract meetings.

Promoting Quality within Nursing and Care Homes

Tameside and Glossop Strategic Commission is working to develop quality assurance and improvement within Care and Nursing Homes;

A proposal for a dedicated Quality Improvement Team for the Care Sector was approved by the Strategic Commissioning Board in May 2017. The team will have varied skill mix and work within Provider Quality Improvement Programme (PQIP) framework to provide support and drive up quality within the sector.

An internal review of current processes has been initiated by the Strategic Commission. All contractual documentation, quality assurance processes, and governance is in the process of being reviewed and a subsequent action plan will be developed to ensure that processes are in line with CQC KLOEs, GM Standards and be proactive in identifying areas of support required from the Quality Improvement Team. This work will continue to be a priority area for development.

Assurance and Governance Structures

Tameside and Glossop SCF Quality and Performance Assurance Group:

The purpose of the Quality and Performance Assurance Group is to provide assurance to the Strategic Commission Board and to the Governing Body of the quality of all commissioned services. The group will promote and provide assurance on all matters relating to the vision and framework for continuous improvement, covering all aspects of efficient, effective services, patient safety and experience and ensuring compliance with regulatory standards. It will provide assurance that arrangements are in place to proactively identify early warnings of a failing service, and that there are appropriate arrangements in place to deal with and learn from Serious Untoward Incidents (SUIs) and Never Events.

The Quality and Performance Assurance Group relies on both quantitative and qualitative information, hard and soft intelligence to provide assurance on quality of care. High levels of trust and well developed relationships between commissioners and providers are vitally important.

No one source of information by itself is sufficient to provide complete assurance or to signal potential areas of risk. Much of the data comes from providers and the quality team draw assurance from this information, along with triangulating information from other sources such as patient experience data, to develop a complete picture as possible on quality of care for any and each provider:

Strategic Commission Board

The Strategic Commission Board is not a statutory body and does not replace any of the existing statutory bodies in the locality; it acts as an advisory group making recommendations to the two statutory organisations (Tameside Metropolitan Borough Council and NHS Tameside and Glossop Clinical Commissioning Group)

Members make recommendations on the design, commissioning and on the overall delivery of health and care services including the oversight of their quality and performance.

Greater Manchester Health and Social Care Partnership Arrangements for Quality

Greater Manchester Health and Social Care Partnership has established a Quality Board (formerly the Quality Surveillance Group) which has representation from all CCG's, Monitor, CQC, Local Authority representation and Health Watch representation. The Quality Board systematically brings together the different parts of the health and social care system to share information. It is a proactive forum which provides: -

- a shared view of risks to quality through sharing intelligence;
- an early warning mechanism of risk about poor quality; and
- opportunity to coordinate actions to drive improvement, respecting statutory responsibilities of and on-going operational liaison between organisations.

Where improvements about quality are not achieved and concerns remain about quality or safeguarding then these are escalated to Single Item Quality Surveillance Group meetings

The Quality Board acts as a virtual team across a health and social care economy, bringing together organisations and their respective information and intelligence gathered through performance monitoring, commissioning, and regulatory activities. By collectively considering and triangulating information and intelligence, Quality Board will work to safeguard the quality of care that people receive.

Quality Priorities for 2017/2019

National priorities: Quality should permeate everything we do: from the way we plan and commission care, to the way we work with services to drive improvement and innovation. Alongside the "must do's" in respect of 1. Sustainability and Transformation Plans and 2. Finance the NHS Shared Planning Guidance 2017 – 2019 also describes priority areas where we need a particular focus:

3.Primary Care, including: •implementing the General Practice Forward View; •ensuring local investment meets or exceeds minimum required levels; •tackling workforce and workload issues; and •extending and improving access in line with requirements for new national funding.	4.Urgent and Emergency Care (UEC), including: •delivering the four hour A&E standard, and standards for ambulance response times; •meeting the four priority standards for seven-day hospital services for all urgent network specialist services; and •implementing the UEC Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint.	5. Elective Care, including: •delivering the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from RTT; •delivering patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018; •streamlining elective care pathways; and •implementing the national maternity services review, Better Births.
6. Cancer, including: •implementing the cancer taskforce report; •delivering the NHS Constitution cancer standards; and •improving one-year survival rates.	7. Mental Health, including: •delivering the implementation plan for the Mental Health FYFV; •ensuring delivery of the mental health access and quality standards; •maintaining a dementia diagnosis rate of at least two thirds of estimated local prevalence; and •eliminating out of area placements for non-specialist acute care.	8. People with Learning Disabilities, including: •delivering Transforming Care Partnership plans with local government partners; •reducing inpatient bed capacity; •improving access to healthcare for people with learning disabilities; and

		• reducing premature mortality.
9. Improving quality in organisations: All organisations should implement plans to improve quality of care, particularly for organisations in special measures; drawing on the NQB's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services; and participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare.		

Local Quality Priorities:

1. **Quality Assurance of wider health and social care economy:** In order to deliver on this framework the quality team aim to further develop their existing quality assurance mechanisms to ensure quality assurance across the whole health and social care economy is available to SCB and GB. Priority areas for developments are developing mechanisms to seek assurance on: -

    - Smaller value contracts
    - Public Health contracts
    - Independent Sector; care homes, care homes with Nursing, domiciliary care, supported living.
    - Adult Social Care services.
    - Individualised Commissioning for out of area placements
    - Children's services

2. **Quality Assurance of Services Commissioned by ICFT:** The Strategic Commission remains accountable for the quality of all services commissioned by ICFT including Transformation Programme, Neighbourhoods & Adult Social Care (future). It will therefore need to develop robust mechanisms to seek assurance of the quality of these services and the effectiveness of the ICFT's own contracting and quality assurance mechanisms for these services.

3. **Quality Assurance and Improvement work within Nursing and Care Homes:** The quality team will support and manage the Quality Improvement Team to provide support and drive up quality within the sector; particularly with a focus on those care homes rated by the CQC as Inadequate and requires improvement.

    The quality team will continue strengthen the contracting process to ensure quality assurance mechanisms align with CQC KLOEs, GM standards and support a proactive approach to identifying areas of support from the Quality Improvement Team.

4. **Quality Assurance and Improvement of Mental Health Services:** The quality team will strengthen its mechanisms for understanding and improving the quality of mental health services commissioned on behalf of the local population.

5. **User Experience:** The quality team will strengthen its mechanisms for understanding and providing a rounded view of the experience of people using services commissioned by T&G Strategic Commission.

6. **Quality and performance metrics for an integrated health and social care system:** In order to be assured that the new integrated health and social care system is performing well and improving quality the Strategic Commission will need a whole new set of quality and performance indicators to provide such assurance. The quality team will work with commissioners and key partners across the health and social economy to develop a framework to monitor the quality and performance of the system which reflects commissioning intention priorities and supports the ambition to move towards true outcome based commissioning of health and social care services.

TERMS OF REFERENCE
Quality and Performance Assurance Group

Emphasis that as a group they review quality across all services including Glossop

1. **CONSTITUTION**
The Quality and Performance Assurance Group is an internal CCG and Strategic Commission Function meeting of the Governing Body of Tameside and Glossop Clinical Commissioning Group and of the Strategic Commissioning Board to scrutinise the quality and performance of the services we commission.

2. **AIM**
The group is a forum for reviewing and assessing risk in examining in detail the information received by the Strategic Commission and CCG pertaining to the quality and performance of commissioned services including patient experience.

The group will be the space where the numerous information sources are reviewed together and triangulated and mitigating actions discussed.

The group will not meet in public due to the confidential nature of some of the data. However it will provide public-facing assurances to the Strategic Commissioning Board, and to the Governing Body.

3. **PURPOSE**
The group's purpose is to provide assurance to the Strategic Commission Board, and to the Governing Body of the quality of all commissioned services.

The Quality and Performance Assurance Group is established in accordance with NHS Tameside and Glossop Clinical Commissioning Group's constitution, standing orders and scheme of delegation. It will also align with the new governance arrangements of the Strategic Commission Function, once agreed. These terms of reference set out the membership, remit and responsibilities and reporting arrangements of the group and are an appendix to the CCG's Constitution. The Quality and Performance Assurance Group will promote and provide assurances to the Governing Body and Strategic Commission Board, on all matters relating to the vision and strategy for continuous quality improvement, covering all aspects of efficient, effective services, patient safety and experience, and ensuring compliance with regulatory standards. It will provide assurance that arrangements are in place to pro-actively identify early warnings of a failing service, and that there are appropriate arrangements in place to deal with and learn from Serious Untoward Incidents (SUIs) and Never Events.

The Quality and Performance Assurance Group is authorised to commission reports, reviews, audits, hard and soft intelligence, action plans, including progress and exception reports, investigations and assurance visits through the combined resources of the CCG, Strategic Commission Function and/or local health economy, also requesting attendance of individuals and authorities from within and external to, the CCG and Strategic Commissioning Framework, with relevant experience and expertise, as it deems necessary.

The Quality and Performance Assurance Group is responsible for the development and implementation of a Quality Strategy, which sets out the framework for Quality Improvement and Quality Assurance of all commissioned services.

4. SCOPE & DUTIES OF THE GROUP

The Quality and Performance Assurance Group will:-

4.1 Ensure that the CCG's and SCF's Quality Strategy & Vision are developed and implemented, with tangible actions, milestones and measurable outcomes, to ensure that Commissioning incorporates and upholds the tenets of quality (patient safety, experience and clinical effectiveness) and that the quality priorities within the Operating Framework and recommendations for the National Quality Board, are met.

4.2 Support the Commissioning Strategic Plan and prioritisation within the planning cycle, by ensuring that quality assurance and Clinical Governance mechanisms are systematically addressed and integral to the monitoring of commissioned services, to ensure better outcomes for patients.

4.3 Ensure that the quality agenda leads to improvements in productivity and prevention through innovation whilst providing assurance that patient safety is paramount in decommissioning decisions.

4.4 Provide assurances to the Governing Body and Strategic Commissioning Board that CQUIN (Commissioning for Quality and Innovation) schemes for contracts and Provider Quality Accounts are appropriate, challenging and will lead to significant improvement in quality of services.

4.5 Provide assurance on progress in relation to CCG quality premiums.

4.6 Provide assurance to the Governing Body and the Strategic Commissioning Board that the health economy has appropriate and robust systems and processes in place to fulfil statutory duties for adult and children's safeguarding (Boards) in both Tameside and Derbyshire.

4.7 Ensure the CCG and Strategic Commissioning Function has robust arrangements in place to bring together and review systematically, agreed quality measures for patient safety, clinical effectiveness, patient experience and complaints.

4.8 Identify any areas of quality risk for inclusion within any appropriate Risk Registers and to oversee the processes for mitigation of these risks, ensuring they reflect fully, implications and actions for all Departments/areas of CCG activity.

4.9 Provide as a minimum, quarterly reports and assurances (and as required by exception) to the Governing Body and Strategic Commissioning Board on the quality of commissioned services, and that appropriate interventions are being taken where quality is below acceptable levels, limiting risk and supporting the improvement of public trust in the local health and social care economy.

4.10 Receive reports relating to safeguarding to provide the group with assurance that all commissioned services are compliant with statutory regulations.

4.11 Review and provide commissioning response to provider annual Quality Accounts.

4.12 Oversee the development and monitoring of quality indicators and metrics within commissioned services and seek assurance of implementation through quality schedules.

4.13 Advise the Governing Body and Strategic Commissioning Board on actions required following National Enquiries, Serious Case Reviews (SCRs) – Domestic Homicide, Mental Health assessments learning reviews, National and local reviews undertaken by external agencies (e.g. Care Quality Commission) in relation to commissioned services and oversee the performance management of recommendations implementation.

4.14 Ensure a clear escalation process is in place to enable appropriate engagement of external bodies (e.g. GM Health and Social Care Partnership) on areas of concern in commissioned services.

4.15 Seek assurance on the performance of commissioned services with regard to regulatory requirements in relation to quality and safety, e.g. CQC, Monitor, NICE recommendations/guidelines.

4.16 Publish an annual report setting out progress against the Commissioning for Quality Framework (Appendix 1 – currently being updated).

5. STANDING ITEMS

Reports to be received:

Monthly (circulated for virtual review if no meeting held):

Performance and Quality report (Business Intelligence)
Directorate reports detailing concerns or issues relating to all commissioned services - by exception.
Reports from all Health and Social Care Improvement Boards.
STEIs – Serious Incidents reported in a timely manner with detail of any mitigating action
Updates from improvement Boards

Bi-monthly:

Feedback from the GM Quality Board report

Quarterly:

Adult and Children's Social Care reports
GM Safeguarding Stakeholder report
CQUINs report
Primary Care report
Care Homes/Home Care report including al CQC outcomes and performance visits
Quality Premiums report
Quality report (overall)

Annual:

Safeguarding report (Prior to full Board)
Local Safeguarding Boards Adult and Child reports (Prior to full Board)
Quality Accounts for main providers.
Reports received from Quality Summits or Improvement Boards
HealthWatch Intelligence reports
Annual Report on Quality Premiums

6. MEMBERSHIP

6.1 The membership of the Quality and Performance Assurance Group shall consist of:-

CCG Governing Body Nurse (Chair)
TMBC Executive Member (Deputy Chair)
Governing Body GP and Clinical Lead for Quality
Director of Commissioning
Director of Public Health
Head of Business Intelligence and Performance
Director of Quality and Safeguarding
Director of Adults and Children's Services
HealthWatch (Tameside and Glossop)
Corporate Communications and engagement representative
NB: These will all need to reflect the new roles and needs to state or deputy with authority.

Provider representatives will be invited to attend for specific items at the request of the committee.

Officers of the Strategic Commission Function will attend on an invitation only basis to present reports.

6.2 The group may also co-opt other senior clinicians or managers or clinical representatives from commissioned services as necessary. These will be non-voting members of the group. The Chair of the Governing Body and the Chief Executive of the Strategic Commission has the right to attend any meeting. Additionally, Executive Directors not included in the core membership above, have an open invitation to attend all meetings, and may be requested to attend for specific items.

7. QUORUM & ATTENDANCE

7.1 A quorum will be a third of all members; with a minimum of two of those being members of the Governing Body and the Strategic Commissioning Board, and at least one clinical member should be present.

7.2 An annual calendar of meetings will be agreed. Fourteen days' notice shall normally be given of all meetings, including extraordinary meetings where required. Where fourteen days is not possible, the Group's Chair (in the Chair's absence the Deputy Chair) shall approve any arrangements at short notice. Agenda and supporting papers will be circulated as far as possible seven days before the meeting.

7.3 Fully briefed deputies, with relevant and appropriate decision making authority shall be permitted, where necessary, with the agreement of the Chair.

7.4 Each member is expected to attend a minimum of 75% of scheduled meetings per annum, and, otherwise be represented by a designated deputy.

8.0 FREQUENCY OF MEETINGS

Meetings will be held at such intervals as the Chair should deem necessary for the group to discharge its responsibilities, but shall be at least every two months.

9.0 CONFLICTS OF INTEREST

Members will be expected to declare any conflicts of interest at all meetings and the Chair will determine how those discussions will be conducted.

10.0 AUTHORITY

The Quality and Performance Assurance Group Committee is empowered on behalf of the Governing Body and the Strategic Commissioning Board to examine and investigate any activity pursuant to the above scope/duties.

11.0 REPORTING

The Chair will present bi-monthly assurance update reports (not minutes) to the Strategic Commissioning Board Governing Body following each meeting of the group. The Executive Member will be able to support these presentations regarding the level of scrutiny undertaken by the group.

The Quality and Performance Assurance Group will report to each CCG Governing Body and Strategic Commissioning Board meetings, providing assurances in respect of the areas within its remit. Key matters, concerning performance and risk, including mitigating actions and decisions requested by the Governing Body and Strategic Commissioning Board within the Quality and Performance report and by separate reports by exception when necessary. The Quality and Performance Assurance Group will ensure all relevant matters have been brought to the attention of the Executive Team, and the Audit Committee, in a timely manner, including copies of the minutes of each meeting.

12.0 REVIEW OF TERMS OF REFERENCE

These Terms of Reference will be reviewed by this group in 3 months and as a minimum every 12 months thereafter.

This page is intentionally left blank

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	20 March 2018
Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP**

Report Summary:

Tameside and Glossop Strategic Commission have led the development of a locality vision for an enhanced offer of urgent care i.e. support for conditions that need prompt medical help to avoid them deteriorating but are not life threatening. Officers were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) following public consultation.

This report includes the full detail of the consultation analysis, and an Equality Impact Assessment which responds to issues arising within the consultation and explores mitigations.

Recommendations:

The Strategic Commissioning Board and Clinical Commissioning Group is requested to NOTE:

- The content of this report which charts the process from October 2017, when the Strategic Commission agreed to review options for the future Integrated Urgent Care provision, to drive improvements in clinical outcomes, patient experience and operational efficiency, to the proposed recommendations on the way forward.
- The case for change.
- The responses arising from the Urgent Care consultation and the Strategic Commission responses which have shaped the recommendations to this Board.
- The detailed Equality Impact Assessment which outlines further mitigations.
- The intention of the Tameside and Glossop Strategic Commission to work with partners/stakeholders to continue to develop local, appropriate health and social care provision, including supported accommodation, to meet the needs of our population in the future.

The Strategic Commissioning Board and Clinical Commissioning Group is RECOMMENDED:

- To confirm appropriate mitigations have been identified to address any adverse impacts caused by the relocation of walk in access from Ashton Primary Care Centre to the Hospital site.
- To agree the relocation of walk-in access from Ashton Primary Care Centre to hospital site.
- To approve Option 2, as outlined within the consultation, as the preferred model for future provision of Urgent Care.

Financial Implications:

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

ICF Budget	S 75 £'000	Aligned £'000	In Collab £'000	Total £'000
TMBC Adult Services	-	-	-	-
TMBC Children's Social Care	-	-	-	-
TMBC Population Health	-	-	-	-
TMBC Other Directorate	-	-	-	-
CCG	2,811	-	1,018	3,829
Total	**2,811**	**-**	**1,018**	**3,829**

Section 75 - £'000 **Strategic Commissioning Board**	Out of Hours (£1,744k recurrent), Extended access (£807k recurrent) and Alternatives to Transfer (£260k non recurrent) are all included in the Section 75 pool.
CCG – In Collaboration - £'000 **CCG Governing Body**	GP walk in centre (£1,018k recurrent) is part of the delegated co-commissioned budget with NHS England.

Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison

The paper sets out two options.

Option 2 was favoured in the public consultation is forms the recommendation of this report. Option 2 is affordable within the financial envelope set out above and would be expected to deliver some baseline level of recurrent savings.

However it should be noted that option 1 could be delivered at a lower cost. The savings associated with option 1 would be approximately £121k higher than contained within the recommendation.

Legal Implications:

(Authorised by the Borough Solicitor)

An open and transparent consultation process has been undertaken to attract maximum public engagement in order to ensure the best possible outcome for the community in accordance with the resources available. 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. Such actions also support compliance with the public sector equality duty. This has been

	reflected in the Equality Impact Assessments attached to this report at various appendices, to which decision makers are required by law to have due regard before making any decisions.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The urgent care proposals are in line with the locality plan and the Care Together model of 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 October 2017 and the recommendation to consult on the 2 options for urgent care in Tameside and Glossop, with no preferred option.
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 has been completed and is attached to this report.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of urgent care services to meet individuals' needs across the locality and address health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment (EIA) is attached as an appendix to this report.
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation. The provider of the Urgent Treatment Centre will be Tameside & Glossop Integrated Care NHS Foundation Trust and the GM Safeguarding Standards are included in the ICFT contract. The contract for the Neighbourhood Care Hub and Out of Hours element of the services will also include the GM Safeguarding Standards.
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. The commissioner will seek assurance from all parties involved in the delivery of urgent care that appropriate arrangements are in place. The locality's Information Governance Working Group will sense check the data flows and Information Governance requirements relating to this project.
Risk Management:	This transformation programme will be managed via the Care Together Programme Management Office. The risks will be reported and monitored via this process.

Access to Information :

Appendix 1 – October 2017 Strategic Commissioning Board Report – obtainable at

Tamesideandglossopccg website Get Involved Urgent Care section

Appendix 2 – Consultation Questionnaire

Appendix 3 – Consultation Material Information

Appendix 4 – Social Media information

Appendix 5 – Community and Wider Engagement

Appendix 6 – Analysis of Consultation Survey Responses

Appendix 7 – Quality Impact Assessment

Appendix 8 – Equality Impact Assessment

Appendix 9 – Travel Times and Maps

The background papers relating to this report can be inspected by contacting Elaine Richardson, Head of Delivery and Assurance:

 Telephone: 078554569931

 e-mail: elaine.richardson@nhs.net

1 INTRODUCTION

1.1 Tameside & Glossop Strategic Commission have led the development of a locality vision for an enhanced offer of urgent care i.e. support for conditions that need prompt medical help to avoid them deteriorating but are not life threatening.

1.2 In October 2017, the Strategic Commissioning Board agreed to consult on two options for the delivery of urgent care within Tameside and Glossop locality. Both options involved the development of an Integrated Urgent Treatment Centre at Tameside and Glossop Integrated Care NHS Foundation Trust hospital site and the proposed relocation of the current Ashton Walk-In Centre service to facilitate this. The options differed in the locations for evening and weekend appointments within Neighbourhood Care Hubs and there was no preferred option.

1.3 The two options have been the subject of public consultation over a 12 week period from 1 November 2017 to 26 January 2018. In addition to the public consultation, additional community engagement has taken place through contacting specific groups across Tameside & Glossop.

1.4 This report includes the full detail of the consultation analysis, and an Equality Impact Assessment which responds to issues arising during the consultation and explores mitigations.

2 CASE FOR CHANGE

2.1 The increasing demand on the health and social care system and the local commitment to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment led to a series of service reviews. These along with, national requirements to provide a streaming service in every Accident and Emergency (A&E) and an Urgent Treatment Centre (UTC) - which is GP-led, open 12 hours a day every day and provides access to urgent diagnostics, led to the development of the model outlined in this paper, and the consultation approved by the Single Commissioning Board on 31 October.

2.2 The detail of the 'case for change' was included in the report presented to the Strategic Commissioning Board in October 2017. The October report is attached to this paper at **Appendix 1**.

3 VISION AND OPTIONS DEVELOPMENT AND ENGAGEMENT

3.1 A key principle of Care Together is that people are seen by the right professional in the right place to meet their needs. Ensuring people who have an accident or need emergency acute health care can be treated quickly in A&E and people with an urgent care need can be treated within primary care is fundamental to this principle.

3.2 The vision and options were developed using the learning from conversations with a range of public groups since 2014. In May 2017, the Practice Neighbourhood Groups were involved in discussions specifically around Urgent Care to validate the previous feedback and gather further ideas.

3.3 Transport and access have been central to the option development from the start with initial transport analysis included in discussion papers and workshops. Section 7.14 and the Equality Impact assessment in **Appendix 8** shows how the travel analysis has been considered. Travel maps can be found in **Appendix 9**. Specific reference was made regarding travel in the consultation materials namely: travel time in the Fact Sheet as below:

15	Our proposal is to relocate the Walk in Service from Ashton Primary Care Centre to an Urgent Treatment Centre at Tameside Hospital. Tameside hospital is 1.5 miles from the APCC which means there is no demonstrable difference in travel times for those travelling by car. Some people's journeys may be shorter and some longer. Our transport analysis shows that on average 99.8% of Tameside and Glossop residents are within 0-30 minutes drivetime of both APCC and the hospital whether travelling at peak time weekday morning, peak time weekday afternoon / evenings, off peak weekdays or weekends.

And public transport in the FAQ as below

Q10	Where can I get more information about public transport to the locations where urgent care is provided?
A10	For Tameside go to: www.tfgm.com/Pages/default.aspx For Glossop go to: www.derbysbus.info/times/tt_201_999.htm.

The Find out More option 

on the website provided access to the consultation stage Equality Impact Assessment which included the travel analysis.

3.4 The vision and overarching model was discussed at the Professional Reference Group made up of clinicians, care professionals and officers on 7 June 2017. The early ideas and potential options developed from the feedback were discussed by a Local Design Group made up of representatives from a range of stakeholders - details are included in **Appendix 5**. The options were then further discussed in the Professional Reference Group on 2 August in the light of recently released national guidance. Following the discussion it was agreed to refine the options taking into account analysis of the Local Design Group feedback. Three options were then presented to the 6 September Professional Reference Group. These were refined again taking into account some early feedback from patient representatives, elected councillors and MPs which resulted in the two options presented to the Strategic Commissioning Board in October 2017.

.

3.5 The report presented to the Strategic Commissioning Board in October 2017 included details of the development of options to deliver the vision including the pre-consultation engagement. A copy of the October report can be seen at **Appendix 1 or** Tameside and Glossop SCB papers 31 October 2017. The following key messages around urgent care services have been taken from all these conversations.

3.6 Key factors in deciding where to go when an urgent need arises were:

- how serious the need was;
- trust in the person they will be seen by;
- ease of getting to a service; and
- the time it would take.

3.7 A&E and 999 were seen as the option for Emergency support and not somewhere to go for other needs. However, it was thought that when seeking help for a dependant a more cautious approach would be taken which may increase the tendency to use 999 or A&E.

3.8 People wanted prompt access to a local trusted person who can advise and or treat/resolve an urgent need, with the registered General Medical Practice frequently seen as best placed to fulfil that role. Having fears allayed quickly by speaking to the Practice or Pharmacy was seen as important and knowing, if needed, they will be treated in a timely manner was key

with fewer concerns about where they will be seen. Having access to other services such as Mental Health and Social Care through a more integrated service was seen as beneficial.

3.9 Car parking, distance and public transport links were highlighted as factors that influence where people attend and concerns were raised about the accessibility of the Ashton Primary Care Centre Walk-in Centre site. People felt the hospital site was well known and for Glossop in particular, the hospital site was easier to access than Ashton Primary Care Centre. Having a service at the hospital that differentiated need and avoided unnecessary use of A&E was seen as helpful.

3.10 Consistent opening times and services were seen as very important even if it reduced the number of places where the service was available especially as having too much choice often leads to confusion. Having somewhere in every neighbourhood would reduce how far people would have to travel.

4 THE URGENT CARE OFFER

4.1 The Tameside and Glossop vision for urgent care is that people who develop an urgent care need will be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist, pharmacy, optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service.

4.2 Key outcomes include:

- People are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue.
- People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
- People whose need can be met within a Neighbourhood do not attend A&E.
- People are equipped to reduce the risk of the same need arising in the future.

4.3 The usage of current services and feedback from local people suggests that a simplified service that builds on the trusted relationship between people and their registered practice would enable people to be seen in the most appropriate place by the most appropriate professional.

4.4 The urgent care offer will integrate five key services namely:- the existing Walk-in Centre; Out Of Hours GP services; the Alternative to Transfer service; Extended GP Access and Primary Care Streaming at A&E. It will provide enhanced urgent care through neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs alongside an Urgent Treatment Centre access point at the hospital site in Ashton.

4.5 Our proposed integrated urgent care service is fully in line with national expectations and will enable Tameside and Glossop to use the resources available to deliver an excellent service for local people.

4.6 **Proposed Model of Urgent Care in Tameside & Glossop:** The urgent care offer is centred on strong neighbourhood based access to General Practice to provide trusted advice and reassurance and enable people to be booked into an appropriate appointment 7 days a week.

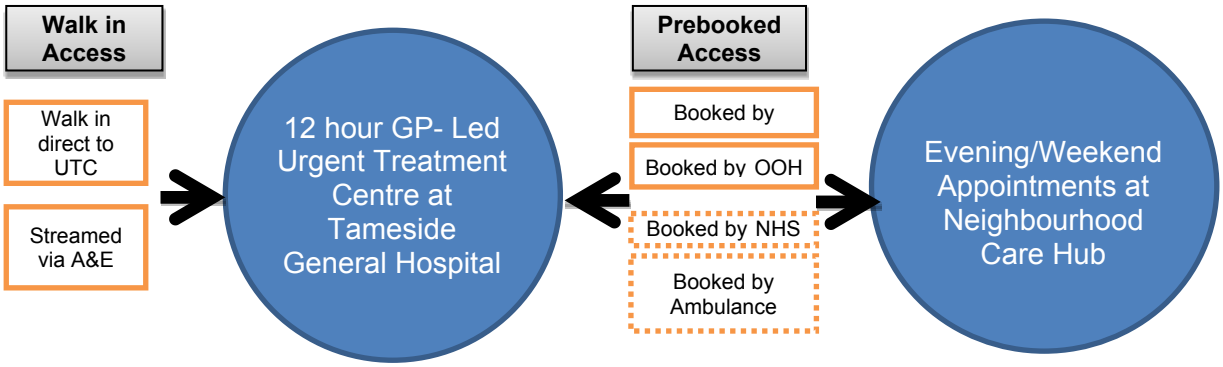
4.7 People will get 24/7 phone access to support either through their practice or NHS 111. The key point of contact ‘in hours’ (8 am to 6:30 pm weekdays) will be an individual’s GP practice. People will make initial contact with their own practice and appropriate advice or an appointment will be provided so when necessary they can be seen by the right professional

on the same day. Out of Hours (6.30 pm to 8.00 am weekdays and all day weekends) people will continue to ring NHS 111 who will be also be able to provide advice or arrange an appointment when required.

4.8 The Urgent Treatment Centre will provide walk-in access to ensure people who prefer not to contact their own GP or NHS 111 in advance or who are not registered with a Tameside and Glossop GP can fully access urgent care.

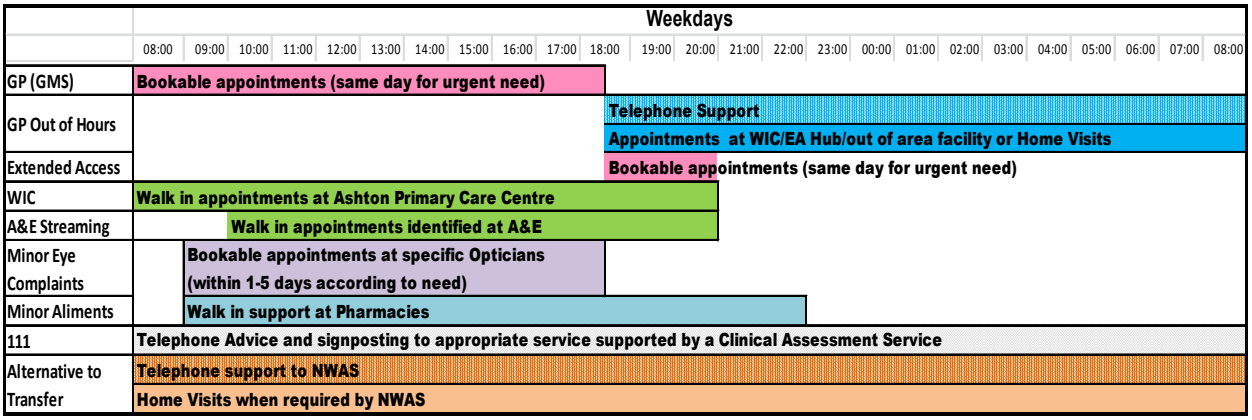
4.9 The Urgent Treatment Centre will be located on the same site as A&E which will enable direct and prompt access to urgent diagnostics, This single walk-in access point will reduce duplication and remove the need for the individual attending to differentiate between an urgent and emergency need as the triage point on the hospital site will ensure the patient is treated by the most appropriate professional. The single access point will also prevent people who walk-in at an out of hospital site needing to have travel themselves or be taken by ambulance to the hospital for diagnostics or emergency care. This will both reduce delays to treatment and make more effective use of ambulance services.

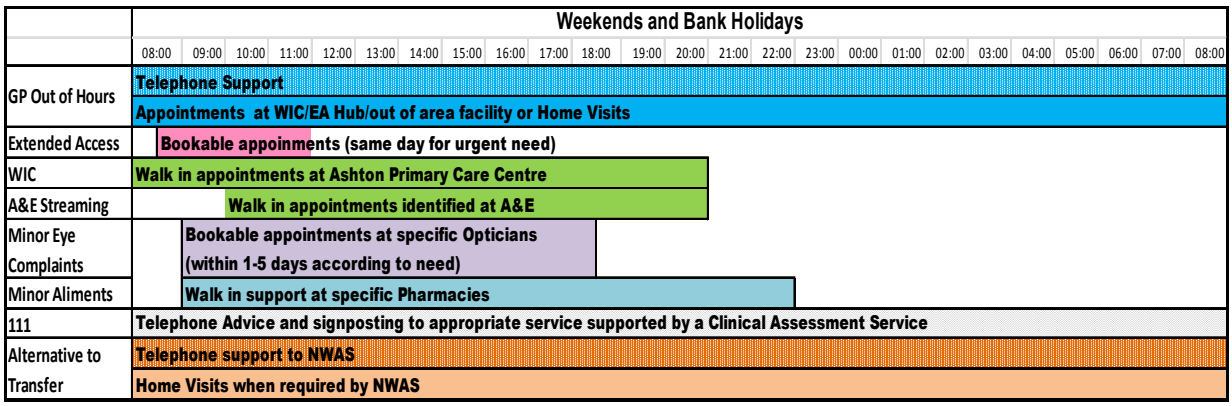
4.10 In summary the Urgent Treatment Centre will provide walk-in access with bookable access available at both the Urgent Treatment Centre and the Neighbourhood Care Hubs as below.



4.11 The services at all access points will include General Medical Primary Care with both routine and urgent needs accommodated through appointments available with GPs or members of the wider Primary Care Team. In addition, the Urgent Treatment Centre will be able to directly access urgent diagnostics e.g. urinalysis, ECG and in some cases X-ray. The integrated nature will enable people to receive a range of physical and mental health support promptly both on the hospital site and within neighbourhoods.

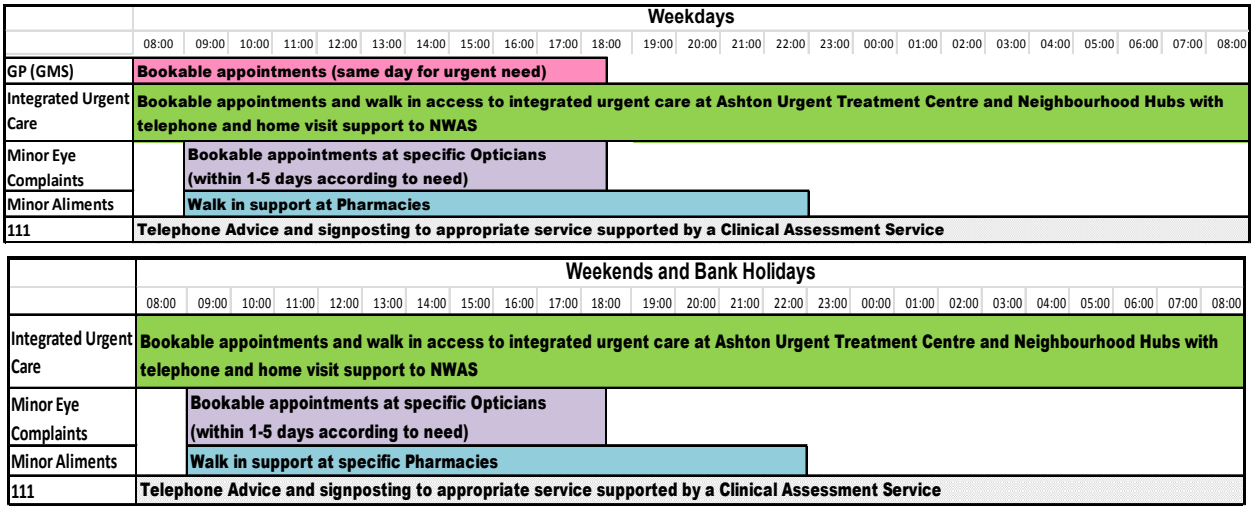
4.12 **Current Provision:** There are a range of separate services and providers delivering Primary Care support for people with an urgent need resulting in multiple access routes and a significant level of duplication in the offer available.





4.13 The national and Greater Manchester directive to have an Urgent Treatment Centre ideally co-located with A&E will add to the layers of service and complexity and would result in further duplication if the way existing services are delivered was not changed.

4.14 Key to the proposal is the simplification of services whilst extending the hours people can book into appointments and providing access to urgent diagnostics. The integrated urgent care service will work alongside the urgent access provided by GPs, Pharmacists and Opticians as seen below.



4.15 On 31st October 2017 the Single Commissioning Board (now known as the Strategic Commissioning Board) agreed to consult on two options for the delivery of urgent care, for a period of 12 weeks, commencing 1st November 2017 and ending on 26th January 2018. The full set of papers presented to the Single Commissioning Board on 31st October is available on the CCG website http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board. A summary of the options is outlined below.

Option 1 - In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Urgent Care booked appointments in **three** Neighbourhood Care Hubs via GP or NHS 111 as below:

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Ashton Primary Care

					Centre
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed

Option 2 - In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Urgent Care booked appointments in five Neighbourhood Care Hubs via GP or NHS 111 as below:

	Opening Hours		**Access**		**Location**
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	Not open*	Yes	No	Ashton Primary Care Centre
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre
South Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed
East Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed
West Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed

Not open* - Appointments can still be booked at the Urgent Treatment Centre and Glossop Hub

5 CONSULTATION PROCESS

5.1 In October 2017 the Strategic Commissioning Board approved the proposal that the urgent care model 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 Strategic Commissioning Board. The consultation was on the following two options:

Option 1 - An Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access and Urgent Care booked appointments in **three** Neighbourhood Care Hubs

Option 2 - An Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access and Urgent Care booked appointments in **five** Neighbourhood Care Hubs

5.2 The consultation ran from 1 November 2017 to 26 January 2018.

5.3 The online consultation closed on Friday 26 January. Paper copies of the questionnaire were accepted until 5pm on Monday 29 January 2018.

5.4 The consultation was hosted on the CCG website http://www.tamesideandglossopccg.org/get-involved/urgent-care-consultation. There was a standard questionnaire 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.**

5.5 In addition to the online consultation, paper copies were made available in all 39 GP surgeries across Tameside & Glossop, the Walk-in-Centre and 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. Copies were available at all public meetings and meetings with community groups. Each paper questionnaire returned was given a 'unique reference number' and inputted to the online consultation system, with the reference number included in the response.

5.6 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.**

5.7 A 'Fact Sheet' and 'Frequently Asked Questions' were posted on the CCG website consultation page and were reviewed throughout the consultation process to ensure they reflected questions raised through the public meetings and other community engagement processes undertaken. These are included at **Appendix 3**.

5.8 The full Equality Impact Assessment at the time of consultation was made available on the website through a Find Out More option. This included detailed transport analysis and neighbourhood (referred to as localities in the document) profiles. The updated assessment using analysis from the consultation can be found in **Appendix 8**.

Planning, assuring and delivering service change for patients

5.9 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.[1]

5.10 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

5.11 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

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

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

Promotion and Communications

5.13 The urgent care consultation has been promoted extensively since 1st November 2017. The NHS T&G CCG website included a webpage hosting the consultation which includes a copy of the full report presented at Strategic Commissioning Board, a booklet outlining key information relating to the proposed options, a key factsheet, frequently asked questions, the full Equality Impact Assessment and a link to the consultation itself (http://www.tamesideandglossopccg.org/get-involved/urgent-care-consultation)

5.14 In addition the consultation has been shared and promoted in a number of ways, as summarised below.

- The Urgent Care Consultation was available via the Tameside Council, Care Together and Big Conversation websites
- Press release issued to:
  - Mossley Correspondent
  - BBC Radio Manchester
  - Probash Bangla news
  - Revolution radio
  - High Peak radio
  - Tameside Reporter
  - In & Around Tameside magazine
  - Key 103
  - Glossop Chronicle
  - Manchester Evening News
  - BBC News online
  - Granada Reports
  - About Tameside magazine
  - Your Tameside magazine
- Articles on the Tameside Reporter and Glossop Chronicle websites on 2 January 2018. The same article also featured in the print edition of the Tameside Reporter on 2nd January 2018.
  https://glossopchronicle.com/2018/01/time-is-running-out-to-have-your-say-on-urgent-care-access/
  https://tamesidereporter.com/2018/01/time-is-running-out-to-have-your-say-on-urgent-care-access/
- Big Conversation online (consultation and engagement) community members (249) were directly emailed about the Urgent Care Consultation.
- E mails were sent outlining details of the consultation 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.
- The Urgent Care Consultation was promoted by social media messages posted on the Tameside Council, Tameside and Glossop CCG, and Care Together social media accounts. Details can be found in **Appendix 4**.
- A4 and A3 promotional posters, paper copies of the consultation, and pre-paid return envelopes were sent to all Tameside and Glossop GP Practices, Ashton Primary Care Centre, and all Tameside and High Peak libraries.
- Item included in the Chief Executive's Brief (3 November) for all Council staff which includes pension fund and Elected members, all CCG staff, all GPs, Practice Nurses and Practice Managers, CCG Board, ECG Board and Mark Tweedie.
- Advertisement in Tameside Reporter and Glossop Chronicle - 9 November 2017.

Response Rates

5.15 In total, 380 responses were received to the online questionnaire hosted on the CCG website. This includes 63 returned paper questionnaires. The analysis of the responses can be found in section 7 and **Appendix 6**.

6 COMMUNITY AND WIDER FEEDBACK

Community and Patient Engagement

6.1 In addition to the consultation hosted on the CCG website, and the public meetings, over 120 community and patient groups were contacted by the CCG 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 5**.

6.2 The consultation was presented to a number of stakeholders between 1 November 2017 and 26 January 2018 through a range of meetings.

6.3 These included Local Authority fora and meetings, across the Tameside (Tameside Metropolitan Borough Council) and Glossop (Derbyshire County Council) neighbourhoods, including the Overview & Scrutiny Panels and formal town council meetings.

	Date
Audenshaw Town Council	7 November 2017
Hyde Town Council	13 November 2017
Dukinfield Town Council	16 November 2017
Ashton Town Council	21 November 2017
Scrutiny - Derbyshire – Health	27 November 2017
Community Select Committee (High Peak)	29 November 2017
Stalybridge Town Council	06 December 2017
Mossley Town Council	06 December 2017
HWBB – Derbyshire	07 December 2017
Denton Town Council	07 December 2017
Longdendale Town Council	12 December 2017
Scrutiny - Tameside - Integrated Care	11 January 2018
HWBB – Tameside	25 January 2018

6.4 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 CCG representatives to attend their meetings. This information is summarised in the table below.

	Date
Practice Neighbourhood Group – Ashton	17 November 2017
BME Group	23 November 2017
Carers Rights	24 November 2017
Practice Neighbourhood Group – Glossop	12 December 2017
Gamesley Men's Group	15 January 2018
Gamesley Ladies Group	25 January 2018
Millbrook PPG	24 January 2018
Gamesley Integrated Team	25 January 2018
Homelessness Support	26 January 2018

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

	Date
Ashton Neighbourhood	1st November 2017
Denton Neighbourhood	7th November 2017
Practice Nurse Forum	6th November 2017
Hyde Neighbourhood	3rd November 2017
Practice Nurse Forum	09 November 2017
Local Medical Committee	13 November 2017
Stalybridge/Mossley Neighbourhood meeting	14 November 2017
GP Target	16 November 2017
GP Practice Managers	21 November 2017
Glossop Neighbourhood meeting	30 November 2017
Primary Care Committee	06 December 2017
CCG Governing Body Meeting	20 December 2017

6.6 A summary of the issues raised in the meetings referred to above is as follows:

- Costs and availability of car parking on the hospital site;
- Lack of walk-in access at Glossop;
- Variation across practices for availability of same day appointments;
- Difficulties with being able to get through to practice by telephone;
- Availability of access when bus passes can be utilised;
- Neighbourhood Hub locations need to be accessible to whole neighbourhood;
- Concerns about having primary care at the hospital as may encourage people to use it if more access available;
- Will need good communication to avoid people attending Ashton Primary Care Centre by mistake once WIC moves;
- All practices and NHS 111 will need to offer the evening and weekend appointments.

Positive comments:

- Support for single place for walk-in access with professionals ensuring an individual is seen by the right person;
- Single walk-in access avoids the risk of having to still attend A&E when went to an alternative Walk-in Centre;
- From Glossop easier to get to hospital site than Ashton Primary Care Centre by public transport;
- Having increased neighbourhood services.

6.7 More detailed comments raised in the meetings can be found in **Appendix 5**.

Provider Engagement

6.8 Local providers of urgent and emergency care services are represented on the Tameside and Glossop A&E Delivery Board which meets monthly. An update on the proposed urgent care service has been provided at all meetings since March 2017.

6.9 Tameside and Glossop Integrated Care Foundation Trust, Pennine Care, Go to Doc, Orbit, GM Primary Eye Care and the Local Primary Care Representative committees were all contacted by email to inform them of the consultation and an offer was made to attend any meetings to present the proposal.

6.10 Meetings were attended with Orbit, GM Primary Eye Care and the Local Medical Committee.

6.11 All providers were asked to actively promote the consultation amongst their users.

Members of Parliament

6.12 The Members of Parliament representing the four constituencies in Tameside & Glossop were invited to a briefing on 20th October. Two attended with the others being briefed separately outside of the meeting. No formal feedback has been received.

Public Meetings

6.13 During the consultation period, three 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
5 December 2017, 6pm, Guardsman Tony Downes House Droylsden	4
6 December 2017, 12noon at Action Together, 95 Penny Meadow, Ashton-under-Lyne	2
11 January 2018, 10am, Glossop Cricket Club, Glossop	5

6.14 The public meetings were all recorded and Key points and issues raised are included in the summaries below:

Droylsden - 5 December 2017

- General consensus was positive and feedback given from PPG member in attendance was that it was a 'no brainer'
- Comments around clarification of various elements of the process streaming etc.

Ashton - 6 December 2017

- End of life/hospice care may impact Urgent Care Services and felt there was a way to look at this proactively to avoid urgent responses being required - A Lea spoke of aspirations to ensure daytime GP hours are freed up to allow GPs to proactively plan more effectively to tackle this issue.
- Negative feedback through Healthwatch channels around how moving the walk-in element to the hospital would take away from the heart of the community and also cause issues with night time access.
- Healthwatch were asked to provide any assistance they felt helpful throughout the process.
- Transport and car parking were important factors - Explanation given around how transport was a theme being looked at and how parking will also be factored into this with an additional 300 spaces to be provided.
- Described how having diagnostics on site would streamline the service.

Glossop - 10 January 2018

- General consensus was positive.
- Questions were raised around the need for a Walk-in centre at Glossop. It was noted that there was not much difference in the distance between the New Mills Walk in centre and the Ashton walk-in centre.
- Glossop PCC - Public view is that there is disappointment with how it is utilised.
- Car parking at Glossop PCC is also an issue
- Would there be flexibility with the sessions on Saturdays and Sundays?
- Is the Ashton Primary Care Centre still the best site for Tameside?
- What happens to the building with the transfer of the Walk-in service? Are we locked in to keeping the building?
- Pharmacy cover for Glossop on bank holidays was an issue with none open. - CCGs do not have much influence but we can look into the issue. PPGs to also look into this further as previous issues to lobby local pharmacist have seen successful (Boots Hadfield example).

6.15 Many of the issues above were also reflected in the survey feedback which can be found in section 7.14 of this report. This identifies the key themes of the responses to this consultation, and the commissioner response.

7 CONSULTATION RESPONSES

Analysis of Consultation Survey Responses

7.1 In total, **380** responses were received to the online questionnaire hosted on the CCG website, **63** of which have been received as paper copies.

7.2 Of the **380** total responses received **21** (5.5%) answered only answered only Question 1, "Are you currently registered with a GP in Tameside & Glossop?" and left all additional questions blank.

7.3 Nine-in-ten respondents (91.0%) reported that they are currently registered with a GP in Tameside and Glossop.

7.4 Around three-quarters of respondents provided information around their demographic profile (includes prefer not to say option where relevant).

7.5 A Pharmacy was the service most likely to have been used by respondents for an urgent health care need **within the last week** (22.1%). This was followed by GP Practice appointments at 16.7%. Likewise these were also the two services most likely to have been **used within the last month**; Pharmacies (34.4%) and GP Practice appointments (29.9%).

7.6 Of those respondents who indicated their use of the Walk-In Service at Ashton Primary Care Centre, 30.6% have **never used it**. A similar proportion (30.0%) used it **more than one year ago**.

7.7 Respondents were asked to explain what impact there would be for them if the walk-in service currently provided at Ashton Primary Care Centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site. The majority of comments made relating to this were themed as:

- Relocation will have no/minimal impact (27.2%)
- Parking is worse at hospital site (22.2%)
- Services will be less locally accessible (21.8%)

7.8 **Option 2** was the option most respondents (63.2%) felt would best suit the urgent care needs of the population across Tameside & Glossop. **Option 1** was selected by 36.8% of respondents.

7.9 The most commonly mentioned reasons for selecting **Option 2** were:

- Preferred option will provide more local services (62.1%);
- Preferred option provides more choice e.g. locations, options to access service (55.6%);
- Preferred option will have better availability of appointments/services (32.0%).

7.10 The most commonly mentioned reasons for selecting **Option 1** were:

- Preferred option will have better weekend availability (34.8%);
- Preferred option will have better availability of appointments/services (25.0%);
- Preferred option will provide more local services (22.8%).

7.11 Respondents were also asked if they had an alternative option on how Urgent Care could be delivered across Tameside & Glossop. The most commonly mentioned themes relating to alternative options were:

- No alternative option provided (23.6%);
- Suggestions relating to/positive comments around reducing the misuse of services (19.1%);
- Concerns about whether there are enough locally available services (15.7%).

7.12 Cross tabulation of results by demographic group has not been undertaken due to the small numbers by individual category, making meaningful analysis not possible.

7.13 A full analysis of the responses received to the consultation is attached at **Appendix 6** of this report.

Summary of Consultation Themes and Tameside & Glossop Strategic Commission Response

7.14 Below is a summary of the themes drawn from the narrative comments collated in the consultation process, and the wider stakeholder engagement carried out during the consultation. Further details can be found in the associated Equality Impact Assessment (EIA).

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
Services Will Be More Locally Accessible Comments relate to: • Relocated walk-in service at the ICFT site will be nearer/closer • Relocated walk-in service at the ICFT will be more convenient to access • Hubs will be nearer to home • More hubs at more locations provides more local services • Quick and easy to access a local hub Survey responses 152 (50.5%)	Accessibility and travel time were key considerations when developing the proposed urgent care service. The relocation of walk-in access to the hospital involves a move of 1.5 miles whilst keeping access within the Ashton Neighbourhood. The travel analysis undertaken considered public transport, drive times and walking times to both the Ashton Primary Care Centre (APCC) and the hospital site from 14 areas. 8 of the areas will have shorter travel times to the Urgent Treatment Centre at the hospital site as shown below:
Services Will Be Easier To Access In Terms Of Transport/Public Transport Comments relate to: • ICFT site is easier to access • Better to travel to the ICFT site • More hubs will mean they are easier to access Survey responses 26 (8.6%)	
Relocation Of Walk-in Service Will Mean Walk-in Service Is Closer, Nearer Or The Same Distance/Hubs Closer To Home Comments stating: • The ICFT site would be closer or nearer for patients than current walk-in service • The hubs are nearer to home for patients to access services Survey responses 71 (23.6%)	
Services Will Be Less Locally Accessible/Concerns About Services Not Being Local Enough Concerns related to:	

	Shortest Travel to	**Maximum additional public transport travel time**
Ashton	APCC	10 minutes
Mossley	Hospital	
Stalybridge	Hospital	
Dukinfield	APCC	20 minutes
Hyde	APCC	17 minutes
Broadbottom	Hospital	
Hattersley	Hospital	
Mottram	Hospital	
Denton	APCC	20 minutes
Audenshaw	APCC	16 minutes
Droylsden	APCC	17 minutes
Hadfield	Hospital	
Gamesley	Hospital	
Glossop	Hospital	

The additional public transport time for those who have longer journeys varies but the maximum

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
• Current APCC walk-in centre is easier to access than ICFT site • ICFT site is further away for some patients than APCC • Denton has been overlooked by the plans for hubs • Glossop needs to have better facilities and opening hours than those outlined • Droylsden, Littlemoss, Fairfield and Audenshaw (West Neighbourhood) need a closer hub Survey responses 78 (25.9%)	increase is 20 minutes. For all time periods analysed a similar proportion the residents can travel to APCC and the hospital within 0-60 minutes. People who are not registered with a Tameside and Glossop GP will be able to access urgent care in the hospital site. Hospital locations generally easier to find and have robust public travel arrangements so the expectation is that unregistered users will not be disadvantaged by the relocation of the walk-in access.
Concerns About Services Being More Difficult To Access In Terms Of Transport/Public Transport Concerns relate to: • The ICFT site is more difficult to travel to • Traffic along the routes to access the ICFT site can be bad • The ICFT site is difficult to access via public transport • Public transport links from Glossop are problematic • Combining services onto the ICFT site will make traffic more congested and public transport services worse in area • Transport infrastructure to the ICFT site (in terms of public transport and roads), needs to be improved for relocation proposal to work Survey responses 45 (15.0%)	The Neighbourhood focus of the Care Together Programme reflects the need to focus services on the needs of the local population and provide care as close to home as possible whilst still ensuring that quality and cost effectiveness can be maintained. Our proposals are based on the North Hub being located at the Ashton Primary Care Centre and the Glossop Hub being based at the Glossop Primary Care Centre. The locations for hub in the East Neighbourhood (covering Stalybridge, Dukinfield and Mossley), the South Neighbourhood (covering Hyde and Longdendale) and the West Neighbourhood (covering Denton, Droylsden and Audenshaw) are still to be determined. Detailed work to identify appropriate locations will be managed through the Strategic Estates Group. The ability to book appointments at any hub and the Urgent Treatment Centre will increase the opportunity for individuals to plan their visit. This will help those people who have concessional travel and enable people to utilise existing travel services more effectively.
Relocation Will Mean Walk-in Service Would Be Further Away Or Further To Travel/Hubs Are Further Away/Concerns About Distance To Service Concerns related to: • The ICFT site is further away than APCC for some patients • Traffic and transport links make travelling the distance to the ICFT difficult • The hubs in the options do not cater for Droylsden or Audenshaw (West Neighbourhood) • Relocation of walk-in centre means more distance or travel time from Glossop Survey responses 60 (19.9%)	**<u>Key Mitigations</u>** **The increased availability of appointments in practices and neighbourhoods should reduce the need for people to travel to the hospital site.** **When identifying East and West Hub sites travel will be considered.** **A wider review of patient transport is being undertaken and this will include urgent care transport alternatives.**
Proposal / Options Mean Increased Choice e.g. Locations / Options To Access Services Comments relate to:	The proposal both increases the number of urgent appointments available and the number of places where these appointments can be booked.

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
• Option 1 has more choice in terms of availability of weekend appointments • Option 2 is more accessible – more locations closer to home / in different neighbourhoods • Option 2 gives easier access for those without their own transport • Option 2 covers more areas and provides more local options Survey responses 107 (35.5%)	People can access any of the Neighbourhood Care Hubs choosing which best suits their needs – this may be because it is the closest to home, work, or the quickest available appointment. Option 2 is the option preferred by the majority of respondents and it is this option that has fewer locations for access at weekends. However, in both options the total number of appointments available at weekends will be based on expected demand rather than purely on the number of sites open. This means whilst choice is restricted there will be sufficient access to meet people's needs. The single point of walk-in access will ensure that A&E staff are able to focus on emergencies and life threatening situations with the Urgent Care Treatment Centre supporting those people whose needs are urgent. The ability to book through the GP will help practices advise people whether their needs will be best met within the practice itself or through the hubs/Urgent Treatment Centre.
Proposal / Options Mean Better Availability Of Appointments / Services Comments Include: • Option 1 Would Be Better In Terms Of Weekend Availability • Option 1 Hours Are More Accessible For Those Who Work • Option 1 More Beneficial If You Want To See Someone On The Day You Fall Ill • Option 2 – Adding More Hubs Dilutes What Is Available Via Option 1 • Option 2 Greater Convenience Of Hubs • Option 2 – More Options For All • Option 2 Covers More Areas In The Evening • Option 2 May Reduce Waiting Times If Service Available Across Five Areas • Proposals Will Reduce Demand On Hospital • Proposals Will Reduce Demand On GP Appointments, Making Them More Available Survey Responses 82 (27.2%)	
Proposals Will Reduce Misuse Of Services/Positive Comments Re Misuse Of Services Comments relate to: • Relocation of walk-in service will take the pressure off A&E • The more hubs there are, the less strain will be put on GPs and the hospital • Co-location of A&E and walk-in service makes escalating or de-escalating patients to the correct service easier Survey responses 43 (14.3%)	The feedback through the pre-consultation discussions was that it is difficult for people to decide whether a condition is urgent or not and that carers would usually default to using A&E to avoid the risk of delaying treatment. The single point of walk-in access will ensure that A&E staff are able to focus on emergencies and life threatening situations with the Urgent Care Treatment Centre supporting those people whose needs are urgent. The booking of appointments through the GP or 111 will help people access the service that most meets their needs including services such as the Minor Eye Conditions Service and the Minor Aliments Service. **<u>Key Mitigation</u>** **Supporting people to care for themselves and**
Concerns Over Misuse Of Services Concerns relate to: • Relocation of walk-in access to UTC resulting in more people visiting A&E • Shouldn't we be trying to avoid more	

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
people accessing A&E? • Need to address inappropriate and inevitable presentations at the hospital site – concern the proposals do not address this • The fact that A&E attendees and urgent care attendees will be seen in one place – preference would be that these are separate / in different waiting areas • That relocation will result in longer queues / waiting times • Reference to current abuse of A&E services e.g. people using A&E if they can't get a GP appointment • More neighbourhood hubs will mean people are more likely to visit them for minor issues Survey responses 33 (11.0%)	**make informed choices regarding future use of services will one of the service outcomes.**
General Positive Comments Comments relate to: • The proposal to relocate walk-in service makes sense • It would have a positive impact • Proposals will improve service and make things better • The preferred option is a good idea/way forward • Proposals will work Survey responses 68 (22.6%)	The proposal for the urgent care service is based on delivering high quality, clinically effective care in an affordable way. Local feedback through pre-consultation and the Local Design Group reiterated the need locally for a simpler service with consistent opening times and common service offer. Both of these factors along with the feedback that the GP practice was the trusted place for advice were central to the development of our urgent care proposal and the options consulted on.
General Negative Comments Concerns relate to: • Bias towards Tameside services compared to Glossop • The 111 number does not work in an emergency • Neither of the proposed options are ideal • The CCG will make their mind up regardless of what the public think • Negative comments relating to social services • The waiting area at APCC is inadequate • Proposals are just not good enough • No need for change Survey responses 32 (10.6%)	The options were developed following analysis of the pre-consultation feedback, were refined through a local design group of stakeholder representatives and following discussion with representatives of our population. There was no preferred option. Both options increase local access to urgent care services and enable people to book in advance thereby allowing them to plan their access. People can choose to ring their practice or 111 to book an appointment or to walk-in to the Urgent Treatment Centre. Retaining the existing arrangements alongside the national requirement to implement an Urgent Treatment centre[2] and to increase access to GP appointments[3] additional would not be clinically or cost effective and would increase duplication and confusion.

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
Concerns Regarding The Availability Of Appointments/Services Concerns relate to: • What happens in terms of appointments after 9pm? • Although Option 2 provides more sites, times and availability of appointments are more restricted • Increased availability of on day appointments needed • Weekend availability is important • Opening times at UTC need to be longer • Glossop hub needs to offer walk-in appointments Survey responses 22 (7.3%)	The timings of the service have been developed following analysis of the local use of existing services and national guidelines. People who need urgent care when neither the Urgent Treatment Centre nor Neighbourhood hubs are open will be seen within Tameside and Glossop through the Primary Care Access service. The opening hours of the Urgent Treatment Centre are in line with the national standards of 12 hours 7 days a week. The hours will however be reviewed on an on-going basis to ensure local services can meet demand. The analysis of demand suggests that duplicating walk-in access in Glossop would not be clinically or cost effective. **Key Mitigation** **Both options provide additional same day appointments and the total number of appointments available at weekends will be based on expected demand rather than purely on the number of sites open.**
Comments Relating To Appointments And Services e.g. Availability, Waiting Times At Relocated Walk-in Service Variety of comments relating to: • Opening hours of walk-in service need to be longer Waiting times for walk-in service will be longer for some patients if relocated to ICFT • Waiting times for walk-in service will be shorter for some patients if relocated to ICFT • Walk-in service could be much busier if relocated due to proximity to A&E Survey responses 13 (4.3%)	Waiting times are subject to national standards:- • Patients who have a pre-booked appointment should be seen and treated within 30 minutes of their appointment time • Patients who "walk-in" should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary. • Patients will be given an appointment slot, which will not be more than two hours after the time of arrival. **Key Mitigation** **The providers of services will be managed against the above standards.**
Importance Of Local Services Comments relate to: • Beneficial to have more integrated services in local area • Having services more locally will benefit area and patients	Tameside and Glossop's Care Together Programme recognises that an integrated service is the key to local people having long and healthy lives and our neighbourhood approach confirms our commitment to care closer to home.

[2] Urgent Treatment Centres – Principles and Standards, NHS England, July 2017

[3] Next Steps On The NHS Five Year Forward View

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
• Neighbourhood hubs may help reduce pressure on A&E by preventing people visiting A&E unnecessarily • Urgent care should be accessible for all Survey responses 14 (4.7%)	
Need For Better Communications/ Awareness Of Services Comments include: • More awareness is required of what services / advice is available for patients • Need to educate patients so they understand the services available for them to use • Public need to understand A&E is for emergencies only • Need to define what urgent care means • Need for communications campaign if proposals are implemented • Better communication needed between GPs and other services – more effective signposting required Survey responses 14 (4.7%)	The feedback through the pre-consultation discussions was that it is difficult for people to decide whether a condition is urgent or not and that carers would usually default to using A&E to avoid the risk of delaying treatment. The GP is a trusted point of contact for advice and reassurance so the proposal is based around contacting the practice first. This will help ensure that people receive the right care first time. The single point of walk-in access will ensure that A&E staff are able to focus on emergencies and life threatening situations. **<u>Key Mitigation</u>** **A communications plan will be used to ensure that local people are aware how they can access urgent care effectively.**
Better Weekend Availability Comments primarily made around Option 1 relate to: • Better weekend access/availability of weekend appointments • Best combination of weekday and weekend access (Option 1) • For people who work, weekend availability is necessary • Weekend appointments will reduce demand on GPs in week, demand on A&E and other services Survey responses 37 (12.3%)	Both options provide appointments in the evening and at weekends. The ability to book provides greater control for people as they will be able to access any site so may choose to attend a location closer to home or work as best suits their need. Option 2 is the option preferred by the majority of respondents and it is this option that had fewer locations for access at weekends. However, in both options the total number of appointments available at weekends will be based on expected demand rather than purely on the number of sites open. This means whilst choice is restricted there will be sufficient access to meet people's needs. Current Walk- in Centre demand shows that weekend usage accounts for 30% of total usage with Saturday accounting for 14.7% and Sunday 14.3%. **<u>Key Mitigation</u>** **The provision at Glossop Neighbourhood Hub and the Urgent Treatment Centre will be reviewed to ensure there are sufficient appointments to meet demand.**
Concerns About Weekend Availability Concerns about: • Limiting weekend appointments puts pressure on the hospital • A better geographic spread of weekend access is preferable to longer weekend access at fewer locations • Time and availability restrictions are a concern Survey responses 8 (2.7%)	
Preferred Option Utilises Staff/Resources Better	The clinical staffing levels will relate to the number of appointments available and both options will provide

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
Comments relate to: • Less hubs mean less staff are required • More hubs means more job opportunities • Less pressure on staff as services would be used properly Survey responses 8 (2.7%)	45 minutes per 1000 population. The multidisciplinary team approach will support effective use of staff skills. There will be a mix of GP, Nurse, Health Care Assistant and other practitioner appointments to enable the skills of the team to be fully utilised. The balance of appointments will be continually reviewed to ensure that demand can be appropriately managed. Both options reduce duplication and therefore reduce costs through improved efficiency. The location based costs such as rent and reception cover do increase in option 2 with five hubs operating over 5 days and I hub at weekends (27 sessions) compared to 3 hubs operating 7 days (21 sessions). However there is a commitment to neighbourhood based services and the options ensure that we have an understandable and accessible Urgent Care offer which balances quality, access and the best use of our resources. **<u>Key Mitigation</u>** **The ability to 'get through' to the practice to book an urgent appointment is fundamental to the proposal and a range of methods e.g. increased on line booking and improved telephony will be adopted to improve the ability for people to book appointments**
Comments relating to staffing / capacity Comments include: • Relocation of walk-in access to UTC would be beneficial in terms of staffing / capacity • Option 2 will require more staff • Need to recruit / attract more GPs • Need for doctors and not just nurse practitioners • Concern over current inability to book GP appointments • Reference to staff being under pressure in current arrangements Survey responses 28 (9.3%)	
Comments Relating To Cost/Funding A variety of comments including: • Option 1 would be more cost effective due to fewer locations e.g. less administrative and staffing costs • Comments around additional cost of implementing Option 2 due to increased number of hubs • Need for more funding for health service / GPs • Are the proposals a way to save money? Survey responses 23 (7.6%)	
Invest In Services Comments relate to: • Suggestions of investment in services e.g. would the CCG fund Advanced Nurse Practitioner programmes to help with the recruitment of UTC teams? • Staff are currently unable to cope with the demand-need to invest to address this • The George Street building in Glossop is under utilised Survey responses 7 (2.3%)	The Urgent Care proposal is designed to fully utilise the full range of skills of health and social care professionals. The multidisciplinary Team approach will develop in neighbourhoods and in the Urgent Treatment Centre to meet the holistic needs of individuals. The emphasis on prevention and supporting people to manage their own health will help reduce the risk of people needing urgent and emergency care. **<u>Key Mitigation</u>** **The need to improve utilisation of Glossop Primary Care Centre is recognised and consideration is being given to how more services can be brought into the neighbourhood**
Better Urgent Care Facilities For Glossop	The neighbourhood hubs provide additional local access to urgent care appointments working

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
Comments include: • Glossop is isolated from Tameside and needs its own UC facilities • The opening times of the Glossop hub should be extended • The Glossop hub should offer walk-in appointments Survey responses 6 (2.0%)	alongside the appointments within the registered practice. Glossop Neighbourhood Hub is operational 7 days a week. The analysis of demand suggests that duplicating walk-in access in Glossop would not be clinically or cost effective. People are able to make an appointment in any neighbourhood hub or the Urgent Treatment Centre through the practice or 111 which will enable people to plan their visit more effectively. **Key Mitigation** **The capacity in all locations will be regularly reviewed against demand as the service develops.**
Parking Positive Comments Comments relate to: • Easier to park at ICFT • Parking at APCC is impossible so relocation would be beneficial Survey responses ~[4] (~%)	There is a range of car parking at the hospital with the TMBC car parking costs being at comparable across the Borough. The implementation phase will consider the drop off and pick up arrangements at the Urgent Treatment Centre to support people to use the most cost effective car parking option. The ability to book appointments at the Urgent Treatment Centre and waiting time standards will increase the ability for people to plan their visits and potentially reduce costs. **Key Mitigations** **The increased availability of urgent care appointments in Neighbourhoods will reduce the need to travel to the hospital site.** **A development scheme in partnership with the hospital will provide an additional 240 parking spaces.**
Parking-Negative Comments Concerns that: • There is restricted, little or no parking at the ICFT site • There are parking charges at the ICFT site and they are expensive • Parking is difficult /problematic/impossible at ICFT • The parking infrastructure at the ICFT site needs to be improved • There needs to be sufficient parking infrastructure at the proposed hubs Survey responses 62 (20.6%)	
Comments Relating To Parking / Travel Costs Comments relate to: • Do not drive, and due to relocation will need to use taxis or public transport, which will be expensive • Parking at ICFT is expensive • ICFT is further away than APCC which will mean increased travelling costs Survey responses 25 (8.3%)	
Patient Care/Service/Treatment Will Improve Comments relate to:	The proposal for the urgent care service is based on delivering high quality, clinically effective care in an affordable way.

[4] ~ indicates data is supressed due to small numbers

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
• Relocation will mean that if somebody has an emergency or escalating issue and travels to relocated walk-in service, they will already be in the right location for A&E, which is beneficial for patients • Relocation will mean a better healthcare service • Relocation will mean better treatment for patients Survey responses 14 (4.7%)	A key benefit of the single walk-in access point is to ensure prompt access to diagnostics and treatment. The multidisciplinary approach will ensure an individual is supported by the most appropriate professional.
Service Will Be Easier To Access/A More Simple Service Comments relate to: • Relocation of walk-in service will mean people who go to A and E but don't need emergency treatment can be sent to walk-in service and vice versa, i.e. already on same site • The relocation will streamline the service • Proposals would make things better and easier Survey responses 35 (11.6%)	
Centralisation/Integration – Positive Comments include: • One central location (i.e. having A&E and UTC in one place) seems beneficial / is a good idea • If you require further investigation (e.g. X-ray, more tests) you are already on the hospital site • Better access to diagnostics • Would be beneficial to integrate other services into neighbourhood care hubs Survey responses 12 (4.0%)	The access through the GP and single walk-in access point will reduce pressure on A&E as it will ensure that people are supported by the most appropriate person - fully utilising the skills of the wider Primary Care teams. The ability to book appointments in practices, neighbourhood hubs and the Urgent Treatment Centre provides people with the opportunity to choose a location that best suits their needs and reduce congestion in services as it will enable a more planned approach to be taken. Practices will be able to advise people when their need for an urgent diagnostic test may be better met by booking an appointment at the Urgent Treatment Centre rather than within the practice. **<u>Key Mitigations</u>** **The flow of patients through services will be enhanced as the single point of walk-in access will ensure that A&E staff are able to focus on emergencies and life threatening situations with the Urgent Care Treatment Centre supporting those people whose needs are urgent.** **The increased choice will support people to select a location that best meets their needs.**
Centralisation/Integration - Negative Concerns around: • Smaller locations, (i.e. APCC), are better for staff and patients than large, multi-service locations, (i.e. a hospital) • Hospital site and services are already congested adding in the walk-in service would exacerbate this • A&E already perceived as a 'catch-all' or one-stop-shop, putting walk-in service at same location would increase this perception Survey responses ~ (~%)	

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
More Efficient Use Of Existing System Comments relate to: • Better integration of health services would reduce demand on Urgent Care • Urgent needs should be routed to Urgent Care Centres to reduce demand on GPs Survey responses ~ (~%)	Tameside and Glossop's Care Together Programme recognises that an integrated service is the key to local people having long and healthy lives. In, 'A Place-Based Approach to Better Prosperity, Health and Wellbeing'[5] we set out our vision for a single urgent care service aligning a range of urgent and out of hours care services around A&E to make it easier for people in crisis or with an urgent medical to access the most appropriate service. This proposal in a key step towards that vision. The key relationship with GPs and the practice team is retained whilst ensuring that demand can be more appropriately managed.
Disabled/Those With Mobility Issues May Have Difficulty With Access Concerns around: • Relocation would impact people who are disabled • Disabled parking at the ICFT site is of a poor standard • The sprawling nature of the ICFT results in difficulties for disabled people Survey responses ~ (~%)	All the Urgent Care locations will be fully DDA compliant. **<u>Key Mitigation</u>** **The implementation phase will consider the drop off and pick up arrangements at the Urgent Treatment Centre and availability of Disabled car parking.**
Keep Walk-in Service In Current Location / No Need For Change Comments include: • Prefer the walk-in centre where it is now • Walk-in centre should stay where it is • Current arrangements are good – no need to change • Please do not close the walk-in centre at Ashton Survey responses 8 (2.7%)	The national mandate[6] to implement an Urgent Treatment Centre in line with the national specification and the requirement to increase access to GP appointments set out in the 'Next Steps On The NHS Five Year Forward View'[7] means that we have to change the urgent care offer locally. Retaining the existing arrangements alongside the national requirement would not be clinically or cost effective and would increase duplication and confusion.
Need For More Walk-In Centres Comments relate to: • There should be a walk-in service at each neighbourhood hub • There should be more walk-in centres • There should be another walk-in centre in addition to the hospital site Survey responses 7 (2.3%)	The national review of urgent treatment services in the NHS[3], stated that the Urgent Treatment centre standards and principles were designed to end the confusion patients and the public cited around walk-in centres, minor injuries units and urgent care centres. Local feedback through pre-consultation and the Local Design Group reiterated the need locally for a simpler service with consistent opening times and common service offer. Both of these factors along with the feedback that the GP practice was the trusted place for advice were central to the
Concerns About Choice Concerns relate to:	

[5] A Place-Based Approach to Better Prosperity, Health and Wellbeing

[6] Urgent Treatment Centres – Principles and Standards, NHS England, July 2017

[7] Next Steps On The NHS Five Year Forward View

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
• Needs to be more than one walk-in service location • Allow walk-in service at a location apart from ICFT Survey responses ~ (~%)	development of our urgent care proposal and the options consulted on. Having reviewed the level of demand it would not be clinically or cost effective to duplicate walk-in locations. However, people will be able to book same day appointments between 08:00 and 21:00 weekdays and 09:00 and 21:00 at weekends. **Key Mitigation** **A communications plan will be used to ensure that local people are aware they can book urgent care appointments through their practice or 111 and can choice any of the available locations.**
Service Will Be More Difficult To Access /Complex Concerns around: • Co-locating A&E and the walk-in-service in the same location will confuse patients and communication about the difference between the two • It is difficult to find the right building on the hospital site and park in the right place Survey responses ~ (~%)	The single walk-in access point removes the need for the individual to differentiate between an urgent and emergency need as the professional assessing the individual will ensure that they receive the most appropriate care first time. In the past people have been transferred by ambulance from the WIC to A&E leading to a delay in treatment. **Key Mitigation** **The implementation phase will ensure the development of clear signage that directs individuals that walk- in to the correct building and access point.**
Relocation Of Walk-in Service Will Have No/ Minimal Impact Comments state: • None/Nil/No impact • Minimal/Little impact • No/Little impact because home is same or similar distance from APCC and ICFT • No impact because travelling by car means no difference in accessing APCC or ICFT Survey responses 71 (23.6%) **Not Sure What Impact Of Relocation Will Be** Comments state: • Not sure • Have not used APCC so cannot comment Survey responses ~ (~%) **Relocation Will Have A Lot Of Impact** Comment states: • A lot Survey responses ~ (~%)	The above statements set out the travel time impact for people in Tameside and Glossop and address concerns regarding parking.
Unable To Select Either Option / More Information Needed	The options were developed following analysis of the pre-consultation feedback, were refined through a

CONSULTATION FEEDBACK THEME	TAMESIDE & GLOSSOP CCG REPSONSE
Comments include: • Neither of the options are helpful / good • Not sure if either option is a solution to addressing improved access to urgent care • Options do not address those presenting at A&E unnecessarily • CCG will make up their own mind as to which option to implement • Requests for further information e.g. will the hubs be able to offer minor treatment / care? Survey responses 10 (3.3%)	local design group of stakeholder representatives and following discussion with representatives of our population. There was no preferred option. Both options increase local access to urgent care services and enable people to book in advance thereby allowing them to plan their access. The single point of walk-in access will enable professionals to assess which service will best meet an individual's need and so ensure A&E is freed up to treat those most in need.
A Small Number Of Comments Which Could Not Be Assigned To One Of The Other Defined Themes. Comments include: • Reference to personal issues / situation • Do not privatise NHS Survey responses 6 (2.0%)	

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[8] 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'.

8.3 Tameside & Glossop Clinical Commissioning Group have an additional four locally determined protected characteristic groups:

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

8.4 A full Equality Impact Assessment (EIA) has been produced to support this report and can be seen at **Appendix 8**. This EIA has been produced to ensure it responds to issues raised

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

within the consultation, provides a full evaluation of the impact of the proposed model, and explores the required mitigations.

9 IMPLEMENTING THE NEW OFFER

9.1 Details of proposed actions, timelines and milestones for the implementation are included in this section in as much detail as is currently available, pending Strategic Commissioning Board approval to proceed.

9.2 The consultation indicated that should the proposal go ahead, there will be a safe transition to the new model of care utilising the learning from the A&E Streaming already in place. It indicated that the plan is to keep the Walk-In Service at Ashton Primary Care Centre running until Summer 2018 so that there was enough capacity during Winter 2017 when demands on health services will be high.

9.3 The urgent care service whilst integrated will be commissioned as two separate elements as this will maximise the opportunities to build on available expertise around managing the different patient flows and demand in walk-in and bookable services.

- The Urgent Treatment Centre
- The Primary Care Access Service

9.4 The two elements also support a phased implementation approach that can be aligned with existing contract terms.

9.5 The level of integration between the Urgent Treatment Centre, A&E streaming, A&E and diagnostic provision, along with strategic way forward for Tameside and Glossop Integrated Care NHS Foundation Trust, means that the Urgent Treatment Centre element will be commissioned within the ICFT contract. The earliest implementation date will be July 2018 however, as set out in 9.12 below the availability of capital funding is a key determinant of the timeframe for implementation.

9.6 The expected implementation date for the Primary Care Access Service is September 2018. The process for commissioning this element is the subject of another Strategic Commissioning Board paper.

Financial Implications

9.7 In 2017-18, Tameside and Glossop have a recurrent annual budget resource of £3.569 million and a non-recurrent resource of £0.26 million totalling **£3.829 million** for the provision of the urgent care service affected by this proposal. However, there are currently some pressures against these budgets.

9.8 On a recurrent basis there is an expectation that the new urgent care model will be able to deliver significant cost efficiencies as a result of reduced duplication and economies of scope and scale. This will both address the current financial pressures and release significant savings against the historic baseline therefore ensuring that the re-designed urgent care model meets the pre-requisite of making a considerable contribution towards the £70 million economy wide financial gap.

9.9. We recognise that we may not be able to fully realise these savings in year 1 due to set up costs and a period of dual running.

9.10. Relative to the financial envelope set out above both of the options which went to consultation are affordable. Indicative costings suggest that while public consultation favoured option 2, the savings associated with option 1 would be approximately £0.121 million higher.

Estates Implications

9.11. The decision of the Strategic Commissioning Board will be communicated to Tameside & Glossop Integrated Care NHS Foundation Trust who will then take any necessary action with regard to their estate and current contracts/arrangements to implement the arrangements for the Urgent Care Treatment Centre.

9.12. The availability of capital funding will impact on the timeframe for full implementation for the Urgent Treatment Centre as a level of redesign of the current estate is required to ensure the most effective management of patients.

9.13. The precise location of the Neighbourhood Hubs for the South, East and West neighbourhoods is subject to more detailed work. This will be managed through the Strategic Estates Group.

Service Improvements and Outcome Measures

9.14. The CCG will ensure that the outcome of the consultation results in the development of clear outcome measures in the contract with the Integrated Care NHS Foundation Trust and other providers, to enable the monitoring of the quality of urgent care services in Tameside and Glossop. These will be included in the contracts held between Tameside & Glossop Clinical Commissioning Group and Tameside & Glossop Integrated Care NHS Foundation Trust and any other provider.

9.15. A Quality Impact Assessment of the urgent care model has been completed and is attached at **Appendix 7**.

10 CONCLUSIONS

10.1 In October 2017 the Strategic Commissioning Board agreed the outline of a model of urgent care for Tameside & Glossop and approved a proposal to carry out a formal consultation on two options.

10.2 Extensive consultation has been undertaken over a period of 12 weeks.

10.3 As described in this report the Strategic 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.

10.4 **Preparation and planning:** The development of the model for urgent care has been a key workstream for the Tameside and Glossop Accident and Emergency Care Board (A&EDB) and is a part of 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 Strategic Commission 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.

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

10.6 **Leadership and clinical involvement**: The case for change for the urgent care model has been driven by the Tameside and Glossop Accident and Emergency Care Board (A&EDB) the membership of which includes all representatives from existing providers, commissioners and the voluntary sector along with 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 1 November 2017 and 26 January 2018 has been under the leadership of the CCG Chair with support from the CCG Governing Body Clinical Lead for Planned and Urgent Care and the Tameside and Glossop Strategic Commission Interim Director of Commissioning with a significant level of input from local clinicians as documented in this report.

10.7 **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.

11 RECOMMENDATIONS

11.1 As stated on the front of the report.

This page is intentionally left blank

TAMESIDE AND GLOSSOP Caretogether

APPENDIX 2

NHS Tameside and Glossop Clinical Commissioning Group

Urgent Care Consultation

NHS Tameside & Glossop Clinical Commissioning Group is currently reviewing how Urgent Care can be best delivered across Tameside & Glossop. You can access further information about our proposals for Urgent Care in our information document available at www.tamesideandglossopccg.org/urgentcare

1. Are you currently registered with a GP in Tameside & Glossop? (Please tick one box only)

- ☐ Yes (Go to Q3)
- ☐ No (Go to Q2)

2. Are you registered with a GP in another area? (Please tick one box only)

- ☐ Yes
- ☐ No

3. Please indicate how recently you have used the following services when you have had an urgent health care need (Please tick one box per row)

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service
NHS 111 service (telephone service available 24 hours a day)						
NHS Choices (internet based service available 24 hours a day)						
Pharmacies						
Minor eye conditions service within opticians						
GP practice appointments						
Out of hours GP service						
Walk-in Service at Ashton Primary Care Centre						

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service
Walk-in Service outside of Tameside & Glossop						
Accident & Emergency department at Tameside & Glossop ICFT Hospital site (Tameside Hospital)						
Accident & Emergency department at a hospital outside of Tameside & Glossop						

The Proposal

With the mandatory introduction of a streaming service at A&E and the requirement to develop an Urgent Treatment Centre (UTC), we are proposing to move the Walk-in Service at Ashton Primary Care Centre (APCC) to the UTC at the hospital so that it becomes an enhanced Urgent Care service with access to diagnostics.

By providing an UTC on the same site as A&E we believe we will achieve the outcomes we want for our Urgent Care system. A key example of this is should you walk in to the UTC and on assessment, need more specialist diagnostics e.g. an X-ray, you will receive this promptly and without the need to travel to another location. Having one place to walk in to receive assessment on where to go for treatment will mean you do not have to decide where to go – a professional will support you, providing clarity which is likely to particularly help carers and parents.

Our proposal is to create an Urgent Treatment Centre based at Tameside Hospital which will provide walk-in and bookable access 12 hours a day (9.00am to 9.00pm), 7 days a week, 365 days a year. This service will be in addition to your local GP – it doesn't replace it.

	Urgent Treatment Centre (Hospital Site)	Walk in Centre (APCC)
Bookable same day / urgent and routine appointments	✓	×
Walk in access for urgent care	✓	✓
Access to urgent diagnostics	✓	×
Improved patient safety due to emergency services available on site	✓	×
Well known location within Tameside & Glossop	✓	×
Good transport links	✓	✓

In addition to the new streaming service and UTC, we propose to increase the level of same day and routine GP appointments and provide more access to Urgent Care locally through the Neighbourhood Care Hubs. We have two options on how we could do this and want to hear your views on these options. The two options are a combination of sites with variable hours available at each site. There is no preferred option.

4. When the walk in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site what impact will this have for you? (Please explain in the box below)

Further to the relocation of urgent care services to the Urgent Treatment Centre on the Tameside Hospital site, we will also be looking at where to best place Neighbourhood Care Hubs. The Hubs will provide additional locations where people can book appointments. We are inviting your views on **two options** for how we can best deliver increased, local access to Urgent Care across Tameside and Glossop through our Neighbourhood Care Hubs. These are:

Option 1

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 1 proposes Urgent Care access in **three** Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The Glossop Hub (Glossop Primary Care Centre) and the South Hub (Hyde or Longdendale). These hubs will offer booked appointments via your own GP or via NHS 111. Option 1 offers opening hours as detailed below:

	Opening Hours		Access	
Neighbourhood Care Hub	**Weekdays**	**Weekends**	**Booked Appointments**	**Walk-in**
Urgent Treatment Centre at the hospital, Ashton	9.00am to 9.00pm	9:00am to 9:00pm (inc. Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
Glossop Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
South Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No

Option 2

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 2 proposes Urgent Care access in **five** Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The South Hub (Hyde or Longdendale), The East Hub (Stalybridge, Dukinfield or Mossley), The West Hub (Denton, Droylsden, or Audenshaw) and The Glossop Hub (Glossop Primary Care Centre). This option has increased availability in more locations for weekday appointments but offers weekend appointments across fewer locations. This option will offer booked appointments via your own GP or via NHS 111 during the hours detailed below:

	Opening Hours		Access	
Neighbourhood Care Hub	**Weekdays**	**Weekends**	**Booked Appointments**	**Walk-in**
Urgent Treatment Centre at the hospital, Ashton	9.00am to 9.00pm	9:00am to 9:00pm (inc. Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
Glossop Hub	6.30pm to 9.00pm	9.00am to 1.00pm	Yes	No
South Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
East Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No
West Hub	6.30pm to 9.00pm	Appointments available at Urgent Treatment Centre or Glossop Hub	Yes	No

5. Which of the two options above do you think best suit the urgent care needs of the population across Tameside & Glossop? (Please tick one box only)

- ☐ Option 1
- ☐ Option 2

6. Please tell us your reasons for selecting the option you have for Question 5 (Please explain in the box below)

7. If you have an alternative option on how Urgent Care 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.

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

About You

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

- ☐ A member of the public
- ☐ A carer on behalf of someone else
- ☐ An employee of Tameside Council
- ☐ An employee of NHS Tameside & Glossop Clinical Commissioning Group
- ☐ An employee of Tameside & Glossop Integrated Care NHS Foundation Trust
- ☐ A GP who works in Tameside & Glossop
- ☐ A pharmacist, optician or dentist working within Tameside & Glossop
- ☐ A community or voluntary group
- ☐ A partner organisation
- ☐ A business / private organisation
- ☐ Other (please specify below)

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

11. What best describes your gender?

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

12. What is your age? (Please state)

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

Black / African / Caribbean / Black British

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

Asian / Asian British

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

Other ethnic group

- ☐ Arab

- ☐ Any other ethnic group (Please specify)

14. 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

15. 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

16. Are you a member or ex-member of the armed forces?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

17. What is your marital status?

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

18. Are you pregnant, on maternity leave or returning from maternity leave?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

REVIEW OF URGENT CARE IN TAMESIDE AND GLOSSOP

The right care, in the right place, at the right time

Caretogether
SINGLE COMMISSIONING FUNCTION

NHS
Tameside and Glossop
Clinical Commissioning Group

Have YOUR say

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

INTRODUCTION

NHS Tameside and Glossop Clinical Commissioning Group (CCG) is committed to ensuring our residents can access the right care, at the right time and in the right place should you or someone you care for have an urgent medical need. We want to make our urgent care system as simple as possible so that your journey through illness to recovery is clear, easy to access and of a high quality.

With an increasing demand on the health and social care system, health services want to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this, there is now a national requirement to provide a streaming service at every Accident and Emergency (A&E) by October 2017. In addition, we have been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency.

Once implemented in Tameside and Glossop, both of these nationally mandated services will relieve pressure on A&E by streaming people who arrive at our A&E into either the main A&E Department or the UTC ensuring they receive the right care and treatment in the right place. Those who are in most need of emergency care will therefore receive this quickly in A&E and those who do not have major or life threatening illness/injury will receive effective treatment in the UTC.

As commissioners of health and social care services in Tameside and Glossop, we need to look at the way we deliver our whole range of urgent care services so that we can deliver the streaming service and the UTC at the hospital in an affordable way. We also want to ensure that we have understandable and accessible urgent care which balances quality, access and makes the best use of our resources.

This document sets out our proposals for improving our urgent care system and we want your views.

WHAT IS URGENT CARE?

Any form of medical attention that you need on the same day but is not life-threatening is what we deem to be Urgent Care. This could include injuries, an illness (ailment) or any other medical condition where you seek advice from a health professional such as a GP, pharmacist, NHS 111, a walk-in centre or the out of hours GP service when your local doctor's surgery is closed.

WHAT IS A STREAMING SERVICE?

If you arrive at A&E at the Hospital, you will be greeted and assessed by an experienced professional who will make a decision as to whether you need emergency care or urgent care. If your need is assessed as urgent, you will be directed through to the UTC and if you need emergency treatment, you will stay in A&E and receive care there as quickly as possible. This means you, and all patients, will receive the right care, in the right place, delivered by the right healthcare professional.

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

OUR VISION FOR URGENT CARE

The current urgent care services in Tameside and Glossop overlap. This means there are numerous options for people trying to access Urgent Care which leads to confusion, complexity and duplication. We want to ensure our services are easy to understand so you receive effective care first time, in the right place and do not have to visit multiple services for the same issue.

Our vision for urgent care is part of our wider Care Together programme to improve the outcomes and experience of health and social care across Tameside and Glossop. This includes developing a strong focus on prevention and how to self-care as we aim to reduce the risk of people requiring Urgent Care in the first place. Care Together also aims to improve care closer to home by increasing local access to same day appointments through GP practices, pharmacists and Neighbourhood Care Hubs as well as the new Urgent Treatment Centre. We want to provide this range of appointments 7 days a week.

To enable us to achieve this ambition, we have identified the following outcomes for our urgent care system:

- **A simpler system** – telephone help to know where to go and only one place to walk in to receive effective care. Ring your GP first for help and advice. If out of hours, an automated message will tell you what to do.
- **An efficient System** - with your consent, your medical records will be available to clinicians in the Neighbourhood Care Hubs and the Urgent Treatment Centre. This means you won't have to tell your story twice, creating a better care experience.
- **Care closer to home** – increased choice of same day appointments locally either with your local GP, by visiting one of the Neighbourhood Care Hubs or the Urgent Treatment Centre at the hospital.
- **Reduce pressure on A&E** – an effective system to ensure A&E staff are able to focus on emergencies and life threatening situations and enable all who arrive at A&E to receive the appropriate level of treatment and care.
- **Sustainability** – less duplication and complexity to create a more cost effective approach to Urgent Care and ensure people feel better equipped and supported to reduce the risk of the same need arising in the future.

HOW HAVE WE DEVELOPED THE PROPOSALS?

The proposals have been developed following ongoing engagement with local communities and groups discussing Care Together and the approach to future service provision. In recent months, we have engaged specifically on the approach to Urgent Care through various patient/public groups and networks. These sessions identified the following:

- Logistical factors influence where people attend (distance, car parking, public transport)
- People who are unable to get an urgent appointment at their GP are likely to utilise A&E or the Walk In Centre (WiC)
- Confidence in the professional providing treatment influenced the decision whether to use a service or not
- Many people would rather be seen locally than go to hospital unless absolutely necessary
- Desire for social care support to work alongside health support when necessary
- The term "urgent" was not seen as easily understood.

Reflecting on the above, we have developed proposals for the future of Urgent Care and now want to hear your views.

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

THE PROPOSAL

With the mandatory introduction of a streaming service at A&E and the requirement to develop an UTC, we are proposing to move the Walk-in Service at Ashton Primary Care Centre (APCC) to the UTC at the hospital so that it becomes an enhanced Urgent Care service with access to diagnostics.

By providing a UTC on the same site as A&E we believe we will achieve the outcomes we want for our Urgent Care system. A key example of this is should you walk in to the UTC and on assessment, need more specialist diagnostics e.g. an X-ray, you will receive this promptly and without the need to travel to another location. Having one place to walk in to receive assessment on where to go for treatment will mean you do not have to decide where to go – a professional will support you, providing clarity which is likely to particularly help carers and parents.

Our proposal is to create an Urgent Treatment Centre based at Tameside Hospital which will provide walk-in and bookable access 12 hours a day (9.00am to 9.00pm), 7 days a week, 365 days a year. This service will be in addition to your local GP – it doesn't replace it.

	Urgent Treatment Centre (hospital site)	Walk In Centre (APCC)
Bookable same day / urgent and routine appointments	✓	×
Walk in access for urgent care	✓	✓
Access to urgent diagnostics	✓	×
Improved patient safety due to emergency services available on site	✓	×
Well known location within Tameside & Glossop	✓	×
Good transport links	✓	✓

In addition to the new streaming service and UTC, we propose to increase the level of same day and routine GP appointments and provide more access to Urgent Care locally through the Neighbourhood Care Hubs. We have two options on how we could do this and want to hear your views on these options. The two options are a combination of sites with variable hours available at each site. There is no preferred option.

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

OPTION 1

In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Option 1 proposes Urgent Care access in three Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The Glossop Hub (Glossop Primary Care Centre) and the South Hub (Hyde or Longdendale). These hubs will offer booked appointments via your own GP or via NHS 111. Option 1 offers opening hours as detailed below:

	Opening Hours		Access	
	Weekdays	Weekends	Booked Appointments	Walk-in
Urgent Treatment Centre at the hospital, Ashton	9am to 9pm	9am to 9pm (inc Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No

OPTION 2

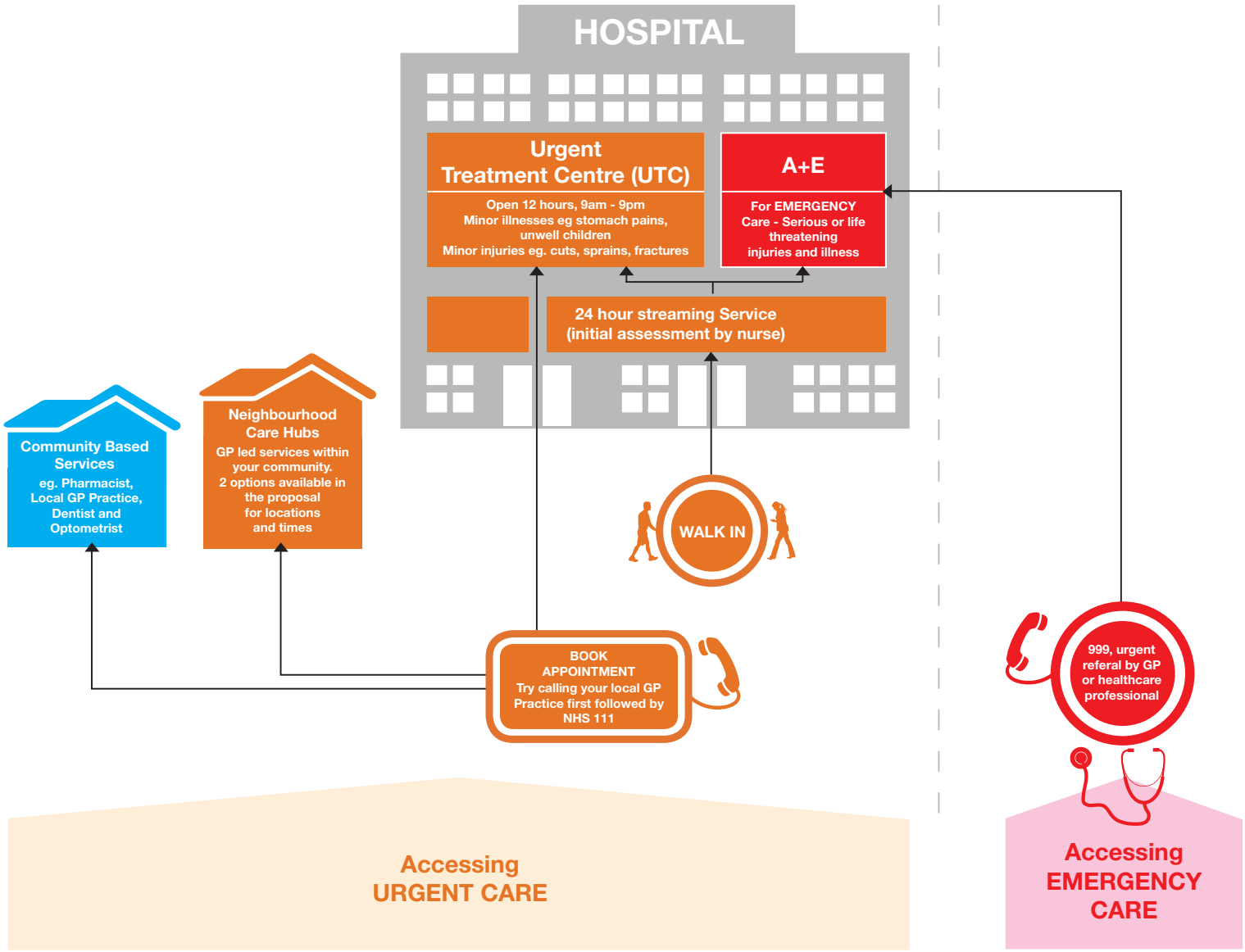
In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments and walk-in access, Option 2 proposes Urgent Care access in five Neighbourhood Care Hubs; The North Hub (Ashton Primary Care Centre), The South Hub (Hyde or Longdendale), The East Hub (Stalybridge, Dukinfield or Mossley), The West Hub (Denton, Droylsden or Audenshaw) and The Glossop Hub (Glossop Primary Care Centre). This option has increased availability in more locations for weekday appointments but offers weekend appointments across fewer locations. This option will offer booked appointments via your own GP or via NHS 111 during the hours detailed below:

	Opening Hours		Access	
	Weekdays	Weekends	Booked Appointments	Walk-in
Urgent Treatment Centre at the hospital, Ashton	9am to 9pm	9am to 9pm (inc Bank Holidays)	Yes	Yes
North Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No
South Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
East Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No
West Hub	6.30pm to 9pm	Appointments available at the UTC and Glossop Hub	Yes	No

ADVANTAGES AND DISADVANTAGES

Options	Advantages	Disadvantages
1	• Easily understandable opening hours as they are the same at the North, Glossop and South Neighbourhood Care Hub • No change in the current availability for evening or weekend bookable access	• Some people will need to travel outside of their neighbourhood
2	• Urgent Care access available in five Neighbourhood Care Hubs • Increased evening access in East and West • No change in Glossop availability for evening or weekend bookable access	• Weekend access at the Glossop Neighbourhood Care Hub and Urgent Treatment Centre only.

URGENT CARE PROPOSED MODEL



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

HOW WILL THIS WORK FOR YOU?

Jenny was worried about her mum Pauline who lives in Droylsden as she seemed off colour and was complaining that her legs really hurt. Jenny rang her mum's GP and when she explained what the matter was, the receptionist offered to book her an appointment at the practice at 3:30pm or at The South Neighbourhood Care Hub at 6:30pm. Jenny chose the appointment at The Hub as then her husband would be able to look after their children whilst she took Pauline to the doctors. At The Hub, the doctor was able to read Pauline's medical records and provide reassurance that this was a symptom of Pauline's ongoing condition as her own GP had recently increased her steroids. The GP advised Pauline to give it a bit more time and re-iterated the management plan in her medical notes.

Teckla and Michael were worried about Sasha their 3 year old daughter who has developed a rash after playing in the garden. Teckla rang NHS 111 as it was 10 am on a Sunday. The children's nurse she spoke to suggested they book an appointment to see a GP in one of the Neighbourhood Care Hubs and offered appointment times that day at The Glossop Hub or The North Hub. They decided to take the 11:30am appointment at The Glossop Hub in the Primary Care Centre where the GP examined Sasha, checked her medical records and prescribed some chlorphenamine for the rash and itch.

Peter was out running on Tuesday evening and tripped over. He felt sore when he went to bed but was not worried. The next morning his ankle and foot were very swollen and it was really difficult to put any weight on it. He rang his GP to see if he could get an appointment and they suggested he would be better going to the Urgent Treatment Centre on the hospital site in Ashton as he may need an X-ray. They offered to book an appointment for him and explained he could also just walk in if he would rather. He decided to book a 1pm appointment so his friend could take him. On arrival, Peter was assessed and had an X-ray which thankfully showed nothing was broken. He had sprained his ankle and was advised to rest, use ice and elevate his leg.

Asad was visiting his cousin Mahir in Denton when he developed a severe headache. Mahir suggested they go to the Urgent Treatment Centre at the hospital. When they arrived they were assessed and then seen by the Advanced Nurse Practitioner who took a full history and performed a neurological examination. The headache was in keeping with a tension type headache, and the family were under stress due to recent bereavements. Support and simple analgesia was offered.

HAVE YOUR SAY ON THE PROPOSALS

We are keen to hear your views on our proposals and whether you have any preferences about the opening hours or locations of our Neighbourhood Hubs. You can provide your views by:

Completing the online survey at www.tamesideandglossopccg.org/urgentcare

- You can pick up a paper copy at local GPs and Libraries across Tameside and Glossop
- You can pick up a paper copy at the Ashton Primary Care Centre
- You can email TGCCG.Communications@nhs.net and we will send you a paper copy

HOW WILL WE USE YOUR COMMENTS?

The consultation will run for 12 weeks from 1 November 2017 until 26 January 2018. Once the consultation closes, we will analyse all responses received by the closing date. Your feedback 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.

We aim to submit a recommendation to the Single Commissioning Board in February 2018. This report will be available on the CCG's website: www.tamesideandglossopccg.org

WHERE CAN I GET MORE INFORMATION ABOUT THIS CONSULTATION?

Additional written information, including the detailed reports presented to the Tameside and Glossop Single Commissioning Board are available on the CCG website: www.tamesideandglossopccg.org

You can write to us at: NHS Tameside and Glossop Clinical Commissioning Group, Dukinfield Town Hall, King Street, Dukinfield, Tameside, SK16 4LA or email us at: tgccgurgentcareconsultation@nhs.net

Alternatively call us on: 0161 342 5517

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

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

REVIEW OF URGENT CARE PROVISION IN TAMESIDE AND GLOSSOP

The right care, at the right time, in the right place

FACT SHEET

An Enhanced Service:

- Giving you increased choice and access to same day Urgent Care and routine appointments locally
- Access to diagnostics for Urgent Care such as X-rays on one site meaning you do not have to visit multiple services for the same issue.
- With your consent, your medical records will be available to clinicians in the Neighbourhood Care Hubs and the Urgent Treatment Centre. This means you won't have to tell your story twice, creating a better care experience.

A Simpler Service:

- Making your journey through illness to recovery clear, easy to access and of a high quality.
- Creating a single walk-in point at the hospital for Urgent Care will mean you receive effective care first time

Care Closer to Home

- Giving you more options locally for same day and routine appointments through your local GP, by visiting one of the Neighbourhood Care Hubs or the Urgent Treatment Centre at the hospital

Reducing Pressure on A&E

- Ensuring those who are the sickest and in most need of emergency care receive the quickest treatment.

A Sustainable Service

- Creating a simple, high quality and cost effective approach to Urgent Care
- Reducing duplication of services to ensure effective use of resources
- The new streaming service and the development of an Urgent Treatment Centre are mandated nationally to ensure those who go to A&E with a non-life threatening condition are directed to the best place for treatment and thus relieving pressures on A&E .

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

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

1. Urgent Care means any form of medical attention that you need on the same day but is not life threatening. This could include injuries, an illness (ailment) or any other medical condition where you could seek advice from a Primary Care Service such as a pharmacist, NHS 111 or a GP.

2. The Review of Urgent Care is part of wider Care Together programme: Improving the individual's experience of health and social care by giving them better access to joined-up, high quality and affordable services. We want people to get the right treatment, in the right place, at the right time.

3. Using Urgent Care will reduce pressure on A&E and ensure that people are supported by the most appropriate person - fully utilising the skills of the wider Primary Care teams rather than unnecessarily going to A&E.

4. We are bringing care closer to home through an enhanced Urgent Care offer. The proposals will provide increased, local access to same day health advice and treatment. This will be through your local GP practices, the Neighbourhood Care Hubs, the Urgent Treatment Centre and increased use of Pharmacists, Opticians and Dentists when an urgent need arises.

5. The government want to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. They have therefore mandated nationally that every A&E has a Primary Care Streaming Service which is now in place at the hospital in Ashton. This will stream people who go to A&E with a non-life threatening condition to the best place for treatment.

6. The government have also mandated that every area has to have an Urgent Treatment Centre (UTC) that will be GP-led, open 12 hours a day, every day, and be equipped to diagnose and deal with many of the most common ailments people attend A&E for. This will ease the pressure on A&E leaving it free to treat the most serious cases.

7. We are proposing to move the Walk-in Service currently provided at the Ashton Primary Care Centre (APCC) and enhance it by locating it within the proposed Urgent Treatment Centre at the hospital so that those attending can also access a range of diagnostics.

8. Providing walk-in access to the Urgent Treatment Centre on the same site as A&E with access to diagnostics meaning those people who on assessment need more specialist diagnostics e.g. X-ray or treatment, will receive the care they need promptly without the need to travel to another location.

9. By bringing services together on the hospital site we are making better use of NHS resources in an increasingly challenging time. We will use staff and resources from the existing services to ensure that we have the right skills and capacity to effectively and efficiently treat patients both on the hospital site and the Neighbourhood Care Hubs.

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

10 The proposed Urgent Treatment Centre at the hospital in addition to the two options for where and when you can book appointments at a Neighbourhood Care Hub will provide extended, more local access to Primary Care services – increasing the availability of same day appointments in the evenings and at weekends.

- Option one includes Hubs in the North (Ashton Primary Care Centre), the South Hub (Hyde or Longdendale) and Glossop (Glossop Primary Care Centre)
- Option two includes Hubs in the North (Ashton Primary Care Centre), the South (Hyde or Longdendale), the East (Stalybridge, Dukinfield or Mossley), the West (Denton, Droylsden or Audenshaw) and Glossop (Glossop Primary Care Centre)

The weekend opening hours in the two options vary and locations within the South, East and West are to be confirmed.

11 The current services that provide Urgent Care in Tameside and Glossop overlap. This means we have multiple access routes for patients who have an urgent need. This is not cost effective and we want to ensure that a patient's journey through care is simple so they receive effective care first time and do not represent to other services for the same issue.

12 The majority of users of the current Walk-In Service at Ashton Primary Care Centre (APCC) are from the North neighbourhood and hence this service is not used evenly across the borough. 73% of users are registered with a Tameside and Glossop GP(June 2017 - May 2017) while 10% are unregistered users.

13 The APCC will remain open and will house a range of GP and outpatient services such as Physiotherapy. It will also be the North Neighbourhood Care Hub with access to bookable same day appointments for Urgent Care in addition to the Urgent Treatment Centre at the hospital with walk-in and bookable access to Urgent Care and access to diagnostics.

14 Introducing the UTC at the hospital alongside the Neighbourhood Care Hubs mean that anyone who needs an appointment out-of-hours will be seen locally within Tameside and Glossop. This is not currently the case as under our current model residents can be sent to Oldham.

15 Our proposal is to relocate the Walk in Service from Ashton Primary Care Centre to an Urgent Treatment Centre at Tameside Hospital. Tameside hospital is 1.5 miles from the APCC which means there is no demonstrable difference in travel times for those travelling by car. Some people's journeys may be shorter and some longer. Our transport analysis shows that on average 99.8% of Tameside and Glossop residents are within 0-30 minutes drivetime of both APCC and the hospital whether travelling at peak time weekday morning, peak time weekday afternoon / evenings, off peak weekdays or weekends.

16 Our proposal is to relocate the Walk in Service from Ashton Primary Care Centre to an Urgent Treatment Centre at Tameside Hospital. Tameside hospital is 1.5 miles from the APCC. The proposed site for the UTC is well served by public transport including links from the Ashton Public Transport Hub.

17 Should the proposal go ahead, we will ensure a safe transition to the new model of care. The streaming at A&E is already in place and we will continue to learn from that what additional services we need to have available at the Urgent Treatment Centre. We will ensure we have strong arrangements for transferring people into more specialist services when they need them e.g. the Early Pregnancy Assessment Unit or Mental Health and social care services. Our plan is to keep the Walk-In Service at APCC running until Summer 2018 so that there is enough capacity during Winter 2017 when demands on health services will be high.

REVIEW OF URGENT CARE PROVISION IN TAMESIDE AND GLOSSOP

The right care, at the right time, in the right place

FAQs

Q1 What is the consultation about?

A1 We are now mandated nationally to have a streaming service at the hospital and an Urgent Treatment Centre - we therefore need to look at the way we deliver our Urgent Care offer across Tameside and Glossop. We want to make sure our services are as simple as possible so that your journey through illness to recovery is clear, easy to access and of high quality. We are particularly keen to hear your views on the two options for locations and opening hours of Neighbourhood Care Hubs which will provide increased access to bookable Urgent Care appointments.

Q2 What is Urgent Care?

A2 Any form of medical attention that you need on the same day but is not life-threatening is what we deem to be Urgent Care. This could include injuries, an illness (ailment) or any other medical condition where you seek advice from a health professional such as a GP, pharmacist, NHS 111, a walk-in centre or the out of hours GP service when your local doctor's surgery is closed.

Q3 Are you reducing the number of sites where I can access Urgent Care?

A3 No. Currently the main site for urgent care is the Walk-in Service at Ashton Primary Care Centre (APCC) with a few practices and Out of Hours also booking people who need Urgent Care into evening and weekend appointments at Neighbourhood hubs in Glossop Primary Care Centre, Hyde and Ashton Primary Care Centre. In the proposal, the Walk-in Service will be moved to the hospital within the new Urgent Treatment Centre to improve the service by giving it access to diagnostics such as X-ray. In addition it will be possible for everyone to book appointments through their GP or Out of Hours at the Urgent Treatment Centre or at a Neighbourhood Care Hub and there are options in the proposal for a varying number and location of Neighbourhood Care Hubs offering bookable same day appointments

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

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

Q4 I can't get an appointment now at my GP so how will this affect me?

A4 Rapid access to GP appointments can be a challenge but we are aware of this and are working hard to resolve in Tameside and Glossop. We are working closely with all our practices to ensure all of them are able to meet the GM primary care access standards by December 2018. In addition we will build on the evening and weekend access arrangements that we have already funded, increasing the number of places where appointments can be made and ensuring that all patients are offered evening and weekend appointments. We believe that all of our population will see the impact of this.

Q5 How will I be able to get an appointment at one of the hubs?

A5 Most people want to see their own GP or a GP within that practice if at all possible. We will support this by improving access to all practices where possible. However, we also realise that sometimes you may not be able to access your practice either due to no appointments being available or through your choice for convenience, urgency or due to having caring responsibilities. In which case, your GP practice will be able to book you directly into an evening or weekend slot within a hub or at the Urgent Treatment Centre based at the hospital. You will also be booked into the appointments by Out of Hours or NHS 111 if it is outside of your GP Practice hours.

Q6 Why is it necessary to move the Walk-in Service at the Ashton Primary Care Centre?

A6 We aim to have effective, high quality services. Moving the Walk-in Service to the hospital within the new Urgent Treatment Centre creates a better service as it will have access to diagnostics. This simplifies and improves a patients journey through care as it means people who on assessment need more specialist diagnostics e.g. X-ray or treatment, will receive the care they need promptly without the need to travel to another location.

Q7 What are the plans for Ashton Primary Care Centre if Urgent Care access moves to the hospital site?

A7 Ashton Primary Care Centre (APCC) will remain open and any space which becomes vacant will be filled by increasing community, social care, primary or acute services such as Physiotherapy. The APCC is also the North Neighbourhood Care Hub and will still offer bookable same day appointments for Urgent Care. We envisage that the APCC will always be a thriving health and social care hub at the heart of the community.

Q8 I can't park at the hospital now - what are you going to about this?

A8 We are all aware of the challenges of car parking at the hospital. We have already commenced a development scheme in partnership with the hospital which will provide an additional 240 parking spaces. We believe this will be complete by the end of December 2017 and therefore will ease car parking.

Q9 Will I still be able to go to A&E if I need to?

A9 If you have an urgent medical condition that can't be diagnosed/ treated via NHS 111, at your pharmacy or at your registered GP practice, then yes, you can still go to A&E. When assessed by the streaming service you may be treated within the Urgent Treatment Centre at the hospital rather than A&E

Q10 Where can I get more information about public transport to the locations where urgent care is provided?

A10 For Tameside go to: www.tfgm.com/Pages/default.aspx
For Glossop go to: www.derbysbus.info/times/tt_201_999.htm

Q11 Can I use any of the Neighbourhood Care Hubs across Tameside and Glossop?

A11 Yes, you can.

Q12 Where can I go to access Urgent Care?

A12 You can access Urgent Care through appointments at your local GP. If an appointment isn't available or convenient to you, you can access any of the Neighbourhood Care Hubs which best suits your needs – this may be because it is the closest to where you live, work, or the quickest available appointment.

Q13 Where will the Neighbourhood Care Hubs providing access to Urgent Care be located?

A13 Our proposals include Urgent Care access at Neighbourhood Care Hubs across Tameside & Glossop. Option 1 proposes access in three Neighbourhood Care Hubs in addition to the Urgent Treatment Centre based at the Tameside Hospital site. Option 2 proposes access in five Neighbourhood Care Hubs in addition to the Urgent Treatment Centre based at the Tameside Hospital site.

Our proposals are based on the North Hub being located at the Ashton Primary Care Centre and the Glossop Hub being based at the Glossop Primary Care Centre. The locations for hub in the East Neighbourhood (covering Stalybridge, Dukinfield and Mossley), the South Neighbourhood (covering Hyde and Longdendale) and the West Neighbourhood (covering Denton, Droylsden and Audenshaw) are still to be determined.

Travel time analysis for the potential access in the Hubs has been undertaken to assess any possible travel implications for residents. When modelling this travel time analysis indicative locations for the East, South and West Hubs have been used. These are – East Hub (St. Andrew's Medical Centre, Stalybridge), South Hub (Haughton Thornley Medical Practice, Hyde) and West Hub (Denton Festival Hall). The exact locations of the Neighbourhood Care Hubs will be determined following the consultation period.

Q14 Can I get an evening or weekend appointment for something that is not urgent?

A14 Yes, if you do not have an urgent medical need, you can book a routine appointment with your GP Practice or at one of the Neighbourhood Hubs.

Q15 What is the difference between the Hubs and the walk-in at the hospital?

A15 The Hubs are accessed through booked appointments only via your GP, Out of Hours or NHS 111. The walk-in service at the hospital means you will go through the streaming service and be assessed by a medical professional as to whether you have a non-urgent, urgent or emergency medical need. You will then be directed to the right place for the right treatment. For Urgent Care you will go to the Urgent Treatment Centre on site which has access to diagnostics such as X-rays so should you have this additional need you can be treated in one place. For emergency care you will be directed to A&E. If when you use the walk-in service and once assessed your need is not urgent you may be advised to contact your own GP or another service for support.

Q16 Is this just about closing services?

A16 No, we will retain all current Urgent Care services and enhance them. We need to make changes as outlined in the consultation booklet in order to deliver the mandated services while still providing the best health and social care and value for the people of Tameside and Glossop.

Q17 Why can't you leave things as they are?

A17 As commissioners of health and social care services in Tameside and Glossop, we need to look at the way we deliver our range of Urgent Care services so that we can provide the mandated streaming service and Urgent Treatment Centre at the hospital in an affordable way. We also want to ensure that we have an understandable and accessible Urgent Care offer built around this which balances quality, access and the best use of our resources.

Q18 How have you calculated how long it takes for people to travel to the location of the current Walk in Service at Ashton Primary Care Centre, the proposed site for the Urgent Treatment Centre at Tameside Hospital and the potential locations of the Neighbourhood Care Hubs?

A18 Basemap's TRACC software was used to calculate travel times to Ashton Primary Care Centre, Tameside hospital (Tameside and Glossop Integrated Care NHS Foundation Trust) and the potential locations of the Neighbourhood Care Hubs 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.

The data processed through Tracc to extract the travel times is called Trafficmaster TM Speed. Trafficmaster TM Speed data is GPS sourced and centrally purchased by the Department of Transport

The drive time in minutes figures are bi-directional so are an average of both directions of travel. The drive time in minutes is by any available road route and Tracc calculates the 'fastest route' between the given locations

Trafficmaster TM Speed data is calculated annually, meaning that the figure is derived from the speed of sample cars travelling Monday-Friday throughout the entire year (this would include school holidays and bank holidays).

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

Q19 How will my responses to the consultation help you make a decision?

A19 There is no preferred option in the proposal for the location and opening hours of the Neighbourhood Hubs. We are therefore keen to hear your views so that we can take your feedback into account when making the final decision.

Q20 When will the final decision be made?

A20 Once the consultation period finishes on 26 January 2018, we will analyse all responses received. We aim to submit a recommendation to the Single Commissioning Board in February 2018. This report will be available on the CCG's website: www.tamesideandglossopccg.org

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

Have YOUR say

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

REVIEW OF URGENT CARE PROVISION IN TAMESIDE AND GLOSSOP

The right care, at the right time, in the right place

1 NOVEMBER 2017 – 26 JANUARY 2018

Urgent Care is any form of medical attention that you need on the same day but is not life-threatening. We want to ensure our services are easy to understand so that you receive effective care first time, in the right place and do not have to visit multiple services for the same issue.

Your views are important to us in making a decision on how we can best deliver our Urgent Care services so that we balance an enhanced, accessible service with affordability.

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

WWW.TAMESIDEANDGLOSSOPCCG.ORG/URGENTCARE

OR PICK UP A PAPER COPY FROM YOUR LOCAL GP

Have YOUR say

TAMESIDE AND GLOSSOP Caretogether SINGLE COMMISSIONING FUNCTION

NHS Tameside and Glossop Clinical Commissioning Group

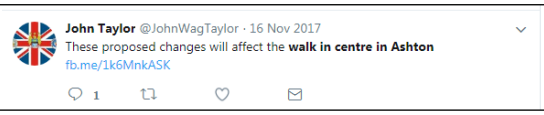
This page is intentionally left blank

APPENDIX 4

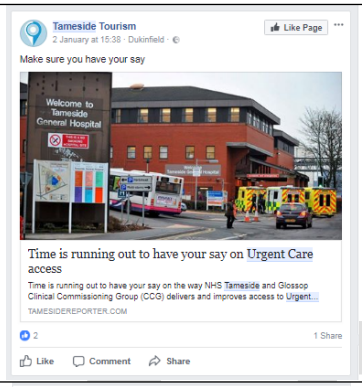
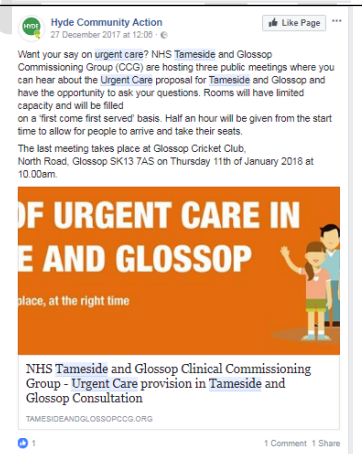
Social Media information

Twitter

Who	What	When
Tameside Reporter	**Tameside Reporter** @newsintameside · Jan 2 Time is running out to have your say on the way @TGCCG delivers **Urgent Care** in **#Tameside** tamesidereporter.com/2018/01/time-i...  4	January 2, 1:15pm
High Peak Borough Council	**High Peak BC** @HighPeakBC · 28 Dec 2017 NHS **Tameside** and Glossop Clinical Commissioning Group (CCG) is currently holding a consultation on options **Urgent Care** within the area - #HaveYourSay by 26th Jan! ow.ly/G1Dq30gV1wX NHS Tameside and Glossop Clinical Commissioning Group 1	December 28, 4:25pm December 21, 12:35pm December 19, 4:35pm December 18, 9:30am December 14, 12:30pm December 8, 4:55pm December 6, 12:55pm December 4, 9:15am
AndyWildPhoto (response to High Peak BC tweet)	**AndyWildPhoto** @wildandy67 · 24 Dec 2017 Replying to @HighPeakBC Train your nurses to care and nurse! #disgusted	December 24, 9:04pm
AndyWildPhoto (response to High Peak BC tweet)	**AndyWildPhoto** @wildandy67 · 24 Dec 2017 Replying to @TGCCG Your care is appalling! Your nursing staff need retraining from what I'm experiencing. Third rate care and service! Oldham a million times better	December 24, 9:06pm
Padfield Village Residents	**Residents** @Padfieldvillage · 21 Nov 2017 NHS **Tameside** and Glossop Clinical Commissioning Group - **Urgent Care** provision in **Tameside** and Glossop Consultation tamesideandglossopccg.org/urgentcare	November 21, 6:03pm

Councillor John Taylor		November 16, 8:18pm
Ben (reply to Councillor John Taylor)		November 17, 2:32am

Facebook

Who	What	When
Tameside Tourism		January 2, 3:38pm
Tameside Reporter		January 2, 1:18pm
Hyde Community Action		December 27, 12:06pm
High Peak CVS		December 1, 9:52am

Councillor John Taylor			November 16, 8:17pm

Internal Comms

Social Media

Page	Tweets	Comments	Retweets	Likes
TamesideCouncil Twitter Page	41	0	13	5
T&G CCG Twitter Page	25	1	17	5
Care Together Twitter Page	24	0	7	6

This page is intentionally left blank

APPENDIX 5

Community and Wider Engagement

Email to Stakeholders
From: Urgentcareconsultation (NHS TAMESIDE AND GLOSSOP CCG)
Subject: Launch of Urgent Care Consultation

As you know we are continually looking at new ways to provide vital high quality health and care services to our patients while balancing the need to ensure they meet the growing demands of an ageing population but are still affordable. Through the Care Together programme every aspect of our work with our partners across social care, community services and both primary and secondary care is being looked at to achieve those aims.

At the Single Commissioning Board (31 October 2017) we agreed to start a consultation from the 1st November 2017 on options for Urgent Care running for twelve weeks until 26th January 2018.

We are committed to ensuring that people with an urgent need are assessed and treated on the same day by the most appropriate professional. We recognise that for most people Primary Care is best suited to meet urgent (non-life threatening) care needs but this can only happen if we increase the appointments available.

The importance of freeing up A&E to care for the sickest people, including older people is at the centre of our plans. We have introduced A&E Streaming in line with National policy and our consultation includes our plan to deliver the mandated Urgent Treatment Centre that will provide additional access to urgent diagnostics.

The options being consulted on and further detail on the proposals can be found at this link http://www.tamesideandglossopccg.org/urgentcare

We and the Single Commissioning Board are committed to listening to the views of a range of stakeholders alongside those of the public and patients before making any decision on which option to take forward. With this in mind commissioning officers and clinical leads will be attending meetings across Tameside and Glossop to present the proposal and the consultation process. If there are any specific groups who you think it would be useful for us to engage with please let us know via tgccg.urgentcareconsultation@nhs.net and we will look to add them to our consultation programme. Please feel free to share details of the consultation with interested parties.

If you have any questions please do not hesitate to contact us through tgccg.urgentcareconsultation@nhs.net and we will come back to you.

Regards,

Alison Lea — GP Governing Body Member

Jessica Williams — Interim Director of Commissioning

Urgent Care Consultation Mailbox
NHS Tameside and Glossop Clinical Commissioning Group | Dukinfield Town Hall | King Street | Dukinfield | SK16 4LA
Direct Dial: 0161 342 5517| Email: tgccg.urgentcareconsultation@nhs.net
Website: http://www.tamesideandglossopccg.org/urgentcare

Key Stakeholders

Providers
ICFT
GTD
Orbit
GMPEC
Local Optical Committee
Local Pharmaceutical Committee
Local Dental Committee
Local Medical Committee
Pennine Care
Strategic Commisioners
CCG Governing Body Meeting
Strategic Commissioning Board
Executive Board - Tameside Council
Primary Care Committee
Scrutiny/LA
Scrutiny - Tameside - Integrated Care
Scrutiny - Derbyshire - Health
Community Select Committee (High Peak)
High Peak and Derbyshire Councillor Briefing
HWBB - Tameside
HWBB - Derbyshire
Patient representatives
Patient Neighbourhood Group - Glossop
Patient Neighbourhood Group - Hyde
Patient Neighbourhood Group - Ashton
Patient Neighbourhood Group -Dukinfield/ Stalybridge/Mossley
Homeless representatives
Public representative groups
Healthwatch Derbyshire
Healthwatch Tameside
The Bureau (GVC)
Action Together
High Peak CVS
Council Groups
Denton Town Council
Hyde Town Council
Dukinfield Town Council
Audenshaw Town Council
Mossley Town Council
Droylsden Town Council
Longdendale Town Council
Stalybridge Town Council
Ashton Town Council

Practices
GPs
Practice Managers
Practice Nurses
Ashton Neighbourhood meeting
Glossop Neighbourhood meeting
Hyde Neighbourhood meeting
Stalybridge/Mossley Neighbourhood meeting
Denton Neighbourhood meeting
MPs
General Public
Community Groups

Local Design Group

Organisation/Representing	Type of Organisation / Representing
T&G ICFT Council of Governors	Veteran
Hyde Bangladesh Welfare Association	Bangladeshi Community Group
Infinity Initiatives	Support homelessness, substance instance, financial and debt problems, isolations, loneliness, anti-social behaviour victims and perpetrators
Anthony Seddon Centre	Peer-led community mental health project
Greystone Housing Group	Homelessness
Change, Grow, Live	Provides help and support to adults, children, young people and families. Services cover a wide variety of areas including health and wellbeing, substance use, mental health, criminal justice, domestic abuse and homelessness.
Adullam Homes	
Glossop Practice Neighbourhood Group	GP Registered Patients
Stroke.org	Support for people who have had a stroke and their family and carers.

Community Groups Contacted

Targeted groups

Targeted Cohorts/Engagement work undertaken from Equality Impact Assessment
Disability Deaf & Hearing Support/VIP/Tameside Fibromyalgia & ME/CFS Support group/High Peak MS support contacted to offer attendance at meeting/targeted engagement. **Ethnicity** Hyde Bangladesh Welfare contacted to offer attendance at meeting/targeted engagement. **LBGT** Anna Hynes at Action Together contacted to seek relevant group but was advised that there is no group in operation at the moment. **Mental Health** Anthony Seddon Trust contacted to offer attendance at meeting/targeted engagement.

Homelessness
Greystones contacted to offer attendance at meeting/targeted engagement.

Workshop held Friday 26 January to engage with relevant stakeholders. Those in attendance included Regenda homes/New Charter/Change Grow live/Tameside Housing Advice/Foundation UK/TMBC/Ashton Pioneer Homes

Maternity
Verbal update/paper questionnaires and supporting information given to Tameside NCT Breastfeeding group at Ikea Ashton Tuesday 16 January

Verbal update/paper questionnaires and supporting information given to Ashton Library - Rhyme Time

Paper questionnaires/supporting information/posters circulated to Tameside libraries/Children's centres

T&G Housing Groups	T&G E&D Groups	Other Tameside & Glossop Groups
Accent Group	Andrew Gilliver	Active Tameside
Adullam Homes	Caroline Gregory	Carers Support Group
Ashton Pioneer Homes	Jean Hurlston	Countryside Volunteers
Contour Homes	Jennifer Voorhees	Grafton Centre
Enable Housing Association	Katy Robinson	Information Ambassador Network
Greystones	Nicola Jeffery Sykes	Live, Work, Invest
Irwell Valley HA	Penny Noel	Town Team Chairs
Mosscare Housing	Pete Forrester	Youth Forum
New Charter	Rehana Begum	
Peak Valley Housing Association	Safina Rashid	
Regenda Homes		
Sanctuary Group		
Stockport Homes		
Your Response Homes		

General Community Groups

Access Glossop	G52	Padfield Community Coffee Group
Alzheimers Society	GALOP (over 50s group)	Padfield Residents Society
Alzheimers Society Dementia Support Group	Glossop Arts Project	Parish Church of All Saints Glossop
Amber Trust	Glossop Sure Start Children's Centre	Parkinsons UK – Denton Methodist Church
Anthony Seddon Centre	Glossopdale Furniture Project	Patient Advice & Liaison Service
Ashton Asian Carers Support Group	Glossopdale VIP Group	Peak Active Sport
Bare Necessities	Glossopdale Women's Institute	Peak Film Society
Be Well	High Peak Disability Sport	Peaks and Dales Advocacy
Blythe House	High Peak Fibromyalgia& ME CFC Support Group	People First
Branching Out Glossop	High Peak Foodbank	Reubens Retreat
Cancer Warriors	High Peak MS Suport Local Contact	Samaritans Buxton
Carers Connect Support Group	High Peak Nightstop	SSAFA
Carers Support Group	High Peak Prostate Cancer Support Group	St Mary's RC Church
Cascade Baby Bundles	High Peak ROKPA	Stockport Cerebal Palsey Society
Central Methodist Church Hyde	Home Start High Peak	Tameside African Refugee Association
Change, Grow, Live	Hyde Bangladesh Welfare Association	Tameside Armed Service Community (TASC)
Church of the Nazarene	Hyde Community Action	Tameside Arts over 50's (carers and cared for)
Citizens Advice Bureau	Infinity Initiatives	Tameside Fibromyalgia & ME/CFS Support Group
Countryside Volunteers	Jericho Café	TASCA (Tameside Action for Social Communication and Autism Support Group)
Cranberries	Khush Amdid	The Helping Hand Hyde
Deaf & Hearing Support	Life You Choose	Timeswap Time Bank
Dementia Carers Support Café	MIND TOG	Trinity Church Audenshaw
Derbyshire Alcohol Advice Service	National Childbirth Trust Glossop and District	Wellbeing Group – Age UK
Derbyshire Carers	New Life Church Ashton	West African Development
Dream Centre Carers Support Group	Outreach Glossop	Whitfield House (supported living)
Europia	Over 50s Computer Group	Whitfield Parish
Fairplay		Write From the Heart
Forget Me Not Buddies		Youth Forum

Ashton Patient Neighbourhood Group 17 November 2017	➢ Questions about the sense of creating increased services at the hospital when for years been trying to reduce use of A&E ➢ Questions about Car parking at the hospital site and the need to ensure sufficient spaces ➢ Comments about learning from GTD and how they developed their service ➢ Questions about use of APPC if WIC leaves
Hyde Town Council 13 November 2017	➢ Recognition that same day appointments were improving though there are issues with waits for more routine appointments. ➢ View from Hyde is that the Hubs/EA needs to be promoted more and that GPs also need to publicise better. ➢ Issue raised with quality of access at some practices
Dukinfield Town Council 16 November 2017	➢ Concerns about people not realising WIC closed and paying for parking then discovering- can we ensure we look at putting poster in car parks before and after any planned relocation. ➢ Would like self-care to be reinforced
Denton Town Council 7 December 2017	➢ Concerns about being able to access practice to book appointments ➢ Concerns about travel
Ashton Town Council 21 November 2017	➢ Extended discussion with main issues being; - Telephone access to GPs – stories shared of having to ring 30 times to get through - Access to GP for urgent and routine appointments - Reception staff being rude - Want to keep evening surgeries local ➢ No major objections to the relocation of the WIC
Audenshaw Town Council 7 November 2017	➢ If I have an urgent problem and I go to the hospital, how will the service prevent me from just going to A&E anyway? ➢ Have we identified sites for Stalybridge and Denton yet? ➢ Clarity on the options (weekday and 7 day provision and where) ➢ Who will we be seen by at the UTC? ➢ What will the walk-in bit look like?
Stalybridge Town Council 6 December 2017	➢ Car parking at APCC and the ICFT noted as an issue – responded to confirm additional spaces being made at the hospital and by relocating the WiC to the ICFT, carparking should ease at the PCC. ➢ Clarity on times that the hubs etc will be open and what each will provide. ➢ Locations for hubs in Stalybridge and Denton queried – confirmed not yet identified

	➢ Comms – has the consultation been publicised in local newspapers etc? good way to reach local communities
Mossley Town Council 6 December 2017	➢ Encouraged the use of innovative means of providing consultations such as Skpe
Longdendale Town Council 12 December 2017	➢ Positive feedback
Practice Manager Forum 21 November 2017	➢ Concerns about having primary care at the hospital as will encourage people to use it is more access available ➢ Questions about the letters practices will get from A&E streaming and UTC to say that patients have attended. Some practices wanted to be able to see easily when patients did not need to attend so they can challenge them ➢ Questions about ensuring the GPs working in EA and UTC are familiar with local standards and processes so deliver same quality of care ➢ Wanted to understand the pathways for referrals from UTC and streaming in particular. ➢ Some thought WIC should have always been at the hospital site ➢ Would like self-care to be reinforced along with using own GP.
Practice Nurse Forum 6/9 November 2017	➢ Some questions at the meeting regarding: ➢ Interoperability of clinical systems and data sharing ➢ Clarification of options and 7 day access in each option ➢ Members of the group confirmed that they have seen the comms that was sent out about the consultation last week.
Gamesley Mens group 15 January 2018	➢ 7 attendees plus representatives from the volunteer bureau. UTC impacts ➢ Transport – 3 buses to Ashton PCC via the hospital, 2 buses to the ICFT ➢ Combination of transport requirements for the group including public transport, carers with cars and community transport service users ➢ 'Brilliant idea' – know can go there ➢ Very little negative discussion about the UTC model aside from transport to Ashton Options ➢ Access to a registered GP is mixed (individuals within the group are registered across a range of practices in the Glossop footprint) ➢ The local pharmacist was highly rated and used for minor ailments by the group ➢ The timing of health appointments is very important to this group, as those using a bus pass can only do so between 9.30am-4pm. Further feedback:

	➢ Dental access is a problem in the Gamesley area and patients locally do not access a dentist ➢ Need for chiropody service for the community ➢ What services are in Glossop PCC? Impression that it is not well utilised.
Practice Managers Meeting 17 November 2017	Elaine Richardson – Urgent Care Consultation Money has been put into Social Care to prevent people staying in hospital when don't need to. Nationally also been asked to put in AE Streaming which is a Primary Care Practice at the front door in AE. No new money for this. Went live from 1 October. The building isn't best designed for this but no capital money. Patient attends AE, are assessed to see if its Primary Care. They will be treated but the message could be, watch and wait and see your GP if no better. It is urgent care, non-life threatening. Unlikely they will refer. (What do reports look like?). Looking at urgent care system, the service developed over time has caused duplication. Have consulted and looked at how people use the service. Two options – currently two places where can walk in for care is confusing. NHS has mandated a urgent treatment centre, access to diagnostics, have to be able to walk-in and book in. This would be on same site as hospital, so single place. This would re locate the walk-in centre in Ashton to the hospital. Neighbourhood care hubs – Glossop, Ashton and Hyde (venue to be arranged). Open for bookable appointments. Book via GP. Out of hours will still exist. It will work differently, use appointments more. Option Two – Five neighbourhood care hubs. Glossop. Ashton. Hyde. Denton. Stalybridge. At weekends just Glossop and Urgent Treatment Centre. The Options are out to consultation. Practices have paper copies, plus electronic. Have had responses, thus far option two is preferred. Currently, 10% of users at walk-in centre are not registered with a GP. 11% are from other areas in Greater Manchester. 5% registered outside of GM. Request for PM's to promote this. Need to make sure that people are listened to. Decision to be made on the 7 February, Primary Care Committee and Strategic Management Board.

	Consultation end on 26 January. Staffing will be via commissioning a service from a Provider.
Derbyshire Health and Wellbeing Board 7 December 2017	**73/17 NHS TAMESIDE AND GLOSSOP CLINICAL COMMISSIONING GROUP URGENT CARE CONSULTATION** Dr A Dow provided an update on the Tameside and Glossop Urgent Care Consultation. Key to the proposal was the simplification of access to urgent care whilst improving the level of service available. Multiple access points would be replaced by telephone access through a patient's own GP practice to book appointments, as well as a single location for urgent walk-in services, and reduce the need for people to 'self-triage'. The aim of the consultation, which was to run from 1 November 2017 to 26 January 2018, was to inform the public about the implementation of the Urgent Treatment Centre at Tameside and Glossop Integrated Care NHS Foundation Trust hospital site, the proposed relocation of the current Aston Walk-In Centre service to facilitate this and the locations for evening and weekend appointments. Two options were included in the consultation; all included the Urgent Treatment Centre operating 9.00 am to 9.00 pm, seven days a week at the hospital in Ashton-Under-Lyne and offered a choice on additional evening and weekend appointments. Feedback from the consultation would be collated and analysed and the final proposal would be presented to the Strategic Commissioning Board and the Primary Care Committee on 7 February 2018 for dual approval, with the initial implementation of the final proposal anticipated to take place in July 2018. **RESOLVED** to note the Public Consultation on Urgent Care being undertaken by Tameside and Glossop Clinical Commissioning Group.
Tameside Health and Wellbeing Board 25 January 2018	**31. TAMESIDE AND GLOSSOP PROPOSAL FOR EFFECTIVE URGENT CARE** Consideration was given to a report of the Interim Director of Commissioning and accompanying presentation explaining that the proposal for effective urgent care was considered at the Single Commissioning Board on 31 October 2017 and approval was given for formal consultation. She provided an update on the consultation that started on 1 November 2017 continuing to 6 January 2018 and meetings scheduled with interested parties. The proposed integrated urgent care service would ensure people were seen by the right professional in the right place to meet their needs. It built on the trusted relationship with GPs making practices the key point for access for advice and treatment. Through the practice, Out of

	Hours service or NHS 111, people would be able to book appointments seven days a week in the most appropriate Primary Care service. Walk-in access would be maintained but the proposal moved the Walk-in service at Aston Primary Care Centre to the hospital to create an Urgent Treatment Centre that was co-located with A&E and ale to provide Primary Care services and access to diagnostics. There were two options for the delivery of the integrated urgent care service. Both created an Urgent Treatment Centre based at the hospital site open 12 hours a day, seven days a week from 9.00 am to 9.00 pm. This would offer bookable, same day / urgent and routine general practice appointments and walk-in access for urgent care. The options varied in the number of Neighbourhood Care hubs where bookable appointments could be made and when those hubs would be open. It was reported that as of Tuesday 9 January 2018, 284 surveys had been submitted. 89% indicated they were registered with a GP in Tameside and Glossop. Respondents included people with caring responsibilities and people whose day to day activities were limited because of a health problem or disability. The majority of respondents who had stated a preference preferred Option 2, as 63% stated Option 2 and 37% Option 1. Of those who chose Option 2, 27% mentioned a positive impact on local services in their response, 27% mentioned an increase in choice of service or location in their response and 18% thought Option 2 might have a positive impact on the availability of appointments. Of those who chose Option 1, 3% believed that it had better weekend availability and 8% thought Option 1 might have a positive impact on the availability of appointments. The survey would continue to be analysed and used to inform the final proposal that would be presented for decision to the Strategic Commissioning Board and Primary Care Committee in March 2018. **RESOLVED** **That the process of engagement and consultation being followed to develop the integrated urgent care service be noted.**

Tameside Scrutiny Board 11 January 2018	**26. REVIEW OF URGENT CARE IN TAMESIDE AND GLOSSOP** The Panel welcomed Jessica Williams, Programme Director of Care Together, to receive an update on the review and consultation process for the delivery of Urgent Care in Tameside and Glossop. It was reported that urgent care consists of any form of medical attention needed on the same day which is not life threatening and requires prompt assessment and treatment. This includes a range of injuries and medical conditions which can be dealt with effectively without the need to attend hospital. The Panel heard that the Care Together programme is committed to making the urgent care system in Tameside and Glossop as simple as possible in order that a person's journey through illness to recovery is clear, easy to access and of high quality. Current services don't always work together as well as they could and the consultation includes proposals for improvement. There is a significant need to generate more capacity for Accident & Emergency (A&E) at the hospital to care for the sickest people. In order to show demand across services, the presentation provided data relating to attendances at Tameside's urgent and emergency care centres. It showed that: • The Ashton Walk-in Centre currently sees around 154 people per day, with many conditions being non-urgent and requiring self-care support. • A&E at the hospital sees on average 236 people per day, of which around 80 are judged to have only minor and non-emergency health needs. Health systems need to ensure that those in most need of emergency care receive the quickest treatment. From October 2017, there was a national requirement to provide a streaming service at every A&E department. In addition to this, we are mandated to provide an Urgent Treatment Centre which is led by GPs, open 12 hours a day, 7 days a week. Ms Williams informed the Panel that we want to ensure our services are easy to understand so that people receive appropriate care first time, in the right place and do not have to visit multiple services for the same issue. To enable improvements to happen a number of outcomes have been identified in order for plans to be achieved.

	□ A simpler system □ An efficient system □ Care closer to home □ Reduce pressure on A&E □ Sustainability The Panel heard that as part of wider Care Together consultation and engagement, work has been carried out to talk to residents with the view to developing proposals for the future of urgent care in Tameside and Glossop. This has included talks with Practice Neighbourhood Groups and ensured protected and under-represented groups have their voices heard on urgent care. Feedback has told us that defining and understanding what is 'urgent' can be a problem and that communications on this need to improve. Residents also want a simpler means of access and consistent opening times to avoid confusion, even if this means less choice. The 12 week public consultation on Urgent Care has run from 1 November 2017 and will end on 26 January 2018. Proposals show a simplification of access to urgent care services with the planned introduction of a 12 hour GP-led Urgent Treatment Centre (UTC) at the Hospital site and across Neighbourhood Care Hubs. The UTC will have access to urgent diagnostic equipment such as X-Ray and ECG. Patient records will be accessible and up-to-date wherever a person is seen to aid safer transfer when specialist care is needed. The consultation provides two options for urgent care delivery, with no preference. Both options create additional bookable appointments at the UTC and a single location for walk-in access that removes the need for a person to 'self-triage'. The options differ in the number of locality hubs and weekend access. The Panel asked about the future of the GP surgery based at Ashton Primary Care Centre if urgent care services are relocated to the hospital site. Ms Williams informed members that the centre would remain as an enhanced hub and GP surgery. The plan will be for more services from the hospital to be moved into the centre and it is also important to note that more work is required to increase the number of appointments available within general practice across Tameside and Glossop.

	The Panel asked about the risks associated with a shortage of GPs nationally and potential issues this may cause at a local level to ensure new delivery plans for urgent care are achievable and able to make a real difference. Ms Williams advised that GP shortages remain an issue nationally and this is no different in Tameside. Both delivery options for urgent care bring workforce challenges, including GPs. A wider and more specific piece of work will need to be undertaken for how to manage GP capacity, the support from Go-to-Doc and patients having access to the right professional which may not always be a GP. This work will also include the way health services are supported within the community and the role of pharmacists. **RESOLVED:** (1) That Ms Williams be thanked for attending the meeting. (2) That following outcomes from the consultation and the decision on urgent care, the Panel receive a future update on delivery plans and timescales.
Improvement and Scrutiny Committee 27 November 2017	**30/17 REVIEW OF URGENT CARE IN TAMESIDE AND GLOSSOP** Jessica Williams of Tameside and Glossop CCG presented information on a review on the options for the delivery of urgent care. The purpose of the review was to look at 'care together' by driving up healthy life expectancy, reducing inequalities, improving outcomes and improving financial stability. This form of care was designed to support local people to remain well, provide high quality integrated services designed around the needs of the individual in the most appropriate location and equip people to take greater control over their own care needs and the services they receive. Urgent care is any form of medical attention needed on the same day but is not life threatening and includes injuries, an illness, ailment or any other medical condition where advice is sought from a health professional (GP, pharmacist, NHS 111 or a Walk-in-Centre). The review proposed two options for consideration: Walk-in Access to 12-hour GP-led urgent treatment centre in hospital or pre-booked access evening/weekend appointments at neighbourhood care hubs. These are being considered for development. The ultimate outcome of the review would be to free up more A&E resources for emergency treatment. **RESOLVED** that the report be noted.
Community Select Committee 29 November 2017	**18/27 URGENT CARE CONSULTATION - TAMESIDE AND GLOSSOP CCG** (Agenda Item 7) Dr Alan Dow, Chair of Tameside and Glossop CCG and Elaine Richardson, Head of Delivery and Assurance at Tameside and Glossop CCG outlined the review of urgent care provision in

	Tameside and Glossop being undertaken by the CCG. In line with national requirements, the CCG needed to establish streaming at A & E departments, and to establish an urgent care centre within each locality. It was proposed that the walk-in centre at Ashton under Lyne would be moved to Tameside Hospital where there would also be access to diagnostics. Neighbourhood Care hubs will provide extended, more local access to primary care services and appointments could be booked either through GP surgeries, out of hours or via the 111 service. Appointments could also be booked for the urgent care centre between 9 am – 9 pm. Two options were being proposed for the neighbourhood care hubs, option 1 included hubs in Ashton, Hyde or Longdendale and Glossop, and option 2 included hubs in Ashton, Hyde or Longdendale, Stalybridge, Dukinfield or Mossley, Denton, Droylsden or Audenshaw and Glossop. Under both options, the neighbourhood care hubs would be open from 6.30 pm – 9.00 pm weekdays and from 9 am – 1 pm at weekends (Glossop hub only under option 2). Three public meetings were to be held to discuss the proposals, with the Glossop meeting being on 11 January at Glossop Cricket Club. Regarding funding, it was confirmed that no new funding was available for the development of the streaming service at A & E, or for the urgent care centre, but there was some ring fenced funding available for extended access. Regarding the current use of Glossop Primary Care Centre, members were assured that where services were delivered out of the facility they would be offered to residents, but it was acknowledged that it has taken some time to get services to be delivered from the facility. Some concern was expressed regarding Glossop being the only hub available under option 2, to which members were advised that this was as a result of the additional hubs being offered under option 2, and that appointments would also be available at the urgent care centre. Reference was made to the 111 service, and instances where Glossop callers had been directed to Derbyshire services rather than Tameside and Glossop, which would be investigated. Some concern was also expressed regarding the need to book extended hours services through the 111 service.

	RESOLVED: That the presentation be welcomed, together with the investigations into the 111 service.
Stalybridge Neighbourhood meeting 14 November 2017	**Urgent Care Consultation**: Janna Rigby attended the meeting to discuss the Urgent Care Consultation. At the Single Commissioning Board on 31 October 2017 a decision was taken to start a consultation on options for access to Urgent Care in Tameside and Glossop. This will run for 12 weeks from 1 November 2017 until 26 January 2018. With an increasing demand on the health and social care system, we need to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this there is now a national requirement to provide a streaming service in every Accident and Emergency (A&E). In addition, we have also been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency.
Denton Neighbourhood Meeting 7 November 2017	**Urgent Care Consultation**: Elaine Richardson attended the meeting to discuss the Urgent Care Consultation. At the Single Commissioning Board on 31 October 2017 a decision was taken to start a consultation on options for access to Urgent Care in Tameside and Glossop. This will run for 12 weeks from 1 November 2017 until 26 January 2018. With an increasing demand on the health and social care system, we need to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this there is now a national requirement to provide a streaming service in every Accident and Emergency (A&E). In addition, we have also been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency. ➢ Concerns about how resource practices to handle more calls ➢ Droylsden patients will have further to get to hospital ➢ Location of Denton hub to suit all may be difficult
Ashton Neighbourhood Meeting 1 November 2017	**Urgent Care Consultation:** Jess Williams attended the meeting to discuss the Urgent Care Consultation. At the Single Commissioning Board on 31 October 2017 a decision was taken to start a consultation on

	options for access to Urgent Care in Tameside and Glossop. This will run for 12 weeks from 1 November 2017 until 26 January 2018. With an increasing demand on the health and social care system, we need to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this there is now a national requirement to provide a streaming service in every Accident and Emergency (A&E). In addition, we have also been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency. Practices will receive a pack within the next week including paper copies of the feedback forms for those residents who do not have access to the on-line version.
Glossop Neighbourhood Meeting 30 November 2017	**Urgent Care Consultation:** Elaine Richardson updated the meeting on the Urgent Care Consultation. At the Single Commissioning Board on 31 October 2017 a decision was taken to start a consultation on options for access to Urgent Care in Tameside and Glossop. This will run for 12 weeks from 1 November 2017 until 26 January 2018. With an increasing demand on the health and social care system, we need to ensure that those who are the sickest and in most need of emergency care receive the quickest treatment. To achieve this there is now a national requirement to provide a streaming service in every Accident and Emergency (A&E). In addition, we have also been mandated to provide an Urgent Treatment Centre (UTC) which is GP-led, open 12 hours a day, every day. This UTC needs to be equipped to diagnose and deal with many of the most common ailments which people attend A&E with that aren't a life-threatening emergency.
Homelessness Workshop 26 January 2018	Issues/points raised regarding our homeless population and their use of our services included:- - Tend not to be registered with GP, they will access A&E. Registering with a GP would be low on their priority lists. - Some do have GP – Can sometimes be resistance from GPs if the homeless person has not presented for a while. - GPs seem to put in place barriers to homeless people to access practices. Will also access walk in centre, some GPs want photo ID – not always available. - If homeless person is placed out of borough temporarily, GPs sometimes see this as a change of address when it's not. - Drugs & Alcohol clients tend to be registered due to their needs - None diagnosed mental health issues prevalent amongst homeless.

	- Fighting between organisations as to who owns a person's care - In terms of transience patients/clients tend to stay around same area in Tameside - T&G ICFT good at dealing with homeless patients. - Partnership working in Tameside is key. - This year's rough sleeper count = 43 in Tameside which is triple last year's figures. Knock on effect of providers losing bed spaces. - Location wise prominence is within Ashton Town Centre and professionals feel 43 is an underestimate. - 38 Households B&B plus social services in temporary accommodation at this point in time. - Single males most likely to make up homeless cohort. Drug & alcohol often drives to this but bereavement is often underlying cause. - Difficult to get mental health support for these clients – particularly if still using drugs and alcohol. - Long Ambulance waiting times. - Varying age ranges but often within their 30s/40s. This range is getting older though. - Housing associations working on preventative measures e.g. shared lives. Affordability criteria and assessment to look at sustainability of tenancy. Often those aged 25-40 (previously homeless) whose tenancies fail challenge to join up spaces, homeless people and ensuring sustainable. There is a need for ongoing support. - Can only support small numbers in Tameside. Gap to working with / supporting those with Secondary Mental Health. - Ashton Pioneer purchased Enville Place – discussions with Local Authority as to way to best utilise property. - Some families (with children) in B&B settings and sometimes English is not the first language. Families do tend to be registered with a GP. <u>Our Proposals</u> Relocation of walk in access from Walk in Centre to ICFT site. What problems do you envisage? - Location of current Walk In Centre close to housing advice, job centre and homelessness organisations however hospital isn't too far away. There may be travel implications but a lot of homelessness people got to A&E anyway. - How can we ensure people got to the right place?

	- How long will people have to wait? Should not be there 4 hours in A&E and 2 hours in Urgent Treatment Centre. There needs to be clarity that the time should not be any longer than at the current walk in centre. - Language is important – you will be getting better to do things this way. If you don't have a GP Urgent Treatment Centre is only place you can go. Different posters/comms messages for homeless cohort, need to manage expectations and promote that it is not an easy route to get a bed. - There is more likeliness to walk to A&E (sometimes put in a taxi if an urgent situation) - Need to think about how to inform those not linked in with services. *Homeless people will often use last address they were registered at/can't remember. - Term urgent care is important - Need to tie in with Drug & Alcohol services - Connection needed with Housing Advice – ICFT to contact if dealing with discharge for homeless. - Do those registered use GP? – Waiting times for GP appointments can dissuade people from booking appointments. Having bookable appointments would be really helpful for those who are homeless but are registered with Tameside & Glossop GP. - Care professional bookings – Can these be made to Urgent Treatment Centre rather than the patient calling themselves? - Should all be arranged within one call and can there be feedback confirming that the client attended the appointment. - Option 1 or 2? - Option 1 provides enough cover for people to access weekend access from a homelessness perspective would be beneficial. Simpler for service users to understand with fewer locations. - Would link in with new personal plans for those who are homeless. - Reconvene meeting to discuss comms and best way to do this. - Potential confusion by still including Primary Care Committee as North hub. People may still turn up there to access Walk in Centre services. - Where can prescriptions be dispensed/issued? At ICFT only or any other pharmacies.
Practice Nurses 6 and 9 November 2017	• Interoperability of clinical systems and data sharing • Clarification of options and 7 day access in each option I addressed each of these during the discussion. Members of the group confirmed that they have seen the comms that was sent out about the consultation last week.

Gamesley Ladies 25 January 2018	11 in attendance (plus me and Elaine) – stakeholder representation Comments/ Issues raised: • Access to own GP – getting through on the phone • Utilisation of George St – would be good to know all the services that are in there and future plans as view is that it is not well used • A&E waiting times – some bad experiences with long waits including with children • Transport to the hospital site from Glossop/ Gamesley – community transport has been relocated to Bakewell A lot of discussion about the above points but no general feedback about the model to challenge the proposal. Opportunities for this community to see the benefits of a more integrated UC service model.
Carers Rights Group 24 November 2017	Good and productive engagement following the presentation. Main queries raised were about how challenging it can be to get access to a GP promptly (4 carers provided lived examples) and so how extended hours might be able to help in this was explained. No objections received regarding the proposed relocation of the Walk In Centre. Handed out a number of paper versions of the consultation document.

APPENDIX 6

Analysis of Consultation Survey Responses

1.0 Executive Summary

- There were **380** responses to the Urgent Care consultation
- Nine-in-ten respondents (91.0%) reported that they are **currently registered with a GP in Tameside and Glossop**.
- A Pharmacy was the service most likely to have been used by respondents for an urgent health care need **within the last week** (22.1%). This was followed by GP Practice appointments at 16.7%. Likewise these were also the two services most likely to have been **used within the last month**; Pharmacies (34.4%) and GP Practice appointments (29.9%).
- Of those respondents who indicated their use of the Walk-In Service at Ashton Primary Care Centre, 30.6% have **never used it**. A similar proportion (30.0%) used it **more than one year ago**.
- Respondents were asked to explain what impact there would be for them if the walk-in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site. The majority of comments made relating to this were themed as:
  - Relocation will have no / minimal impact (27.2%)
  - Parking is worse at hospital site (22.2%)
  - Services will be less locally accessible (21.8%)
- **Option 2** was the option most respondents (**63.2%**) felt would best suit the urgent care needs of the population across Tameside & Glossop. **Option 1** was selected by **36.8%** of respondents.
- Respondents were asked to explain their reasons for selecting either Option 1 or Option 2 as the option they felt would best suit the urgent care needs of the local population.
- The most commonly mentioned reasons for selecting **Option 1** were:
  - Preferred option will have better weekend availability (34.8%)
  - Preferred option will have better availability of appointments / services (25.0%)
  - Preferred option will provide more local services (22.8%)
- The most commonly mentioned reasons for selecting **Option 2** were:
  - Preferred option will provide more local services (62.1%)
  - Preferred option provides more choice e.g. locations, options to access service (55.6%)
  - Preferred option will have better availability of appointments / services (32.0%)
- Respondents were also asked if they had an alternative option on how Urgent Care could be delivered across Tameside & Glossop. The most commonly mentioned themes relating to alternative options were:
  - No alternative option provided (23.6%)
  - Suggestions relating to / positive comments around reducing the misuse of services (19.1%)
  - Concerns about whether there are enough locally available services (15.7%)
- Cross tabulation of results by demographic group has not been undertaken due to the small numbers by individual category, making meaningful analysis not possible.

2.0 Response Rates

2.1 In total, **380** responses were received to the Urgent Care consultation survey.

2.2 In addition to being hosted on the Tameside & Glossop Clinical Commissioning Group website, paper copies of the consultation were issued to all Tameside & Glossop GP practices, made available in the Walk-in Centre, all libraries in Tameside and the High Peak area (Glossop, Hadfield and Gamesley) and were available on request. Pre-paid envelopes were provided for the surveys to be returned. **63** paper copies were returned to NHS Tameside & Glossop Clinical Commissioning Group (CCG). These 63 returned paper responses are included in the total number of responses.

2.3 Of the total **380** responses received, **21** (5.5%) answered only Question 1, "Are you currently registered with a GP in Tameside & Glossop?" and left all additional questions blank.

2.4 Table 1 details the number of responses by question. Questions 1, 2, 3 and 5 were quantitative questions and questions 4, 6, 7 and 8 were qualitative questions. Detailed analysis of all questions can be found at section 4.0 Consultation Analysis.

Table 1: Responses by question

Question	No. of responses
1. Are you currently registered with a GP in Tameside & Glossop?	377
2. Are you registered with a GP in another area?	35
3. Please indicate how recently you have used the following services when you have had an urgent health care need? (list of services provided)	See Table 8 for details
4. If the walk-in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site what impact will this have for you?	261
5. Which of the two options above do you think best suit the urgent care needs of the population across Tameside & Glossop?	291
6. Please tell us your reasons for selecting the option you have for Question 5?	268
7. If you have an alternative option on how Urgent Care 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.	89
8. Do you have any other comments you would like to make about Urgent Care services in Tameside & Glossop?	128

2.5 Responses to questions 4, 6, 7 and 8 were assigned themes based on the content of respondent's comments. Table 2 details the number of themes for each qualitative question.

Table 2: Number of themes for qualitative questions (4, 6, 7 and 8)

Question	No. of themes per question
4. If the walk-in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site what impact will this have for you?	27
6. Please tell us your reasons for selecting the option you have for Question 5?	23
7. If you have an alternative option on how Urgent Care could be delivered	22

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.	
8. Do you have any other comments you would like to make about Urgent Care services in Tameside & Glossop?	18

3.0 Demographic Information

3.1 Of the 380 respondents, around three-quarters provided information relating to their demographic profile. This information is outlined in table 3.

Table 3: Demographic data responses

Demographic Group	Number of Responses[1]	% of Responses
Gender	287	75.5
Age	271	71.3
Ethnic Group	281	73.9
Disability	288	75.8
Carers	284	74.7
Veterans	287	75.5
Marital Status	285	75.0
Pregnancy & Maternity	285	75.0
Postcode[2]	272	71.6

3.2 Table 4 details the number of respondents who provided demographic data by question.

Table 4: Demographic data responses

	Q1	Q2	Q3[3]	Q4	Q5	Q6	Q7	Q8
Gender	286	19	241	237	274	255	87	122
Age Group	270	15	233	226	261	242	82	116
Ethnic Group	280	17	236	231	268	248	83	117
Disability	287	18	241	237	273	254	88	122
Carers	283	18	241	236	271	253	86	121
Armed Forces	286	18	240	237	272	254	88	122
Marital Status	284	18	240	234	270	251	86	122
Pregnancy & Maternity	284	18	241	236	272	254	87	122
Health Neighbourhood[4]	272	9	227	226	262	246	85	116

[1] Includes those who selected 'Prefer not to say'
[2] Based on those respondents who provided a postcode which matched a Tameside & Glossop postcode, or provided a part postcode enabling categorisation into a Tameside & Glossop health neighbourhood. The following part postcodes were categorised into health neighbourhoods as follows: North (OL6, OL7), South (SK14), East (SK15, SK16, OL5), West (M34, M43), Glossop (SK13)
[3] Based on those respondents who selected at least one option across the whole of Question 3
[4] Based on those respondents who provided a valid Tameside & Glossop postcode or part postcode enabling them to be categorised into a health neighbourhood

3.3 Table 5 details the achieved sample from the survey against the Tameside & Glossop population.

Table 5: Population and achieved sample

Demographic Group	Tameside & Glossop Population (%)	Achieved Sample (%)
Gender		
Male	49.1	25.8
Female	50.9	71.4
Prefer to self-describe	Not available	0.0
Prefer not to say		2.8
Age[5]		
Under 18	21.9	0.4
18 – 29	14.5	11.8
30 – 49	26.3	33.9
50 - 64	19.8	34.3
65+	17.5	19.6
Ethnicity		
White	91.8	89.0
BME	8.2	11.0
Disability		
Yes	20.5	28.8
No	79.5	71.2
Carer		
Yes	10.9	28.5
No	89.1	71.5
Armed Forces Member / Ex-Member		
Yes	Not available	2.1
No		94.4
Prefer not to say		3.5
Marital Status		
Single	34.8	19.3
Married / Civil Partnership	44.4	66.6
Divorced	13.2	6.3
Widowed	7.5	1.8
Prefer not to say	Not available	6.0
Pregnancy & Maternity		
Yes	Not available	4.2
No		90.2
Prefer not to say		5.6

3.4 Table 6 details the achieved sample from the survey by neighbourhood area compared to the Tameside & Glossop population. The achieved sample figures are based on the 272 respondents who provided a postcode which matched a Tameside & Glossop postcode, or provided a part postcode enabling categorisation into a Tameside & Glossop health neighbourhood.

[5] Based on those respondents who provided an exact age to enable categorisation

Table 6: Population and achieved sample

Health Neighbourhood	Tameside & Glossop Households[6] (%)	Achieved sample (%)
North (Ashton)	18.4	22.8
South (Hyde & Longdendale)	18.2	18.0
East (Stalybridge, Dukinfield & Mossley)	27.5	21.3
West (Denton, Droylsden & Audenshaw)	23.1	24.8
Glossop	12.9	12.1

3.5 A total of 286 respondents also stated their interest in the consultation (Question 9). Three-quarters of respondents (75.5%) were a member of the public. Responses are detailed in table 7.

Table 7: Respondent's interest in consultation

Interest in Issue	%
A member of the public	75.5
A carer on behalf of someone else	4.9
An employee of Tameside Council	3.8
An employee of NHS Tameside & Glossop Clinical Commissioning Group	1.0
An employee of Tameside & Glossop Integrated Care NHS Foundation Trust	5.6
A GP who works in Tameside & Glossop	2.8
A pharmacist, optician or dentist working within Tameside & Glossop	0.3
A community or voluntary group	1.0
A partner organisation	0.7
A business / private organisation	0.3
Other	3.8

3.6 Weighting the data to account for over and under-sampling of particular sections of the population is not necessary, given that the Urgent Care consultation was available via NHS Tameside & Glossop Clinical Commissioning Group web pages and was open to all residents and is not a fixed/controlled sample. No personal data was collected as part of the consultation process.

4.0 Consultation Analysis

4.1 Nine-in-ten respondents (91.0%) reported that they are currently registered with a GP in Tameside and Glossop. 9.0% reported that they are not currently registered with a Tameside and Glossop GP.

4. 2 Respondents who said they were not registered with a GP in Tameside and Glossop were asked if they are registered with a GP in another area. Of those not registered with a GP in Tameside and Glossop, 94.3% are registered with a GP in another area and 5.7% are not.

[6] Figures are based on the number of households in each postcode sector area.

4.3 Respondents were then asked to indicate how recently they had used a variety of services when they had an urgent health care need. The services and frequency of use indicated by respondents is detailed in full in table 8.

4.4 A Pharmacy was the service most likely to have been used by respondents for an urgent health care need **within the last week** (22.1%). This was followed by GP Practice appointments at 16.7%. Likewise these were also the two services **most likely to have been used within the last month**; Pharmacies (34.4%) and GP Practice appointments (29.9%).

4.5 Just less than a third of respondents (30.8%) state they have used a GP Practice appointment **within the last six months**. This was the service most likely to have been used within the last six month period.

4.6 Of those respondents who indicated their use of the Walk-In Service at Ashton Primary Care Centre, 30.6% **have never used it**. A similar proportion (30.0%) used it **more than one year ago**.

4.7 The Accident & Emergency department at Tameside & Glossop ICFT Hospital site (Tameside Hospital) was the service respondents were most likely to have used **more than one year ago** (45.6%).

4.8 GP Practice appointments was the service **least likely to have never been used** by respondents. Just 5.0% of respondents said they have never used GP Practice appointments. Conversely, respondents were **most likely to have never used** a walk-in service outside of Tameside & Glossop with eight in ten respondents (80.5%) stating they had 'never used this service'.

Table 8: Frequency of services used by respondents for an urgent health care need

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service	Total
NHS 111 service (telephone service available 24 hours a day)	2.7% 9	4.8% 16	9.9% 33	13.8% 46	27.5% 92	41.3% 138	**334**
NHS Choices (internet based service available 24 hours a day)	7.3% 24	10.3% 34	10.0% 33	7.9% 26	9.4% 31	55.3% 183	**331**
Pharmacies	22.1% 70	34.4% 109	16.4% 52	6.9% 22	7.3% 23	12.9% 41	**317**
Minor eye conditions service within opticians	0.3% 1	2.8% 9	8.9% 29	10.4% 34	14.4% 47	63.2% 206	**326**
GP practice appointments	16.7% 57	29.9% 102	30.8% 105	9.7% 33	7.9% 27	5.0% 17	**341**
Out of hours GP service	1.5% 5	2.8% 9	9.3% 30	6.8% 22	30.9% 100	48.8% 158	**324**
Walk-in Service at Ashton Primary	1.5% 5	4.8% 16	16.4% 54	16.7% 55	30.0% 99	30.6% 101	**330**

	Within the last week	Within the last month	Within the last six months	Within the last year	More than one year ago	I have never used this service	Total
Care Centre							
Walk-in Service outside of Tameside & Glossop	0	0.3% 1	1.5% 5	3.4% 11	14.2% 46	80.5% 260	**323**
Accident & Emergency department at Tameside & Glossop ICFT Hospital site (Tameside Hospital)	3.8% 13	5.0% 17	14.2% 48	11.5% 39	45.6% 154	19.8% 67	**338**
Accident & Emergency department at a hospital outside of Tameside & Glossop	0.9% 3	0.9% 3	3.4% 11	2.5% 8	29.8% 97	62.5% 203	**325**

4.9 Question 4 asked respondents to explain what impact there would be for them if the walk-in service currently provided at Ashton Primary Care centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site. This was a qualitative (open ended question) which respondents could answer as they wished. Responses to this question were themed to identify the key issues raised by respondents. Of the 261 respondents who answered this question, the most commonly mentioned impacts identified were:

- Relocation will have no / minimal impact (27.2%)
- Parking is worse at ICFT site (22.2%)
- Services will be less locally accessible (21.8%)

4.10 Table 9 outlines the number and proportion of respondents who made reference to a particular theme within their response to question 4.

Table 9: Number / % of responses by theme to Question 4

Theme	No.	%
Relocation will have no / minimal impact	71	27.2
Parking is worse at the ICFT site	58	22.2
Services will be less locally accessible	57	21.8
Relocation will mean walk-in service would be further away or further to travel	54	20.7
General positive comments about proposal to relocate walk-in service	42	16.1
Services will be more locally accessible	41	15.7
Service will be easier to access / a more simple service	26	10
Comments relating to parking / travel costs	25	9.6

Relocation will mean walk-in service is closer, nearer or the same distance	24	9.2
Relocation will mean walk-in service will be more difficult to access in terms of transport	23	8.8
Relocation will mean walk-in service is more difficult to access via public transport	19	7.3
Patient care / service / treatment will be better as a result of service relocation	14	5.4
Comments relating to appointments and services e.g. availability, waiting times etc	13	5
General negative comments about proposal to relocate walk-in service	10	3.8
Relocation of service will reduce misuse of services	10	3.8
The relocated walk-in service will be easier to access in terms of transport	9	3.4
Centralisation of services will be beneficial	9	3.4
Relocation may increase misuse of services	8	3.1
Parking is better at the ICFT site	~	~
Centralisation of services may be detrimental	~	~
Comments relating to staffing / capacity	~	~
Disabled / those with mobility issues may have difficulty accessing hospital site	~	~
Relocation will mean the walk-in service is more accessible via public transport	~	~
Other	~	~
Service will be more difficult to access / a more complicated service	~	~
Not sure what impact of relocation will be	~	~
Relocation will have a lot of impact	~	~

4.11 Respondents were asked to identify which of the two options presented within the proposal they thought would best suit the urgent care needs of the population across Tameside & Glossop. **Option 2** was the most preferred option with **63.2%** selecting this as the option they thought would best suit the urgent care needs of the local population. Over a third of respondents (**36.8%**) selected **Option 1**.

4.12 Question 6 asked respondents to explain their reasons for selecting either Option 1 or Option 2 at question 5. This was a qualitative question so responses have been themed to identify the main reasons provided. A total of 268 respondents provided an answer to question 6. Where the respondent had also provided an answer to Question 5 (the option they feel would best suit the urgent care needs of the population across Tameside & Glossop) analysis has been undertaken to identify the main reasons for their choice[7].

4.13 The most commonly mentioned reasons for selecting **Option 1** were:

- Preferred option will have better weekend availability (34.8%)
- Preferred option will have better availability of appointments / services (25.0%)
- Preferred option will provide more local services (22.8%)

[7] For Option 1 this is based on 92 respondents who provided an answer to both Question 5 and Question 6, and for Option 2 this is based on 169 respondents who provided an answer to both questions.

4.14 The most commonly mentioned reasons for selecting **Option 2** were:

- Preferred option will provide more local services (62.1%)
- Preferred option provides more choice e.g. locations, options to access service (55.6%)
- Preferred option will have better availability of appointments / services (32.0%)

4.15 Table 10 outlines the key reasons why respondents selected Option 1 or Option 2.

Table 10: Number / % of responses by theme to Question 6 for Option 1, Option 2 and Overall

Theme	Option 1		Option 2		Overall	
	No.	%	No.	%	No.	%
Preferred option will provide more local services	21	22.8	105	62.1	126	47
Preferred option provides more choice e.g. locations, options to access service	10	10.9	94	55.6	104	38.8
Preferred option will have better availability of appointments / services	23	25.0	54	32.0	77	28.7
Preferred option means hubs will be closer / nearer / care will be closer to home	~	~	46	27.2	50	18.7
Preferred option will have better weekend availability	32	34.8	~	~	37	13.8
Preferred option has better transport / public transport links	~	~	16	9.5	20	7.5
Preferred option will reduce misuse of services	9	9.8	9	5.3	18	6.7
General positive comments relating to options	8	8.7	~	~	12	4.5
Comments about services not being local enough	~	~	~	~	10	3.7
Comments relating to costs	6	6.5	~	~	10	3.7
Preferred option is simpler and easier	8	8.7	~	~	9	3.4
Concerns about availability of appointments / services	~	~	~	~	8	3.0
Concerns about weekend availability	~	~	6	3.6	8	3.0
General negative comments relating to options	~	~	~	~	8	3.0
Preferred option will utilise staff and resources better / more efficiently	~	~	~	~	8	3.0
Unable to select either option	~	~	~	~	7	2.6
Concerns about distance to the hubs	~	~	~	~	6	2.2
Concern about misuse of services	~	~	~	~	~	~
Concerns about transport /	~	~	~	~	~	~

public transport						
Comments relating to parking	~	~	~	~	~	~
Concerns about staffing / capacity	~	~	~	~	~	~
Reiteration that the walk-in service should remain at current location	-	-	-	-	~	~
Other	~	~	~	~	~	~

4.16 Respondents were also asked if they had an alternative option on how Urgent Care could be delivered across Tameside & Glossop. They were invited to explain the benefits this alternative option would bring and any financial considerations.

4.17 The most commonly mentioned themes relating to alternative options were:

- No alternative option provided (23.6%)
- Suggestions relating to / positive comments around reducing the misuse of services (19.1%)
- Concerns about whether there are enough locally available services (15.7%)

Table 11 outlines the number and proportion of respondents who made reference to a particular theme within their response to question 7.

Table 11: Number / % of responses by theme to Question 7

Theme	No.	%
No alternative option provided	21	23.6
Suggestions relating to / positive comments around reducing the misuse of services	17	19.1
Concerns about whether there are enough locally available services	14	15.7
Comments relating to staffing / capacity	13	14.6
Reiteration of the importance of local services	11	12.4
Concerns about misuse of services	10	11.2
General positive comments	8	9
Keep walk-in service in Ashton Primary Care Centre / no need for change	7	7.9
Need for more Walk-in Centres	7	7.9
Comments related to increased availability of appointments	6	6.7
Concerns about availability of appointments	6	6.7
Comments about cost / need for more funding	6	6.7
Better provision of urgent care facilities for Glossop	6	6.7
Concerns about distance to access services	~	~
Suggestions relating to increased choice of services	~	~
More efficient use of the existing system	~	~
Distance / transport positive comments	~	~
Concerns about choice of service available	~	~
Need for communication / better awareness of services available	~	~
Integrate other public services into the hubs	~	~
Questions or requests for more information	~	~
Need for sufficient parking	~	~

4.18 Finally, respondents were provided with an opportunity to make any other comments they would like to about Urgent Care services in Tameside & Glossop. The responses to this question have been themed and those most commonly mentioned include:

- No comment to make (21.9%)
- General comments – positive (15.6%)
- General comments – negative (14.8%)

Table 12 outlines the number and proportion of respondents who made reference to a particular theme within their response to question 8.

Table 12: Number / % of responses by theme to Question 8

Theme	No.	%
No comment	28	21.9
General comments - positive	20	15.6
General comments - negative	19	14.8
Concerns about the misuse of services	17	13.3
Concerns about services not being local enough	16	12.5
Comments around staffing / capacity	13	10.2
Concerns about transport / public transport links / distance to travel	11	8.6
Need for effective communication / education of which services are available to use	11	8.6
Comments relating to availability of appointments	8	6.3
Comments relating to costs	7	5.5
Invest in Services	7	5.5
Comments around reduction of misuse of services	6	4.7
Comments relating to importance of local services	~	~
Asking questions/requesting further information	~	~
Parking - negative comments	~	~
Further integration of services	~	~
Public transport / transport positive comments	~	~
Do not privatise NHS	~	~

4.19 Cross tabulation of results by demographic group has not been undertaken due to the small numbers by individual category, making meaningful analysis not possible.

Appendix 7

Quality Impact Assessment
Urgent Care Review
September 2017

Quality Impact Assessment

Title of scheme: Urgent Care

Project Lead for scheme: Elaine Richardson

Tameside and Glossop Strategic Commission have led the development of a locality vision for an enhanced offer of urgent care i.e. support for conditions that need prompt medical help to avoid them deteriorating but are not life threatening. Officers were asked to bring back a fully developed proposed model to the Strategic Commissioning Board (SCB) following public consultation.

This quality impact assessment is based on the model set out in the consultation and in particular option 2 which was the preferred option of most consultation respondents.

Our vision is that:

> **People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery.**

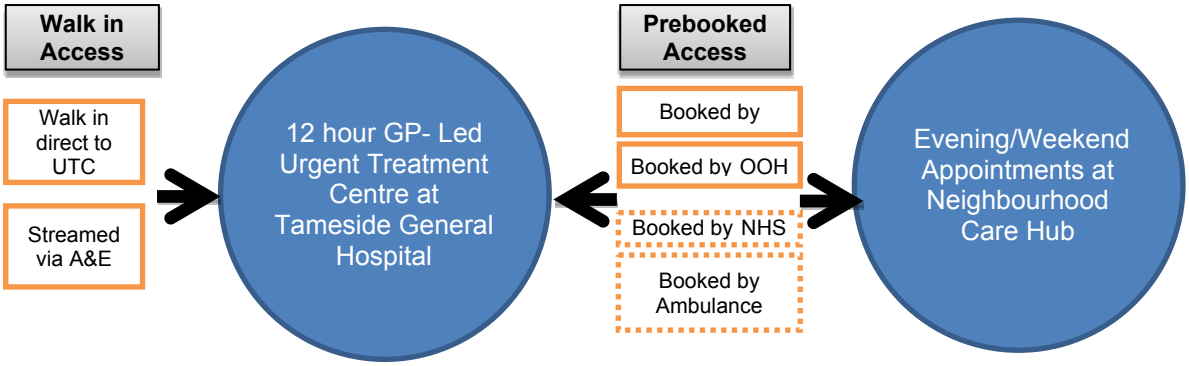
By 2022 we expect people who develop an urgent care need to be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist or pharmacy or optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service.

Key Outcomes will include:-

- People are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue.
- People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
- People whose need can be met within a Neighbourhood do not attend A&E.
- People are equipped to reduce the risk of the same need arising in the future.

People will have 24/7 access to urgent care within Tameside and Glossop with the GP telephone number being the key number to use for support and direction. People registered with a Tameside and Glossop practice with be able to book same day appointments in their own practice, in a Neighbourhood Care Hub or at the Urgent Treatment Centre on the hospital site. People who are not registered with a Tameside and Glossop GP or who prefer not to book in advance will be able to walk-in to the Urgent Treatment Centre. People who need to be seen by a GP when practices, the Neighbourhood Care Hubs and Urgent Treatment Centre i.e. 9pm to 8 am weekdays and 9pm to 9am weekends and Bank Holidays are closed will be seen on the hospital site.

In summary the Urgent Treatment Centre will provide walk-in access with bookable access available at both the Urgent Treatment Centre and the Neighbourhood Care Hubs as below.



The services at all access points will include General Medical Primary Care with both routine and urgent needs accommodated through appointments available with GPs or members of the wider Primary Care Team. In addition, the Urgent Treatment Centre will be able to directly access urgent diagnostics e.g. urinalysis, ECG and in some cases X-ray. The integrated nature will enable people to receive a range of physical and mental health support promptly both on the hospital site and within neighbourhoods.

The two options within the consultation were:

Option 1 - In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Urgent Care booked appointments in **three** Neighbourhood Care Hubs via GP or NHS 111 as below:

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Ashton Primary Care Centre
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed

Option 2 - In addition to the Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access, Urgent Care booked appointments in five Neighbourhood Care Hubs via GP or NHS 111 as below:

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	Not open*	Yes	No	Ashton Primary Care Centre
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre
South Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed
East Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed
West Hub	6.30pm to 9pm	Not open*	Yes	No	To be Confirmed

Not open* - Appointments can still be booked at the Urgent Treatment Centre and Glossop Hub

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.							What is the likelihood of risk occurring?						What is the overall risk score (impact x likelihood			
	Neutral / Positive Impact	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	Low	Moderate	High	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	
Patient Safety	x						x						x			A positive impact is anticipated The ability to book appointments in advance through the registered GP will enable people to be treated at the place that is best suited to meet the described need and ensure if urgent diagnostics may be required appointments are arranged at the Urgent Treatment Centre. The ability to book appointments until 9 pm will support people to plan their access and so reduce congestion in walk-in services. People who chose to walk-in will attend the Urgent Treatment Centre will be assessed on arrival and seen by the most appropriate professional with prompt transfer to on the same site to emergency care when needed. Simplifying the pathways and locations will improve patient access to the most appropriate services including diagnostics. The single point of walk-in access will avoid the need for people to 'self-triage' and reduce the risk of an individual selecting a service that cannot meet a person's need. The increased access to urgent care and the initial assessment at the

															Urgent Treatment Centre will reduce the use of A&E for non-life threatening conditions and free up resources to manage people who require emergency treatment. The Urgent Treatment Centre and Neighbourhood Care hubs will be able to access patient records with the appropriate consent. The provider will be expected to ensure robust and consistent care and safety for patients. Safety incidents will be reported and monitoring of these will be carried out via provider governance and as part of the performance management and assurance of the contract. Access to patient notes will reduce risk when planning treatment. The provider will need to assure the SCF of its governance and quality assurance mechanisms.
Clinical effectiveness	X						x						x		A positive impact is anticipated The ability to book appointments in advance through the registered GP will enable people to be treated at the place by the most appropriate professional which will improve effectiveness. Access to urgent diagnostics at the Urgent Treatment Centre will improve diagnosis and treatment in a single appointment. Access to patient notes will improve the planning of treatment both immediate and any follow up care. Reduced minor activity in A&E will enable A&E specialists to focus on the most complex patients
Patient experience		x								x			x		Although it is expected that the proposed model will improve patient experience through alignment of access points and increased appointments, a degree of dissatisfaction from some people is anticipated as any change attracts negative responses. This is particularly noted due to negative media interest and patient feedback in other GM localities where there have been complete closure of their Walk-in Centres. The proposed model retains a walk-in element and is fully aligned with national and GM expectations. Through consultation we have collected

people's perception of the impacts so we could identify any areas where we will need to take action to mitigate risk. The feedback shows that some people will have to travel a little further (1.5miles) which will take longer to the walk-in access when it is at the hospital but others will have shorter journeys and journey times. The EIA contains the detailed travel analysis.

To address concerns regarding car parking at the hospital site a development scheme in partnership with the hospital will provide an additional 240 parking spaces.

Both concerns and approval of the co-location with A&E were expressed with regard to the impact on waiting times. The specification for the service will ensure that patients are treated in line with the national expectations and we will encourage use of the Friends and Family test and Care Opinion to gain feedback and identify areas for further improvement.

The majority of comments made relating to impact there would be for them if the walk-in service currently provided at Ashton Primary Care Centre is relocated to an Urgent Treatment Centre on the Tameside Hospital site this were themed as:

- Relocation will have no/minimal impact (27.2%)
- Parking is worse at hospital site (22.2%)
- Services will be less locally accessible (21.8%)

The local availability through hubs was welcomed by many and the implementation plan will ensure strong communications to support people in booking appointments through their practices and 111.

Option 2 was the option most respondents (63.2%) felt would best suit the urgent care needs of the population across Tameside & Glossop. Option 1 was selected by 36.8% of respondents.

The most commonly mentioned reasons for selecting Option 2 were:

- Preferred option will provide more local services (62.1%)

															• Preferred option provides more choice e.g. locations, options to access service (55.6%) • Preferred option will have better availability of appointments/services (32.0%) The most commonly mentioned reasons for selecting Option 1 were: • Preferred option will have better weekend availability (34.8%) • Preferred option will have better availability of appointments/services (25.0%) • Preferred option will provide more local services (22.8%) We will use all the feedback and opinions to ensure effective communication when the final service arrangement is agreed and to support implementation.
Safeguarding children or adults	x						x						x			No impact expected as staff will be fully trained and the provider will have safeguarding procedures in place.

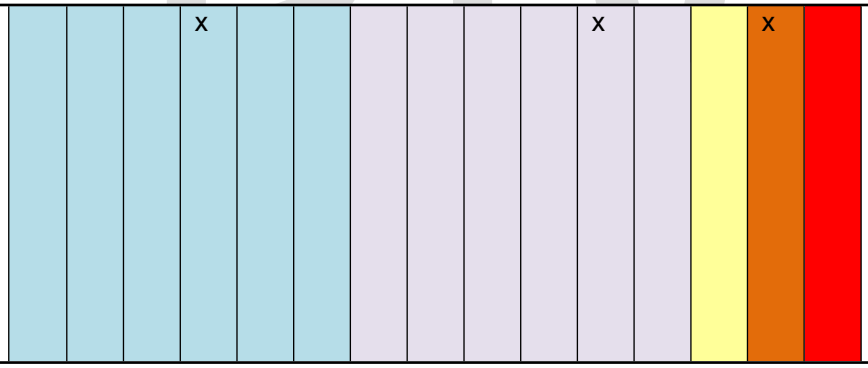
Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented. **NB please see appendix 1 for examples of impact on additional areas.**	**What is the likelihood of risk occurring?**	**What is the overall risk score (impact x likelihood)**	**Comments**

	Neutral / Positive	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	**Low**	**Moderate**	**High**	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	
Human resources/ organisational development/ staffing/ competence			x							x				x		The proposal will provide more flexibility in how skill sets and expertise can be utilised and reduce some of the risks around capacity that the duplication of services suffers. The relocation of the Walk-in services from Ashton Primary Care Centre will have an impact on some people but the services remain within Ashton so disruption should be minimal. The provider will need to carefully manage the transition period and the long term plans for workforce. HR and OD management.
Statutory duty/ inspections	x						x						x			No impact expected – this will be managed by the provider in line with guidance and contractual responsibilities. Any changes to CQC registration will need to be managed by the provider to ensure it is appropriate and up to date.

Adverse publicity/ reputation			x							x				x	

The proposal included changes to existing provision at Ashton Primary Care centre and the Hospital site. This received mixed responses during consultation as shown below

Theme	No.	%
Relocation will have no / minimal impact	71	27.2
Parking is worse at the ICFT site	58	22.2
Services will be less locally accessible	57	21.8
Relocation will mean the walk in centre would be further away or further to travel	54	20.7
General positive comments about proposal to relocate walk in centre	42	16.1
Services will be more locally accessible	41	15.7
Service will be easier to access / a more simple service	26	10
Comments relating to parking / travel costs	25	9.6
Relocation will mean the walk in centre is closer, nearer or the same distance	24	9.2
The relocated walk in centre will be more difficult to access by public transport	23	8.8
Relocation will mean the walk in centre is more difficult to access via public transport	19	7.3
Patient care / service / treatment will be better as a result of service relocation	14	5.4
Comments relating to appointments and services e.g. availability, waiting times etc	13	5
General negative comments about proposal to relocate walk in centre	10	3.8
Relocation of service will reduce misuse of services	10	3.8
The relocated walk in centre will be easier to access by public transport	9	3.4
Centralisation of services will be beneficial	9	3.4
Relocation may increase misuse of services	8	3.1
Parking is better at the ICFT site	5	1.9
Centralisation of services may be detrimental	5	1.9
Comments relating to staffing / capacity	4	1.5
Disabled / those with mobility issues may have difficulty accessing hospital site	4	1.5
Relocation will mean the walk in centre is more accessible via public transport	3	1.1
Other	3	1.1
Service will be more difficult to access / a more complicated service	2	0.8
Not sure what impact of relocation will be	2	0.8
Relocation will have a lot of impact	1	0.4

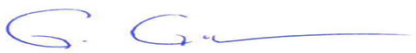
		Developments to mitigate some of the concerns express had already been considered and had been explained in the consultation material e.g. car parking and travel times. Where needed additional mitigation such as effective communication plans, ongoing review of capacity and demand, improved The options within the consultation included one which would mean a reduction in locations for weekend access to booked appointments which could receive negative feedback. This option was Option 2. Option 2 was the option most respondents (63.2%) felt would best suit the urgent care needs of the population across Tameside & Glossop. Option 1 was selected by 36.8% of respondents. A robust communications plan will be in place for the life of this project and communications, engagement and consultation activity will be monitored and evaluated throughout the life of the plan. The data we have relating to current usage of existing services is known. Transport mapping has been done to demonstrate the impact of relocation by car and public transport – and this shows that more people will have a shorter journey to services located at the hospital site rather than Ashton Primary Care Centre. All of the mapping and data we have available was shared as part of the consultation documentation.
Finance		Existing funding will be used. The national mandate for A&E Streaming and the GM requirement for an Urgent Treatment Centre in Tameside and Glossop have to be delivered within existing funding. By maximising efficiency and reducing duplication the risk of additional costs will be minimised and the new service should be able to contribute to financial recovery. A Capital funding requirement at the ICFT site has been identified as part of the A&E Streaming project and a submission has been made to NHSE.

Service/ business interruption				x						x				x		Mobilisation phase of delivery will need to be robust and of sufficient duration to ensure transition is planned and managed to mitigate potential interruptions to service provision.
Environmental impact		x						x					x			There will be a change to the location of services within the proposed model (specifically Ashton PCC to ICFT). The travel in relation to this will increase footfall at the hospital site, with a greater number of cars on site. There will be a corresponding positive impact at the Ashton PCC site.
Compliance with NHS Constitution	x						x						x			The ability to focus A&E on Emergency patients will reduce the risk of failure of the national standard for A&E waiting times.
Partnerships	x											x	x			A positive impact is expected as the service will involve integrated and partnership working to deliver the service.

Public Choice	x						x						x			No negative impact on quality anticipated; the service will enable appointments to be made outside traditional working hours and at different locations which will provide more choice and convenience. The service will offer choice for urgent care access and enable people to be in more control of when they are seen. The consultation feedback showed that choice was a factor is some people's decision regarding their preferred option. The most commonly mentioned reasons for selecting Option 2 were: • Preferred option will provide more local services (62.1%) • Preferred option provides more choice e.g. locations, options to access service (55.6%) • Preferred option will have better availability of appointments/services (32.0%) Whilst there was some feedback was that there should be a choice of walk-in services many recognised the benefit of a simpler single walk-in access point that could ensure people could get the right care first time.
Public Access	x						x						x			No negative impact on quality anticipated The service will enable appointments to be made outside traditional working hours and at different locations. In terms of transport and travel times this has been mapped and the findings suggest that a greater proportion of the population will have a shorter journey time, particularly in relation to the relocation of services from Ashton PCC to the ICFT. A key element of the mobilisation phase will be to ensure that those identified in the EIA to be impacted by this will have the information about the changes to enable them to plan how they will attend services in the future. To address concerns regarding car parking at the hospital site a development scheme in partnership with the hospital will provide an additional 240 parking spaces.

Has an equality analysis assessment been completed?	YES	
Is there evidence of appropriate public engagement / consultation?	YES	The consultation has informed a review of this document

Sign off:

Quality Impact assessment completed by	**Elaine Richardson**
Position	**Head of Delivery and Assurance**
Signature	
Date	**20/2/18**
Nursing and Quality Directorate Review	
Name	**Gill Gibson**
Position	**Director of Safeguarding and Quality**
Signature	
Date	**8th March 2018**

This page is intentionally left blank

APPENDIX 8

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside & Glossop Single Commissioning Function
Equality Impact Assessment (EIA) Form

Subject / Title	Urgent Care

Team	**Department**	**Directorate**
Commissioning	Commissioning	Commissioning

Start Date	**Completion Date**
June 2017	March 2018

Project Lead Officer	Elaine Richardson
Contract / Commissioning Manager	Janna Rigby
Assistant Director/ Director	Jessica Williams

EIA Group (lead contact first)	**Job title**	**Service**
Elaine Richardson	Head of Delivery and Assurance	Commissioning
Jessica Williams	Interim Director of Commissioning and Care Together Programme Director	Commissioning
Janna Rigby	Head of Primary Care	Commissioning
Jody Stewart	Policy, Research and Improvement Manager	Policy and Communications

PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	The proposal sets out a vision for urgent care within Tameside and Glossop and how services will be configured to deliver the vision. The final arrangement will be decided following a public consultation with a decision being made at the February 2018 Single Commissioning Board. This assessment will be refreshed in response to the consultation and included in the documents presented at the February Board meeting.

1b.	**What are the main aims of the project, proposal or service / contract change?**	The vision is that: **People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery**. By 2022 we expect people who develop an urgent care need to be assessed by the most appropriate person on the same day within primary care (whether this is registered GP practice, dentist or pharmacy or optician or through a Locality-wide service) and either a treatment plan agreed to manage the immediate need within the service or a safe transfer made to the care of another neighbourhood based service. Our proposed urgent care service will integrate the existing Walk-in Centre with Primary Care Streaming at A&E and the planned Urgent Treatment Centre all of which provide/will provide direct support to people along with our Alternative to Transfer service that works with paramedics. This will provide a key access point at the Tameside Hospital site alongside neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs People will have 24/7 access to urgent care within Tameside and Glossop. They with be able to book same day appointments in their own practice, in a Neighbourhood Care Hub or at the Urgent Treatment Centre on the hospital site. People who are not registered with a Tameside and Glossop GP or who prefer not to book in advance will be able to walk-in to the Urgent Treatment Centre. People who need to be seen by a GP when practices, the Neighbourhood Care Hubs and Urgent Treatment Centre (i.e. 9pm to 8 am weekdays and 9pm to 9am weekends and Bank Holidays) are closed, will be seen on the hospital site. Key Outcomes will include:- • People are able to access urgent primary care 24/7 and are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue. • People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams. • People whose need can be met within a Neighbourhood do not attend A&E. • People are equipped to reduce the risk of the

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics? Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.				
Protected Characteristic	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Age	x			Urgent care services, including the Walk-in Centre are accessible and available to the whole population of Tameside and Glossop. However the age profile of attendances at the Walk-in centre shows that attendances are predominantly younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is the Under 16 age bracket (31.9%) of which the majority (55.9%) are aged 4 and under. The consultation process will be inclusive and accessible to ensure the views of this age group are sought, and effort will be made to ensure a representative response is received. Service user demographics are shown at appendix 1.
Disability	x			There is disabled access to both Ashton Primary Care Centre and the hospital and both sites are accessible by car and public transport. 2015/16 Fingertips data suggests that Chapel Street MP have 73.4% and Hattersley Group Practice have 72.2% of patients with a long standing condition that is significantly different to the England average. All other practices (including those with highest Walk-in Centre attendances) have patient numbers that are not statistically significant to the England average.
Ethnicity		x		The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South. 2016 Fingertips data shows that the practices with the highest walk-in centre usage have ethnicity profiles as follows;

				Albion Medical Centre: 1.6% mixed, 14.3% Asian, 1.1% Black Bedford Medical Practice: 1.6% mixed, 13.5% Asian, 1.0% Black Tame Valley: 1.6% mixed, 14.9% Asian, 1.1% Black Medlock Vale 1.5% mixed, 3.1% Asian, 1.0% Black Denton Medical Practice: 1.7% mixed, 2.5% Asian, 1.1% Black Market Street Medical Practice:1.7% mixed, 3.3% Asian, 1.9% Black Guide Bridge: 1.7% mixed, 6.9% Asian 1.3% Black HighlandsTrafalgar: 1.7% mixed, 16.2% Asian, 1.6% Black Chapel Street: 1.6% mixed 12.5% Asian, 1.3% Black This is compared to 91.8% White, 1.4% Mixed, 5.9% Asian, 0.7% Black and 0.2% Other for Tameside & Glossop overall (Census 2011).
Sex / Gender		x		Walk-in Centre data shows that there are more female service users than male, with 58.7% being female. This is compared to the Tameside & Glossop overall population which is 49% male and 51% female (2014 mid-year population estimates ONS)
Religion or Belief			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on religion or belief in any significant sense.
Sexual Orientation			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on sexual orientation in any significant sense.
Gender Reassignment			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on gender reassignment in any significant sense.
Pregnancy & Maternity		x		Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17. We also know that the greatest percentage of attendances is in the Under 16

				age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies.
Marriage & Civil Partnership			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on marriage and civil partnership in any significant sense.
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	x			Tameside and Glossop's Mental Health prevalence rate is 0.83% (2024 people); and the national prevalence is 0.9%. Depression; 10.71% (20969 people) for Tameside &Glossop and 8.3% nationally. The proposed consultation will include targeted engagement with these groups. Access and transport times may be affected by the relocation of services. Changes to location and access points will have clear links to mental health pathways for this group to maintain quality of care. There are 7 (Medlock Vale, Awburn House, Lockside, Churchgate, The Smithy, The Hollies and Simmondley) practices in Tameside and Glossop whose Mental Health prevalence is significantly different (lower) than the average. All other practices are within the normal range and this includes those practices whose Walk-in Centre attendances are highest.
Carers	x			Access and transport times may be affected by the relocation of services. Change in location of the walk-in centre may impact on accessibility for those being cared for and therefore their carers. Of the practices identified with the highest usage of the Walk in Centre, the % of carers registered is as follows: Albion:19.1% Bedford House MP: 16.3% Tame Valley: 25%

				West End MP: 20.8% Medlock Vale: 17.1% Donneybrook: 15.6% Denton MP: 21.7% Market St MP: 16.8% Guide Bridge MC: 13.5% Highlands Trafalgar; 18.1% The CCG average is 18.6% and the England average is 17.8%. The majority of the higher user practices have above average carer populations on their registered lists.
Military Veterans			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on military veterans in any significant sense.
Breast Feeding			x	There is no anticipation that the development or implementation of this model will impact directly or indirectly on breast feeding in any significant sense.

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

Group (*please state)*	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Patients not registered with a GP (either within T&G or within another area)	x			Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless.
Socio-economic	x			The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South. Of the practices identified with the highest usage of the Walk in Centre, Deprivation Score (IMD 2015) as follows: Albion:34.1 Bedford House MP: 33.5 Tame Valley: 35.3 West End MP: 38.7 Medlock Vale: 24.3 Donneybrook: 31.0 Denton MP: 29.4 Market St MP: 26.9 Guide Bridge MC: 31.3 Highlands Trafalgar; 36.6 The CCG average is 27.9 and the

				England average is 21.8 The majority of the higher user practices have above CCG average deprivation scores.

There is no anticipation that the development or implementation of this model will impact directly or indirectly on military veterans in any significant sense. However we will continue to assess any potential impact this group could experience as a result of the proposals throughout the consultation period so these can be addressed accordingly.

1d.	Does the project, proposal or service / contract change require a full EIA?	Yes	No
		x	
1e.	What are your reasons for the decision made at 1d?	The proposal constitutes a significant change to the way in which services are currently commissioned and delivered, however the model retains all of the elements of provision that are currently available. It is also a service that is universally available to everyone and decisions relating to the delivery of the service will affect a wide range of patients, public and stakeholders. A full EIA is required as the protected characteristics of age, disability, ethnicity, sex/gender, pregnancy and maternity, mental health and carers may be directly impacted by the proposed delivery model. There are also socio-economic factors to consider.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

Our vision is that:

People with an urgent care need are assessed by an appropriate Primary Care service and advice or a treatment plan is provided to support their recovery.

Strong neighbourhood based access to General Practice with other support services readily accessible will reduce the need for people to attend A&E unless they have had an accident or need emergency care. It will also support a seamless transfer for people who present as urgent but would be best managed as more routine.

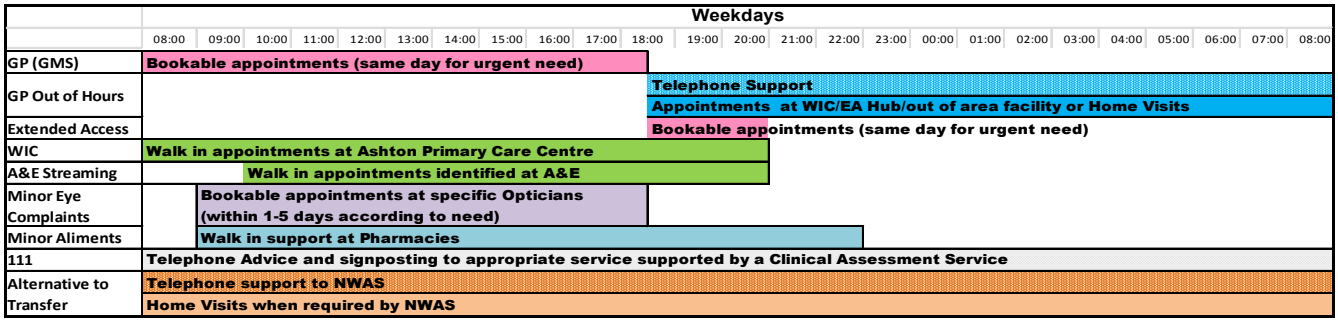
Our vision will be delivered over the next four years as we develop both the range of support that can be delivered in General Medical Practices and other Primary Care providers and the services that can be wrapped around a patient in their own home, including care homes.

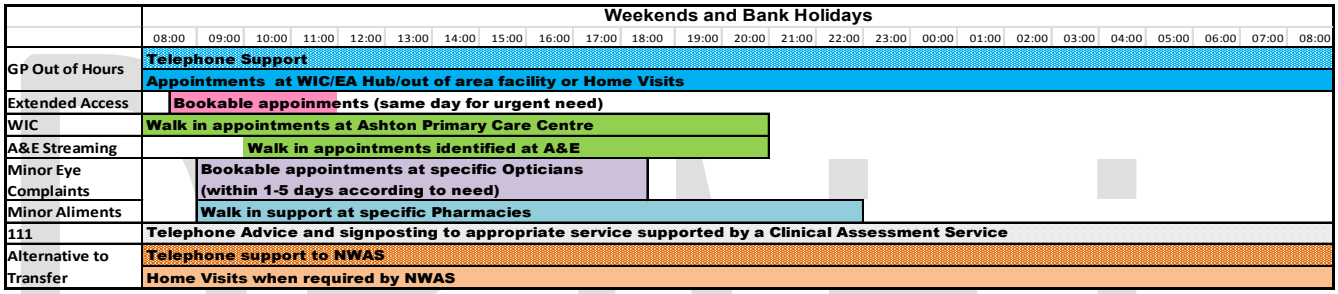
Existing services such as the Community Paramedic Service in Glossop, the Community Response Service, Digital Health and Integrated Urgent Care Team have demonstrated the opportunities to support people in their own homes when an urgent need arises. These working systematically with General Practice, community services and the voluntary sector will maximise the number of people who stay in their own home supported by Primary and Neighbourhood care which will benefit individuals and

their carers/family through prompt recovery and help maintain independence.

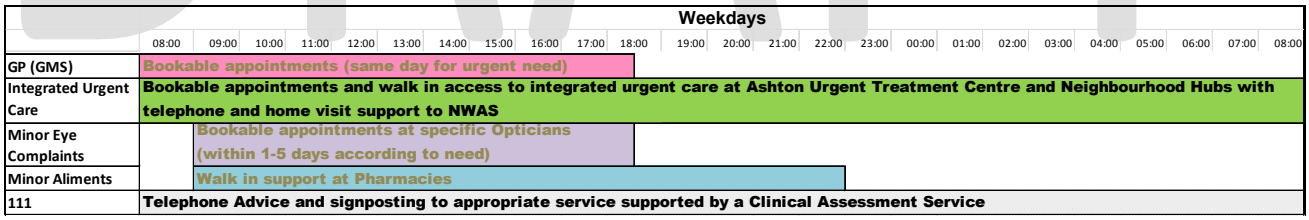
In addition to this vision, there is a mandate from NHS England to implement Primary Care Streaming within the hospital. This was implemented on the 1st October 2017.

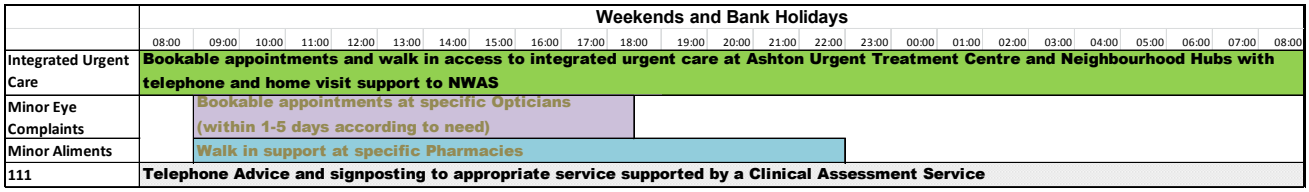
The current services that provide Primary Care support for people with an urgent need overlap as seen below. This means we have multiple access routes for patients who have an urgent but not accident or emergency need and a level of duplication in the offer available





Key to our proposal is the simplification of services whilst extending the hours people can book into appointments and providing access to urgent diagnostics. A single integrated urgent care service will work alongside the urgent access provided by GPs, Pharmacists and Opticians as seen below. This utilises the resources available to better effect, using the skill mix available to deliver care for our population.





There are several key drivers for change. Including the mandated requirement to introduce primary care streaming and develop an Urgent Treatment Centre. The model proposed for urgent care is designed to meet all national requirements whilst making provision more efficient and simpler to navigate for patients.

Urgent care will be delivered across practices, the Neighbourhood Care Hubs and the Urgent Treatment Centre. These will operate as an integrated service to ensure that people:-

- Are able to access urgent care support 24/7 and are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams

- Whose need can be met by Primary Care do not need to access A&E
- Have access to an average of 45 minutes of evening and weekend/BH appointments per 1000 register population per week
- Are able to book routine and urgent appointments at the Urgent Treatment Centre and agreed Neighbourhood Care Hub sites
- Can be seen at the Urgent Treatment Centre 12 hours a day seven days a week including Bank Holidays either by booking an appointment or presenting as a 'Walk-in'
- Receive definitive treatment, which may include self-care advice, prescription issue or treatment of the presenting condition appropriate to primary care and people are equipped to reduce the risk of the same need arising in the future
- Are supported to navigate the system so they receive effective care first time and do not represent to other services for the same issue
- Who require urgent investigations/diagnostics receive these through the Urgent Treatment Centre
- Who need a same day home visit out of hours will either be seen by a GP or another appropriate service
- Can expect, following consent, that the treating clinician has access to their up-to-date electronic patient care record

Our urgent care service will integrate the existing Walk-in Centre, OoH, Extended Access with the live Primary Care Streaming at A&E and the planned Urgent Treatment Centre all of which provide/will provide direct support to people along with our Alternative to Transfer service that works with paramedics. This will provide a key access point at the hospital site in Ashton alongside neighbourhood based access through GPs, Pharmacies, Opticians, Dentists and Neighbourhood Care Hubs.

People will get 24/7 phone access to support through their practice (111 or OOH when the practice is closed) and will be booked into an appropriate appointment of if they need a same day home visit will be seen through the practice/neighbourhood offer, an OOH GP or the Integrated Urgent Care Team. Health care professionals such as paramedics and care home nurses will continue to get 24/7 access through the Health Care Professionals helpline or Alternative to Transfer.

The first point of contact in hours will be an individual's GP practice. People will make initial contact with their own practice and appropriate advice/ appointment will be provided to enable them to be seen by the right professional on the same day or at a later date as required. If a patient needs to be seen that day, it could either be by the General Medical Practice team or appropriate other primary care provider (dentist, optician, pharmacist) or if there is no capacity or due to reasons of convenience, the patients could be booked into a Neighbourhood Care hub.

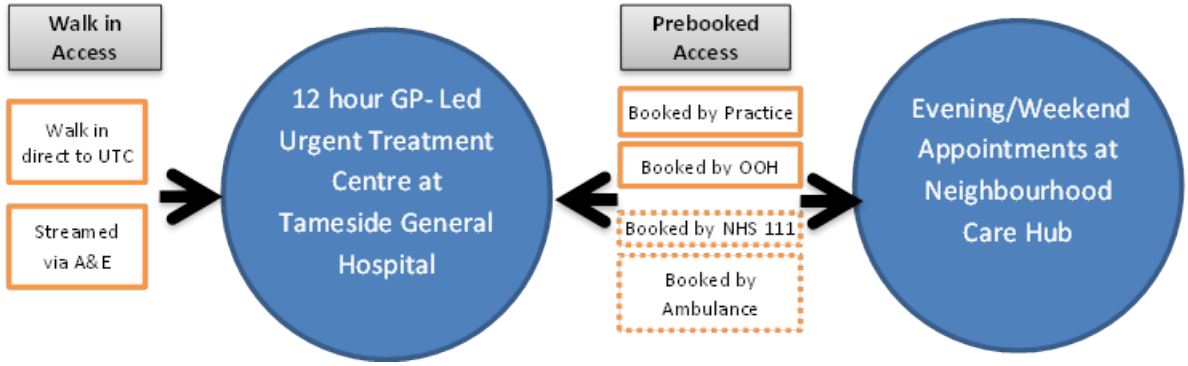
People will still have access to NHS 111 which will continue to direct people with a primary care need to practices/Out of Hours, Minor Eye Condition Service (MECS), Local pharmacies and dentists as appropriate but also to the Neighbourhood Care Hubs.

If a patient needs to be seen by a GP or another practice professional an appointment will be made either at that practice during it's opening hours or a Neighbourhood Care hub where there will be appointments 6.30pm to 9pm Monday to Friday and 9am to 1pm Saturday and Sunday or at the Urgent Treatment Centre open 9am to 9pm seven days a week. People who may need diagnostics or could need to be transferred to a hospital based specialist service may be advised to book an appointment at the Urgent Treatment Centre rather than having a choice of all locations.

If people have eye conditions, minor aliments or dental needs they will be directed to other Primary Care Providers and those with other more social care needs will be advised of the appropriate voluntary or statutory sector support.

People who chose to walk-in at the Ashton Urgent Treatment Centre site will be seen between 9am and 9pm seven days a week and may be booked into an appointment but may have to wait for up-to 2 hours for treatment.

In summary the Urgent Treatment Centre will provide 'Walk-in' Access with Bookable access available at both the Urgent Treatment Centre and the Neighbourhood Care Hubs as shown below.



The services at all access points will include General Medical Primary Care with both routine and urgent needs accommodated through appointments available with GPs or members of the wider Primary Care Team. In addition the Urgent Treatment Centre will be able to directly access urgent diagnostics e.g. urinalysis, ECG and in some cases X-ray. The colocation of the Urgent Treatment Centre on the hospital site will also ensure that patients who require more specialist urgent care will be transferred promptly.

It is expected that the majority of people will contact their GP first and will be given choice of all available appointments reducing the need for people to have to 'walk-in' to the Urgent Treatment Centre and wait to be seen. People who are not registered with a Tameside and Glossop GP will be able to 'walk-in' to the Urgent Treatment Centre. There are national projects to enable Ambulance services and NHS 111 to book into Urgent Treatment Centres, GP and Extended Access appointments so in time unregistered people and visitors may have more options regarding where they are seen.

In Tameside and Glossop medical care is available via a number of access points to both the registered and unregistered population.

An address is not required to register at a GP practice and we do know that there are a number of homeless people who are registered with practices within the locality, however the scale of this is not known. The population that are registered homeless are less likely to attend for routine care for their health, and so access to same day services is required to ensure there is a way for health care to be delivered.

In order to improve the way that patients can access same day and urgent care services, a detailed review of the total urgent primary care offer has been carried out and a new model of delivery with a single point of access to an Urgent Treatment Centre which will include all of the current provision and with access to diagnostics but in a single service, to simplify for patients where they should go if they have an urgent care need. In addition to the Urgent Treatment Centre, there will be further Neighbourhood Care Hubs offering a service that incorporates the Extended Access appointments, out of hours and Alternative to Transfer services, that will be available to pre-book either on the same day or for a date in the near future. There is great potential for the homeless and unregistered populations to benefit from the UTC as it will offer immediate and necessary treatment but also be able to access pre-bookable appointments (which those not registered with a GP cannot otherwise access at the moment), with a skill mix of workforce, which might include Care Navigators who can be trained to the needs of the people attending.

Our proposed integrated urgent care service is fully in line with national expectations and will enable

Tameside and Glossop to use the resources available to deliver an excellent service for local people.

Consultation

In October 2017 the Strategic Commissioning Board approved the proposal that the Urgent Care model 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 Strategic Commissioning Board. The consultation was on the following two options:

> **Option 1 -** An Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access and Urgent Care booked appointments in **three** Neighbourhood Care Hubs
>
> **Option 2 -** An Urgent Treatment Centre based on the Tameside Hospital site offering booked appointments, and walk-in access and Urgent Care booked appointments in **five** Neighbourhood Care Hubs

The consultation ran from 1st November 2017 to 26th January 2018.

The online consultation closed on Friday 26th January. Paper copies of the questionnaire were accepted until 5pm on Monday 29th January 2018.

The consultation was hosted on the CCG website http://www.tamesideandglossopccg.org/get-involved/urgent-care-consultation. There was a standard questionnaire 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 of the main SCB paper for presentation on the 20th March 2018.**

In addition to the online consultation, paper copies were made available in all 39 GP surgeries across Tameside & Glossop, the Walk-in Centre and 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. Copies were also available at all public meetings and meetings with community groups. Each paper questionnaire returned was given a 'unique reference number' and inputted to the online consultation system, with the reference number included in the response.

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 of the main SCB paper for presentation on the 20th March 2018.**

A 'Fact Sheet' and 'Frequently Asked Questions' were posted on the CCG website consultation page and were reviewed throughout the consultation process to ensure they reflected questions raised through the public meetings and other community engagement processes undertaken. These are included at **Appendix 3 of the main SCB paper for presentation on the 20th March 2018.**

URGENT CARE SERVICE OPTIONS

There are two options for the delivery of the urgent care service both of which have the Urgent Treatment Centre based at the hospital site open 12 hours seven days a week 9am to 9pm. This will offer bookable same day/urgent and routine appointments and walk in access for urgent care and be able to provide direct access to urgent diagnostics along with safe transfer to other more specialist services when necessary. It will replace the existing Walk-in service at Ashton Primary Care Centre which will relocate to the hospital site ensuring that patients with an urgent care need will be able to be seen within Tameside and Glossop 24/7.

The early ideas and potential options developed from the feedback were discussed by a Local Design Group made up of representatives from a range of stakeholders details are below:

Organisation/Representing	Type of Organisation / Representing
T&G ICFT Council of Governors	Veteran
Hyde Bangladesh Welfare Association	Bangladeshi Community Group
Infinity Initiatives	Support homelessness, substance instance, financial and debt problems, isolations, loneliness, anti-social behaviour victims and perpetrators
Anthony Seddon Centre	Peer-led community mental health project
Greystone Housing Group	Homelessness
Change, Grow, Live	Provides help and support to adults, children, young people and families. Services cover a wide variety of areas including health and wellbeing, substance use, mental health, criminal justice, domestic abuse and homelessness.
Adullam Homes	
Glossop Practice Neighbourhood Group	GP Registered Patients
Stroke.org	Support for people who have had a stroke and their family and carers.

The options were then further discussed in the Professional Reference Group on 2nd August in the light of recently released national guidance. Following the discussion it was agreed to refine the options taking into account analysis of the Local Design Group feedback. Three options were then presented to the 6th September Professional Reference Group. These were refined again taking into account some early feedback from patient representatives, elected councillors and MPs which resulted in the two options presented to the Strategic Commissioning Board.

The options vary in the number of Neighbourhood Care hubs where bookable appointments can be made and when those hubs will be open as shown below.

Option 1

	Opening Hours		Access		Location
	Weekday	Sat and Sun	Booked appointments	Walk-in	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	9am to 1pm	Yes	No	To be Confirmed

Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre

Option 2

	Opening Hours		Access		Location
	Weekday	**Sat and Sun**	**Booked appointments**	**Walk-in**	
Urgent Treatment Centre	9am to 9pm	9am to 9pm	Yes	Yes	Hospital Site in Ashton
North Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
South Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
West Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
East Hub	6.30pm to 9pm	None*	Yes	No	To be Confirmed
Glossop Hub	6.30pm to 9pm	9am to 1pm	Yes	No	Glossop Primary Care Centre

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

The Key Points are:

- Relocation of the Walk-in access from Ashton PCC Walk-in Centre to the ICFT as an Urgent Treatment Centre which has additional diagnostics and direct access to other services.
- Bookable provision at the Urgent Treatment Centre seven days a week
- Bookable provision in Glossop 6.30-9pm Monday to Friday, and 9am-1pm Sat and Sun
- Bookable provision in other neighbourhoods dependent on options below.
- Out of Hours provision utilising bookable appointments where possible and seeing patients within Tameside and Glossop locality

The options have been developed having considered the feedback from a number of pre-engagement actions, including from a local design group made up of public and stakeholder representatives (28 July 2017).

2b. Issues to Consider

- Travel times
- Transport routes
- Parking (at the hospital site)
- Communications to ensure patients are able to navigate their way to the right services
- Access to appointments within general practice

- Our consultation and pre-engagement will need to be carefully planned and carried out to ensure all relevant groups, stakeholders are able to respond.
- Ensure that the final delivery model does not adversely affect accessibility and how patients are able to manage their usage

Key factors in deciding where to go for help included:

- How serious the need was perceived to be,
- Trust in the person they will be seen by, with trust in general practice being high
- Ease of getting to a service, including transport links and car parking,
- The time it would take to be seen and
- Access to medical records was also seen as important in the quality of any response.

The relocation of the Ashton Primary Care Centre support service that delivers the Walk in element to the hospital site will mean a return to the position before the mandated implementation of A&E Streaming to Primary Care (October 2017) where there is one walk in arrangement for urgent care.

GM Academic Health Sciences Network have undertaken a Literature Review on Walk-In services and the findings suggest that the opening of walk-in centres has a minimal impact on the demand for other urgent care or primary care services, not significantly affecting either ED attendances or activity at primary care services. It is suggested that walk-in centres may instead increase overall demand for urgent care as patients who would previously have self-treated minor illnesses or injuries may instead attend the walk-in centres.

The finding of work based on patient questionnaires looking at what would have happened in an area if there had been no walk-in centre suggests, 50% of people would have attended a GP or requested a home visit, 26% would have attended the ED, 5% would have utilised the pharmacist and almost 10% would have self-treated rather than attended elsewhere and therefore would not increase demand on other services had the walk-in centre been unavailable. However, research into what happens after attending a walk-in centre suggests that almost 40% of patients may have duplicate attendances in other primary or urgent care services rather than using the walk-in centre as an alternative so activity may not increase as suggested from questionnaires. One study reported that 30% of patients attending an A&E facility over a 4 week period stated that the A&E was not their first point of contact. So by ensuring that the first contact delivers the outcome a patient needs it should mitigate any risk of activity increasing in A&E or other services and could decrease current A&E activity.

Access to the Tameside and Glossop Walk In Centre services is through people presenting at Ashton Primary Care Centre although some may be advised to attend by NHS 111, OOH, another clinician or their own practice. As with A&E, people who are not registered with a T&G GP can attend and between 1st June 2016 and 31st May 2017 the service supported around 3700 individuals who were not registered with a GP which represents 10% of the individuals who have used the service. This includes people who are overseas visitors and people who chose not to register.

Ensuring that unregistered people are able to access primary care when they feel they need it is important in maintaining their general health and widening what could be available to them when they attend could improve the level of support they receive and the health outcomes they experience.

	Usage between 1st June 2016 and 31st May 2017					
	T&G Registered	GM (exc T&G) Registered	Out of GM Registered	Unregistered	GP unknown	Total
Unique Individuals	26253	3964	1678	3740	166	35801
	73%	11%	5%	10%	0.5%	

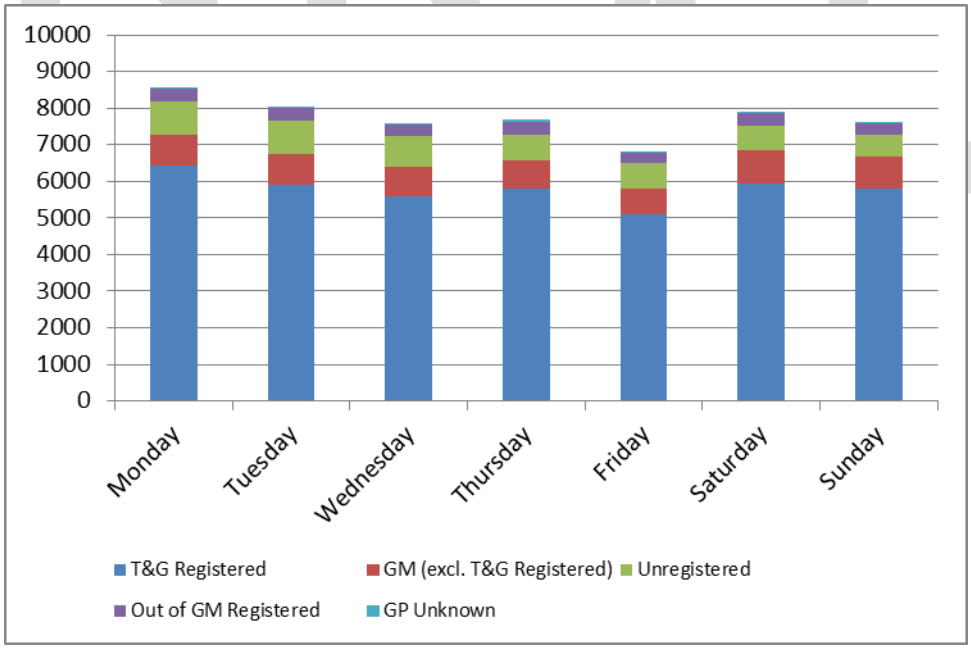
Several individuals have used the service on multiple occasions as shown. Not surprisingly visitors registered out of GM are less likely to attend multiple times.

	T&G Registered	GM (exc T&G) Registered	Out of GM Registered	Unregistered	GP unknown	Total
Attendances	40589	5708	2288	5353	238	54176
	75%	11%	4%	10%	0%	75%

It is suspected that some individuals using the WIC will also attend other services for the same conditions as a GM Academic Health Sciences Network Literature Review of research into what happens after attending a walk-in centre suggests that almost 40% of people may have duplicate attendances in other primary or urgent care services rather than using the walk-in centre. One study reported that 30% of people attending an A&E facility over a 4 week period stated that the A&E was not their first point of contact.

If we can ensure that the first contact with Urgent Primary Care is in the most appropriate place and delivers the outcome a person needs it should mitigate the need for people to attend multiple locations.

There is no real variation in usage by day for any particular cohort of people. The highest daily attendances at the WIC are recorded on a Monday and a Saturday although attendance levels are fairly consistent.



For our registered population weekend activity accounts for 30% of total weekly attendances.

Neighbourhood	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Total
North	2735	2502	2407	2523	2256	2108	1977	16508
West	1626	1473	1379	1396	1207	1381	1285	9747
South	1132	1121	1007	1005	875	1380	1376	7896
East	831	723	685	791	685	881	905	5501
Glossop	115	92	113	99	67	201	250	937
Total	6439	5911	5591	5814	5090	5951	5793	40589
Proportion	15.9%	14.6%	13.8%	14.3%	12.5%	14.7%	14.3%	

North is the only neighbourhood that sees a reduction in usage at the weekend.

The majority of WIC attendances by T&G registered Practices are from North (41%) and West (24%)

neighbourhoods. Similarly North registered people are high users of A&E accounting for 28% of the last 12 months activity with 10% being for minor conditions and 18% for majors. South usage at A&E is similar to North.

Neighbourhood	WIC Usage	A&E Usage		
		Minor	Major	Total
North	41%	10%	18%	28%
West	24%	6%	12%	18%
South	19%	9%	18%	27%
East	14%	6%	12%	18%
Glossop	2%	3%	6%	9%
Total	75%	34%	66%	

Geography may be a key factor in usage as Glossop is a lower user of all the services. There are some anecdotal reports that Glossop people use the New Mills WIC but there is no data to demonstrate how extensive this use is.

For the non-registered user, the data (above) shows that Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless. In addition to this, A&E data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531). The tables below show the actual attendances per month and the average frequency by day of the week.

Unregistered Patient A&E Attendances Per Month	
Month	Attendances
Apr-17	33
Aug-17	57
Dec-16	56
Feb-17	35
Jan-17	45
Jul-17	48
Jun-17	41
Mar-17	30
May-17	34
Nov-16	49
Oct-16	49
Sep-17	54
Total	**531**

Unregistered Patient A&E Attendances by Day	
Attendance Day	Attendances
Friday	82
Monday	77
Saturday	86
Sunday	77
Thursday	66

Tuesday	80
Wednesday	63
Total	**531**

At the Walk-in Centre there is a higher proportion of female to male attendances overall with 58.7% of attendances being by females.

Neighbourhood	Female Service Users	Total Female	Male Service Users	Total Male
North	9854	23973	6653	23862
West	5914	35305	3831	33,298
South	4677	24033	3219	22805
East	3270	29504	2231	28912
Glossop	547	16966	390	16211
Non T&G	7551	N/A	6035	N/A
Proportion	58.7%	50.9%	41.3%	49.00%

The WIC is predominantly used by younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under.

	Females					
Neighbourhood	**Service Users Under 16**	**Total Population Tameside and Glossop Under 16**	**Service Users 16-45**	**Total Population Tameside and Glossop 16-45**	**Service Users 46-65**	**Total Population Tameside and Glossop 46-65**
North	2946	4914	4537	9433	1646	5817
West	1528	6256	2767	12767	1063	9472
South	1331	4864	2301	9102	733	6084
East	817	5567	1653	11149	585	7856
Glossop	155	2930	257	5997	99	4995
Non-T&G	1793	N/A	4047	N/A	1264	N/A
Total	8570	24531	15562	48448	5390	34224
Proportion	16%	9%	29%	19%	10%	13%

	Females			
Neighbourhood	**Service Users 66-75**	**Total Population Tameside and Glossop 66-75**	**Service Users Over 75**	**Total Population Tameside and Glossop Over 75**
North	485	2086	240	1723

West	332	3,696	224	3,114	
South	207	2227	105	1756	
East	141	2853	74	2079	
Glossop	26	1794	10	1250	
Non-T&G	275	N/A	172	N/A	
Total	1466	12656	825	9922	
Proportion	3%	4%	2%	3%	

	Males					
Neighbourhood	**Service Users Under 16**	**Total Population Tameside and Glossop Under 16**	**Service Users 16-45**	**Total Population Tameside and Glossop 16-45**	**Service Users 46-65**	**Total Population Tameside and Glossop 46-65**
North	3014	5223	2011	9308	1057	6133
West	1619	6269	1225	12289	660	9210
South	1292	4770	1201	8609	528	6083
East	838	5846	843	10895	403	7907
Glossop	150	3122	147	5857	67	4802
Non-T&G	1776	N/A	2788	N/A	1082	N/A
Total	8689	25230	8215	46958	3797	34135
Proportion	16%	9%	15%	18%	7%	13%

	Males			
Neighbourhood	**Service Users 66-75**	**Total Population Tameside and Glossop 66-75**	**Service Users Over 75**	**Total Population Tameside and Glossop Over 75**
North	367	2063	204	1135
West	216	3,342	111	2,188
South	135	2139	63	1249
East	108	2858	39	1406
Glossop	13	1627	13	803
Non-T&G	274	N/A	115	N/A
Total	1113	12029	545	6781
Proportion	2%	4%	1%	2%

2c. Impact
The following groups with protected characteristcs were identified prior to the consultation

process as those that would be directly impacted by the proposed changes. Further to this the consultation undertaken made direct contact with a number of stakeholder groups with representation of these protected characteristics. In all, around 50 groups were contacted to take part in the consultation.

Age

Urgent Primary Care services, including the Walk-in Centre are accessible and available to the whole population of Tameside and Glossop. However the age profile of attendances at the Walk-in centres shows that attendances are predominantly younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is the Under 16 age bracket (31.9%) of which the majority (55.9%) are aged 4 and under (see tables in section 2b)

Disability

There is disabled access to both Ashton Primary Care Centre and the ICFT and both sites are accessible by car and public transport. 2015/16 Public Health England's Public Health Profiles (Fingertips data) suggests that Chapel Street MP and Hattersley Group Practice have % of patients with a long standing condition that is significantly different to the England average. All other practices (including those with highest Walk-in Centre attendances) have patient numbers that are not statistically significant to the England average.

Data from 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities 'a lot' and a further 10.2% whose day to day activities were limited 'a little'.

Ethnicity

The neighbourhoods with the highest levels of attendance at the Walk-in Centre are North and West, and for A&E these are North and South.

2016 Fingertips data shows that the practices with the highest walk-in centre usage have ethnicity profiles as follows;

- Albion Medical Centre: 1.6% mixed, 14.3% Asian, 1.1% Black
- Bedford Medical Practice: 1.6% mixed, 13.5% Asian, 1.0% Black
- Tame Valley: 1.6% mixed, 14.9% Asian, 1.1% Black
- Medlock Vale 1.5% mixed, 3.1% Asian, 1.0% Black
- Denton Medical Practice: 1.7% mixed, 2.5% Asian, 1.1% Black
- Market Street Medical Practice:1.7% mixed, 3.3% Asian, 1.9% Black
- Guide Bridge: 1.7% mixed, 6.9% Asian 1.3% Black
- HighlandsTrafalgar: 1.7% mixed, 16.2% Asian, 1.6% Black
- Chapel Street: 1.6% mixed 12.5% Asian, 1.3% Black
- This is compared to 91.8% White, 1.4% Mixed, 5.9% Asian, 0.7% Black and 0.2% Other for Tameside & Glossop overall (Census 2011).

Sex / Gender

Walk-in Centre data shows that there are more female service users than male, with 58.7% being female.

This is compared to the Tameside & Glossop overall population which is 49% male and 51% female (2014 mid-year population estimates ONS)

Pregnancy & Maternity
Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17. We also know that the greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies.

Mental Health
Tameside and Glossop's Mental Health prevalence rate is 0.83% (2024 people); and the national prevalence is 0.9%. Depression; 10.71% (20969 people) for Tameside &Glossop and 8.3% nationally.
Access and transport times may be affected by the relocation of services. Changes to location and access points will have clear links to mental health pathways for this group to maintain quality of care.

Carers
Access and transport times may be affected by the relocation of services.
Change in location of the walk-in centre may impact on accessibility for those being cared for and therefore their carers.

Of the practices identified with the highest usage of the Walk in Centre, the % of carers registered is as follows:

- Albion:19.1%
- Bedford House MP: 16.3%
- Tame Valley: 25%
- West End MP: 20.8%
- Medlock Vale: 17.1%
- Donneybrook: 15.6%
- Denton MP: 21.7%
- Market St MP: 16.8%
- Guide Bridge MC: 13.5%
- Highlands Trafalgar; 18.1%
- The CCG average is 18.6% and the England average is 17.8%.

The majority of the higher user practices have above average carer populations on their registered lists.

Patients not registered with a GP (either within T&G or within another area)
Data tells us that 10% of service users of the Walk-in Centre are unregistered. Communicating the changes to this group will be imperative, particularly to those that are homeless. Data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531).

In Tameside and Glossop medical care is available via a number of access points to both the registered and non-registered population.

An address is not required to register at a GP practice and we do know that there are a number of homeless people who are registered, however the scale of this is not known. The population that are registered homeless are less likely to attend for routine care for their health, and so access to same day services is required to ensure there is a way for health care to be delivered.

In order to improve the way that patients can access same day and urgent care services, a detailed review of the total urgent primary care offer has been carried out and a new model of delivery with a single point of access to an Urgent Treatment Centre which will include all of the current provision and with access to diagnostics but in a single service, to simplify for patients where they should go if they have an urgent care need. In addition to the Urgent Treatment Centre, there will be further Neighbourhood Care Hubs offering Extended Access appointments that will be available to pre-book either on the same day or for a date in the near future. There is great potential for the homeless to benefit from the UTC as it will offer immediate and necessary treatment but also be able to access pre-bookable appointments (which those not registered with a GP cannot otherwise access at the moment), with a skill mix of workforce, which might include Care Navigators who can be trained to the needs of the people attending.

Socio-economic

The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South.

The urgent care services are provided universally for everyone resident and registered across Tameside and Glossop. However it is anticipated that changes to how the service is delivered may impact on those protected characteristics identified; age, disability, ethnicity, sex/gender, pregnancy and maternity, mental health, carers, the unregistered user and socio-economic. The issue anticipated to have the greatest impact is transport and travel times for all of these groups.

It is not possible to provide a data analysis of demographics from the consultation due to the level of responses received.

A primary concern identified through the consultation was transport to an alternative location of the urgent Treatment Centre, from Ashton Primary Care Centre to the hospital site. The impact of this change was noted to have both a positive and negative impact for people according to where they are travelling from. This was an anticipated impact and details of the respective transport offer across the locality are provided below. The consultation responses showed particular transport challenges for residents within Droylesden and Gamesley and transport considerations will need to be included in the transport offer in the future, along with the Neighbourhood Care Hub locations.

Accessibility of Services

Basemap's TRACC software has been used to calculate travel times to Ashton Primary Care Centre, Tameside & Glossop Integrated Care NHS Foundation Trust site and the example out of hours hubs 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.

Detailed drive time, public transport and walk time analysis (Including maps) is attached at appendix 1.

Travel time analysis for Ashton Primary Care Centre and Tameside and Glossop Integrated Care NHS Foundation Trust

Drive Time

For all time periods analysed the proportion of Tameside and Glossop residents who are within travelling distance by car to Ashton Primary Care Centre (APCC) is similar to or the same as the proportion who are within travelling distance by car to Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT).

On weekday mornings at peak times (Monday-Friday 0700-0900):

- 87.2% of residents can travel to APCC by car within 0-15 minutes and 86.3% can travel to T&G ICFT by car within 0-15 minutes.
- 99.8% of residents can travel to both locations by car within 0-30 minutes

On weekdays, off-peak (Monday-Friday 1000-1600):

- 88.4% of residents can travel to APCC by car within 0-15 minutes and 89.3% can travel to T&G ICFT by car within 0-15 minutes.
- Again 99.8% of residents can travel to both locations by car within 0-30 minutes

On weekday afternoon/evenings at peak times (Monday-Friday 1600-1900):,

- 86.5% can travel to APCC and 86.2% can travel to T&G ICFT within 0-15 minutes by car.
- Again, 99.8% of residents can travel to voth locations by car within 0-30 minutes

On weekends (Weekend 0700-1900

- 90.5% can travel to APCC and 92% can travel to T&G ICFT within 0-15 minutes by car.
- Again 99.8% can travel to both locations within 0-30 minutes by car

Public Transport

For all time periods analysed the proportion of Tameside and Glossop residents who are within travelling distance by public transport to Ashton Primary Care Centre (APCC) within 0-60 minutes is similar to the proportion who are within travelling distance by public transport to Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT) within the same time scale. However there are some differences in the proportion of residents who can access both locations via public transport within shorter time scales as outlined below.

On weekday mornings at peak times (example time of Tuesday 0700-0900):

- 97.1% of residents can access APCC and 96.4% of residents can access T&G ICFT within 0-60 minutes.
- Within 0-15 minutes 11.9% can access APCC and 9% ICFT;
- Within 0-30 minutes 58.1% can access APCC and 39.1% can access ICFT;
- Within 0-45 minutes 86.5% can access APCC and 71.6% can access ICFT.

On weekdays at off-peak times (example time of Tuesday 1000-1600):,

- 99.4% of residents can access APCC and 99.2% can access T&G ICFT within 0-60 minutes.
- Within 0-15 minutes 11.5% can access APCC and 9.2% can access ICFT;

- Within 0-30 minutes 62.4% can access APCC and 40.3% ICFT;
- Within 0-45 minutes 89.4% can access APCC and 79.6% can access ICFT.

On weekday afternoon/evenings at peak times (example time of Tuesday 1600-1900):

- 99.2% of residents can access APCC and 99% of residents can access ICFT within 0-60 minutes.
- Within 0-15 minutes 13.5% can access APCC and 8.5% ICFT;
- Within 0-30 minutes 62.4% can access APCC and 37.8% can access ICFT;
- Within 0-45 minutes 88.7% can access APCC and 77.7% can access ICFT.

On weekends (example time of Saturday 1000-1600

- 99.4% of residents can access APCC and 99% of residents can access ICFT within 0-60 minutes.
- Within 0-15 minutes 11.8% can access APCC and 9.2% ICFT;
- Within 0-30 minutes 62.4% can access APCC and 40.1% ICFT;
- Within 0-45 minutes 89.4% can access APCC and 78.7% can access ICFT.

Further to feedback through the Urgent Care Consultation, the following information has been collated to identify the existing public transport availability across the locality.

Bus Routes to ICFT Hospital Site from Key Locations across Tameside and Glossop

Direct bus routes are available from Ashton, Droylsden, Hyde, Mossley, Mottram-in-Longdendale and Stalybridge to Tameside & Glossop ICFT (Tameside Hospital) as shown in the table below. Those travelling from Audenshaw, Denton, Dukinfield, Glossop and Gamesley have to travel via another point and change e.g. at Ashton Bus Station. The routes illustrated in the table below are based on consideration of the most direct service to the hospital site, the least amount of walking, the frequency of service and the earlier and latest bus. There are many other potential routes that could be taken. Routes can be viewed and planned via: https://my.tfgm.com/#/planner/ full timetables can be found at: https://my.tfgm.com/#/timetables/

Direction[1]	Bus Service	Departure and Destination	First Bus (Weekdays)	Last Bus (Weekdays)	Number of buses operating on this route during daily operating hours[2]
Ashton Outbound	350	Ashton-Under-Lyne, Ashton Bus Station (Stand D) to Tameside General Hospital (Stop C)	06:00	22:35	63

[1] 'Outbound' defined as from the key transport points of the towns/areas to the T&G ICFT (Tameside Hospital) site; 'Inbound' defined as from the T&G ICFT (Tameside Hospital) site to the key transport points of the towns/areas

Ashton Inbound		Tameside General Hospital (Stop C) to Ashton-Under Lyne, Ashton Bus Station (Stand D)	05:45	23:24	64	
Droylsden Outbound	231	Droylsden, Edge Lane Tram Stop (Stop C) to Tameside General Hospital (Stop C)	06:40	20:13	36	
Droylsden Inbound		Tameside General Hospital (Stop C) to Droylsden, Edge Lane Tram Stop (Stop F)	06:00	19:08	33	
Hyde Outbound	387	Hyde, Hyde Bus Station (Stand C) to Tameside General Hospital (Stop C)	06:50	18:09	12	
Hyde Inbound		Tameside General Hospital (Stop C) to Hyde, Hyde Bus Station (Stand C)	07:59	18:02	11	
Mossley Outbound	350	Mossley, Mossley Stn (Stop B) to Tameside General Hospital (Stop C)	05:33	23:13	64	
Mossley Inbound		Tameside General Hospital (Stop C) to Mossley, Mossley Stn (Stop C)	06:08	22:42	63	
Mottram-in-Longdendale Outbound	387	Mottram, Mottram Jct (Stop A) to Tameside General Hospital (Stop C)	07:09	18:28	12	
Mottram-in-Longdendale Inbound		Tameside General Hospital (Stop C) to Mottram, Mottram Jct (Stop A)	07:59	18:02	11	
Stalybridge Outbound	387	Stalybridge, Stalybridge Bus Stn (Stop E) to Tameside General Hospital (Stop C)	07:22	18:43	12	
Stalybridge Inbound		Tameside General Hospital (Stop C) to Stalybridge Bus Stn (Stop A)	07:59	18:02	11	
Audenshaw Outbound	216	Audenshaw, Audenshaw Metrolink Stop (Stop B) to Ashton-Under-Lyne, Ashton Bus Station (Stand E) *(Then use 350 as according to Ashton Outbound)*	05:50	23:30	100	
Audenshaw Inbound		(*Use 350 as according to Ashton Inbound then:)* Ashton-Under Lyne, Ashton Bus Station (Stand L) to Audenshaw, Ryecroft Hall (Stop D)	04:31	23:35	102	

[2] Number buses operating on this route during daily operating hours that stops at both departure and destination stops

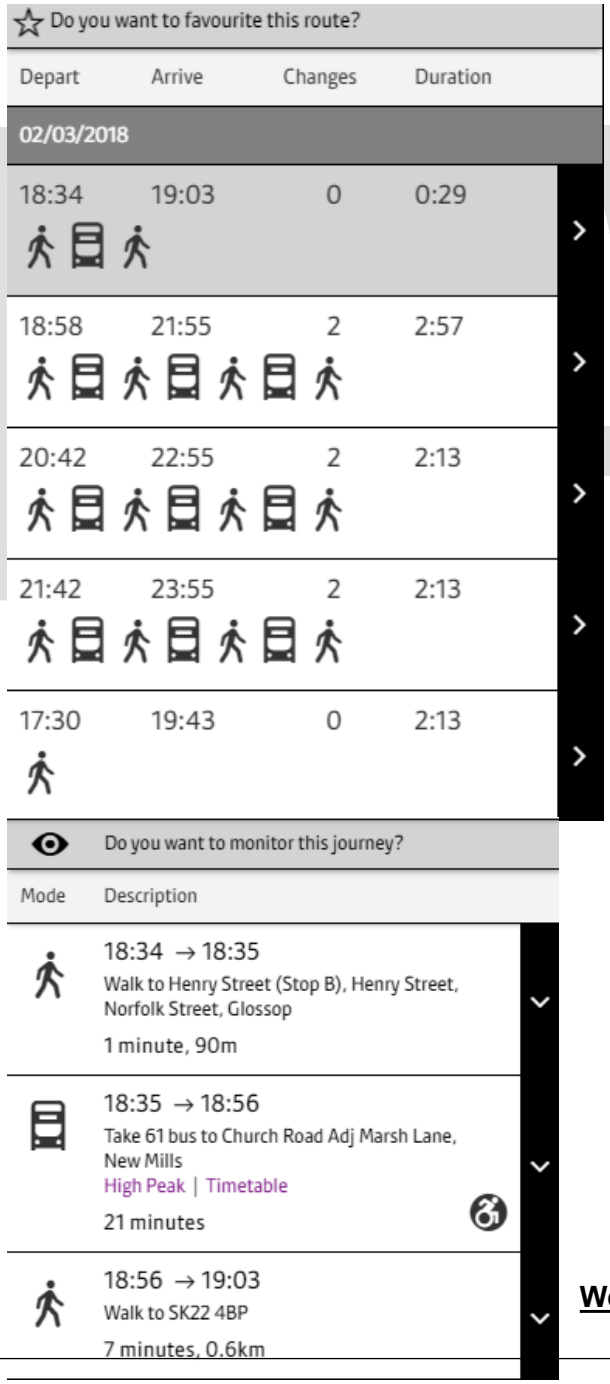
Denton Outbound	347	Denton, Crown Point (Stop F) to Ashton-Under-Lyne, Nr Shopping Centre Ashton Bus Station *(Then use 350 as according to Ashton Outbound)*	05:35	(next day) 00:05	88	
Denton Inbound		*(Use 350 as according to Ashton Inbound then:)* Ashton-Under-Lyne, Ashton Bus Station (Stand H) to Denton, Crown Point (Stop F)	05:05	23:39	88	
Dukinfield Outbound	330	Dukinfield, Dukinfield Town Hall (Stop B) to Ashton-Under-Lyne, Ashton Bus Station (Council Offices) *(Then use 350 as according to Ashton Outbound)*	05:53	(next day) 00:18	95	
Dukinfield Inbound		(*Use 350 as according to Ashton Inbound then:)* Ashton-Under-Lyne, Ashton Bus Station (Stand K) to Dukinfield, Dukinfield Town Hall (Stop A)	04:50	23:30	96	
Glossop Outbound	237	Glossop, opp Arundel Street to Ashton-Under-Lyne, Ashton Bus Station (Stand E) *(Then use 350 as according to Ashton Outbound)*	05:44	23:43	27	
Glossop Inbound		(*Use 350 as according to Ashton Inbound then:)* Ashton-Under-Lyne, Ashton Bus Station (Stand E) to Glossop, adj Arundel Street	06:18	23:31	27	
Gamesley Outbound	341	Gamesley, Opp Samas Roneo to Glossop, adj Arundel Street *(Then use 237 as according to Glossop Outbound then use 350 as according to Ashton Outbound)*	06:35	18:54	15	
Gamesley Inbound		(*Use 350 as according to Ashton Inbound then use 237 as according to Glossop Inbound then:)* Glossop, opp Arundel Street to Gamesley, adj Samas Roneo	07:40	17:15	10	

In addition to travel within Tameside and Glossop, it was identified during the consultation that a number of patients in the Glossop area do make use of the Walk-In Centre in New Mills, Derbyshire. The following travel information has been identified to demonstrate the accessibility to this alternative service:

Glossop to New Mills Clinic

Weekdays

- Searched TFGM Route Planner (https://my.tfgm.com/#/planner/) from Norfolk Square, Glossop (SK13 8) to New Mills Clinic (SK22 4BP) leaving after 17:30
- Tuesday, Wednesday, Thursday and Friday gave the below, where there is only one direct service, the 61 (but which still involves walking), and after that the only routes involve multiple changes and walking. Monday has no evening 61 service at this time.



Weekends

- Saturday: 61 leaves from Henry Street (Stop B), Glossop on the hour, every hour from 08:00 until 17:00 and travels to Adj Marsh Lane, New Mills, which is identified as near the New Mills Clinic
- Sunday: 61 leaves from Henry Street (Stop B), Glossop on the hour, every hour from 09:00 until 16:00, and then again at 17:15, and travels to Adj Marsh Lane, New Mills, which is identified as near the New Mills Clinic

Walk Time

By foot, 4.1% of residents can access APCC within 0-15 minutes, 18.1% within 0-30 minutes, 37.8% within 0-45 minutes and 54.5% within 0-60 minutes. In comparison 3.6% of residents can access the ICFT site within 0-15 minutes, 15.7% within 0-30 minutes, 31.8% within 0-45 minutes and 43.5% within 0-60 minutes.

Key Locations Analysis

Travel times between 14 key locations across Tameside & Glossop (Ashton, Mossley, Stalybridge, Dukinfield, Hyde, Broadbottom, Hattersley, Mottram, Denton, Audenshaw, Droylsden, Hadfield, Gamesley, and Glossop) to both Ashton Primary Care Centre (APCC) and Tameside and Glossop Integrated Care NHS Foundation Trust (T&G ICFT) were calculated for various modes of transport and time periods.

Drive Times

When travelling by car during weekday mornings at peak-time (Monday-Friday 0700-0900), weekday off-peak (Monday-Friday 1000-1600), weekday afternoons/evenings at peak time (Monday-Friday 1600-1900) or weekend (weekend 0700-1900) Ashton town centre was the shortest travel time of all 14 locations to both APCC and T&G ICFT, whilst Glossop town centre was the longest travel time to both sites.

For all four of the drive time time-periods the time in minutes between Glossop town centre and APCC was longer than the time between Glossop town centre and ICFT. For example on weekday mornings the time in minutes between Ashton town centre and APCC was 2.69 and the time in minutes between Ashton town centre and ICFT was 4.67. The time between Glossop town centre and APCC was 19.12 and the time between Glossop town centre and ICFT was 17.55.

Public Transport

When travelling by public transport during weekday mornings at peak time (example Tuesday 0700-0900) weekday off-peak (Tuesday 1000-1600), weekday afternoons/evenings at peak time (Tuesday 1600-1900) or weekend (Saturday 1000-1600) Ashton town centre was the shortest travel time for both APCC and T&G ICFT, whereas the longest travel time varied.

For all four public transport time-periods the travel time in minutes between Ashton town centre and APCC was 3.7, whereas the travel time in minutes between Ashton town centre and ICFT was 12.13 for three of the time-periods and 10.96 for the weekday afternoon/evenings peak time time-period.

For weekday mornings at peak time using public transport the longest time in minutes from APCC was to Gamesley (55.83 minutes) and from ICFT was also to Gamesley (48.65) minutes. For weekdays off-peak using public transport the longest time in minutes from APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (47.93 minutes). For weekday afternoon/evenings peak-time using public transport the longest time in minutes from APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (44.93 minutes). For weekends using public transport the longest time in minutes from

APCC was to Gamesley (46.83 minutes) but from ICFT was to Broadbottom (47.93 minutes).

Walk Times

By foot, Ashton was the shortest walk time to APCC at 8.6 minutes, and the longest walk time for APCC was to Glossop at 158.48 minutes. For ICFT the shortest walk time was to Stalybridge at 22.49 minutes whereas the longest walk time was to Glossop at 137.32 minutes.

Car Availability Census Data

The following data taken from Census 2011 outlines some key information relating to car and van availability across Tameside & Glossop.

1.1% of households in Tameside and Glossop have 4 or more cars or vans, 4% of households have 3 cars or vans, 22.4% have 2 cars or vans, 43.9% have 1 car or van and 28.6% have no car or van. Ashton Primary Care Centre is located in St Peter's ward, which has the highest percentage of any Tameside and Glossop ward for the category of households with no car or van (50.1%). The ward with the lowest percentage of households with no car or van was Simmondley (5.5%). The ward with the highest percentage of households with 4 or more cars or vans was St John's (4.7%). The ward with the lowest percentage of households with 4 or more cars or vans was Gamesley (0.2%).

Example Hubs Census Tables Analysis

The census population tables in appendix 3 show the percentage and count of Tameside and Glossop residents within the time bands of 15, 30, 45, 60 and 60 + minutes of the example hubs (Glossop Primary Care Centre, Haughton Thornley Medical Practice Denton Festival Hall and St Andrew's Medical Centre). The percentage figures are calculated for each mode of transport and time bracket that are displayed on the example hub maps.

Glossop Example Hub

For Glossop Primary Care Centre, when travelling by car:

- Weekdays 0700-0900: 28.2% of residents are within 0-15 minutes.
- Weekdays 1600-1900: 25.6% of residents are within 0-15 minutes.
- Weekend 0700-1900: 36.4% of residents are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Glossop Primary Care Centre, when travelling by public transport:

- Tuesday 0700-0800: 8.9% of residents are within 0-15 minutes and 47.3% are within 0-60 minutes.
- Tuesday 1830-2130: 9.6% of residents are within 0-15 minutes and 86.9% are within 0-60 minutes.
- Saturday 0900-1700: 10% of residents are within 0-15 minutes and 90.5% are within 0-60 minutes.

For Glossop Primary Care Centre, when travelling by foot 3.7% are within 0-15 minutes and 14% are within 0-60 minutes.

South Example Hub

For Haughton Thornley Medical Practice, when travelling by car:

- Weekdays 0700-0900: 87.6% are within 0-15 minutes.
- Weekdays 1600-1900: 82.4% are within 0-15 minutes.
- Weekend 0700-1900: 89.4% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Haughton Thornley Medical Practice, when travelling by public transport:

- Tuesday 0700-0800: 7.2% are within 0-15 minutes and 87.2% are within 0-60 minutes.
- Tuesday 1830-2130: 10.9% are within 0-15 minutes and 98.8% are within 0-60 minutes.
- Saturday 0900-1700: 7.8% are within 0-15 minutes and 99.2% are within 0-60 minutes.

For Haughton Thornley Medical Practice, when travelling by foot 5% are within 0-15 minutes and 36.4% are within 0-60 minutes.

West Example Hub

For Denton Festival Hall, when travelling by car:

- Weekdays 0700-0900: 83.8% are within 0-15 minutes.
- Weekdays 1600-1900: 81.6% are within 0-15 minutes.
- Weekend 0700-1900: 86.3% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For Denton Festival Hall, when travelling by public transport:

- Tuesday 0700-0800: 9.7% are within 0-15 minutes and 81.1% are within 0-60 minutes.
- Tuesday 1830-2130: 13.6% are within 0-15 minutes and 96.3% are within 0-60 minutes.
- Saturday 0900-1700: 13.7% are within 0-15 minutes and 94.9% are within 0-60 minutes.

For Denton Festival Hall, when travelling by foot 3.9% are within 0-15 minutes and 42.2% are within 0-60 minutes.

East Example Hub

For St Andrew's Medical Centre, when travelling by car:

- Weekdays 0700-0900: 95.4% are within 0-15 minutes.
- Weekdays 1600-1900: 91.8% are within 0-15 minutes.
- Weekend 0700-1900: 96.7% are within 0-15 minutes.
- For all three drive time time-periods above, 99.8% of residents are within 0-30 minutes.

For St Andrew's Medical Centre, when travelling by public transport:

- Tuesday 0700-0800: 16.1% are within 0-15 minutes and 96.4% are within 0-60 minutes.

- Tuesday 1830-2130: 20.3% are within 0-15 minutes and 99.1% are within 0-60 minutes.
- Saturday 0900-1700: 15.6% are within 0-15 minutes and 99.5% are within 0-60 minutes.

For St Andrew's Medical Centre, when travelling by foot 4% of residents are within 0-15 minutes and 45.6% are within 0-60 minutes.

Tables show travel time in minutes between each example hub and key locations for each mode of transport and time period. The travel times are calculated for each mode of transport and time bracket that are displayed on the example hub maps. These can be found at appendix 3.

The current service delivery model has access points in Ashton Primary Care Centre (Walk-in Centre, GP Out of Hours and Extended Access appointments), Glossop Primary Care Centre (Extended Access appointments) and Haughton Thornley Medical Practice in Hyde (Extended Access appointment).

The tables below show the travel times from key locations to Ashton Primary Care Centre (APCC) and to the Hospital site (ICFT).

Location	Drive Time Mon-Fri 0700-0900 (Time in Minutes)		Drive Time Mon-Fri 1000-1600 (Time in Minutes)		Drive Time Mon-Fri 1600-1900 (Time in Minutes)		Drive Time Weekend 0700-1900 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT	APCC	ICFT	APCC	ICFT
Ashton	2.69	4.67	2.8	4.5	2.78	4.66	2.7	4.27
Mossley	9.19	7.11	9	7.18	9.39	7.09	8.37	7.02
Stalybridge	5.96	4.71	5.95	4.71	6.47	4.87	5.47	4.58
Dukinfield	3.37	5.98	3.87	5.79	3.97	6	3.31	5.46
Hyde	9.08	12.4	9.22	12.33	9.43	12.8	8.59	11.3
Broadbottom	16.03	14.45	15.63	14.14	16.2	14.43	14.54	13.41
Hattersley	14.12	12.54	13.51	12.02	14.28	12.51	12.7	11.57
Mottram	11.53	9.96	11.03	9.54	11.95	10.18	10.34	9.22
Denton	7.32	10.64	7.21	10.41	7.36	10.73	6.68	9.77
Audenshaw	4.8	8.12	4.24	7.44	4.43	7.8	3.9	6.99
Droylsden	6.54	9.29	6.52	9.16	6.69	9.54	6.35	8.89
Glossop	19.12	17.55	19.62	18.13	20.74	18.98	18.59	17.47

Location	Public Transport Saturday 1000-1600 (Time in Minutes)		Public Transport Tuesday 1000-1600 (Time in Minutes)		Public Transport Tuesday 1600-1900 (Time in Minutes)		Public Transport Tuesday 0700-0900 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT	APCC	ICFT	APCC	ICFT
Ashton	3.7	12.13	3.7	12.13	3.7	10.96	3.7	12.13
Mossley	24.81	14.5	24.81	14.5	24.81	17.5	22.81	15.5
Stalybridge	18.23	14.58	18.23	14.58	18.23	14.58	18.23	14.58
Dukinfield	8.25	25.32	8.25	25.32	7.25	27.14	8.92	28.06
Hyde	21.76	38.83	21.76	38.83	22.76	39.2	24.76	39.2
Broadbottom	36.83	47.93	36.83	47.93	36.24	44.93	39.83	45.81

Hattersley	39.41	34.79	39.41	34.79	41.41	34.79	42.41	32.79
Mottram	30.12	26.51	30.12	26.51	30.12	26.51	30.12	26.38
Denton	19.35	37.37	19.35	36.37	17.35	37.37	20.35	40.39
Audenshaw	15.73	31.77	15.73	31.77	15.73	32.42	14.73	33.92
Droylsden	16.97	31.14	17.97	31.14	16.97	33.34	15.97	31.14
Glossop	42.88	41.06	42.88	41.06	44.67	41.06	45.88	48.49

Location	Walk Time (Time in Minutes)	
	APCC	ICFT
Ashton	8.6	25.9
Mossley	77.12	56.05
Stalybridge	41.9	22.49
Dukinfield	15.2	37.22
Hyde	59.17	69.83
Broadbottom	122.77	101.61
Hattersley	98.44	89.88
Mottram	95.96	74.8
Denton	50.52	80.28
Audenshaw	30.61	60.69
Droylsden	42.61	73.01
Hadfield	134.99	113.82
Gamesley	136.32	115.16
Glossop	158.48	137.32

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Transport and travel times	A series of detailed maps have been produced to show the relative travel times if attending by car, public transport or walking (appendices 1-2). In addition to this, information relating from First Bus and Stagecoach, and Transport for Greater Manchester (appendices 4-9) is available. Community travel options include Ring and Ride which is available to those who hold a TfGM Concessionary Disabled Person Pass; or are 70 years old or over, have mobility issues and hold a TfGM Over 60 Concessionary Pass www.tfgm.com/ringandride/Pages/default.aspx and the Local Link service available to Dane Bank, Glossop and East Tameside through Transport for Greater Manchester www.tfgm.com/buses/local_link/Pages/index.html. There are also a number of buses from Glossop, Hyde, Stalybridge, Denton and Ashton that go to the hospital site. Public Transport routes to both the ICFT and New Mills WiC sites have also been identified and demonstrate the range of routes and frequency of buses between locations.

<table>
<tr><td>Age</td><td>The data in section 2c. shows that the predominant age group using urgent care services are under 45 years of age. The WiC for example, is predominantly used by younger people, with 75.8% of attendances under 45 years old. The greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under. Within the proposed model, access to urgent care will be available 24/7 to accommodate the working day and health care needs.
The Consultation documentation was made available online and paper copies available at GP practices, the Ashton WiC, local libraries, Action Together and The Bureau (Glossop).

Unfortunately it was not possible to provide a data analysis of demographics from the consultation due to the level of responses received.</td></tr>
<tr><td>Disability</td><td>The consultation included targeted contact with the following groups: Deaf & Hearing Support/VIP/Tameside Fibromyalgia & ME/CFS Support group/High Peak MS support contacted to offer attendance at meeting/targeted engagement.

Data from 2011 Census shows that 10.3% of people across Tameside and Glossop had some form of disability which limited day to day activities ‘a lot’ and a further 10.2% whose day to day activities were limited ‘a little’.</td></tr>
<tr><td>Ethnicity</td><td>The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South. The consultation included targeted contact with Hyde Bangladesh Welfare contacted to offer attendance at meeting/targeted engagement.</td></tr>
<tr><td>Sex/ gender</td><td>Walk-in Centre data shows that there are more female service users than male, with 58.7% being female.</td></tr>
<tr><td>Mental Health</td><td>We will work with commissioning leads for mental health to ensure the model of care we develop is appropriate for people with an urgent primary care need and support where they also have a mental health need. The consultation process was inclusive of people with mental health needs and their carers and included targeted contact with Anthony Seddon Trust to offer attendance at meeting/targeted engagement.</td></tr>
<tr><td>Carers</td><td>Carers data taken from Census 2011 for Tameside & Glossop CCG area around provision of unpaid care:

<table>
<tr><th>Care Provision</th><th>No.</th><th>%</th></tr>
<tr><td>Provides no unpaid care</td><td>224,820</td><td>89.1</td></tr>
<tr><td>Provides 1 to 19 hours unpaid care a week</td><td>16,435</td><td>6.5</td></tr>
<tr><td>Provides 20 to 49 hours unpaid care a week</td><td>4,036</td><td>1.6</td></tr>
<tr><td>Provides 50 or more hours unpaid care a week</td><td>7,123</td><td>2.8</td></tr>
</table>
</td></tr>
</table>

	The Consultation documentation was made available online and paper copies available at GP practices, the Ashton WiC, local libraries, Action Together and The Bureau (Glossop). Unfortunately it was not possible to provide a data analysis of demographics from the consultation due to the level of responses received.
Pregnancy and Maternity	*Walk-in Centre usage data shows that there were 260 pregnancy related attendances at the Walk-in Centre during 2016-17.* We also know that the greatest percentage of attendances is in the Under 16 age bracket (31.9%), of which the majority (55.9%) are aged 4 years and under and a proportion of these will be babies. The Consultation documentation was made available online and paper copies available at GP practices, the Ashton WiC, local libraries, Action Together and The Bureau (Glossop). Unfortunately it was not possible to provide a data analysis of demographics from the consultation due to the level of responses received.
Unregistered service users	Data tells us that 10% of service users of the Walk-in Centre are unregistered. Data also tells us that there are an average of 44 attendances at A&E each month is unregistered with a GP (activity data from April-September 2017, n=531). The consultation included targeted contact with The Greystones to offer attendance at meeting/targeted engagement. Workshop held Friday 26 January to engage with relevant stakeholders. Those in attendance included Regenda homes/New Charter/Change Grow live/Tameside Housing Advice/Foundation UK/TMBC/Ashton Pioneer Homes The Consultation documentation was made available online and paper copies available at GP practices, the Ashton WiC, local libraries, Action Together and The Bureau (Glossop). Unfortunately it was not possible to provide a data analysis of demographics from the consultation due to the level of responses received.
Socio-economic factors	The neighbourhoods with the highest levels of attendance at the Walk-in Centre North and West, and for A&E these are North and South.

2e. Evidence Sources
• Activity data supplied from current services including the Walk-in Centre, OOH, Extended Access, ATT and ED • Travel time analysis and mapping for public transport and drive times – Basemap TRACC (attached)

- Greater Manchester Transport routes (attached)
- Staff and public engagement
- Census 2011
- Mid-year population estimates (ONS)
- Fingertips data 2016 http://fingertips.phe.org.uk/profile/general-practice/data#mod,5,pyr,2016,pat,153,par,E38000182,are,P89003,sid1,2000003,ind1,-,sid2,2000005,ind2,639-4

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
The project team will take ongoing responsibility for this work with reporting as required via the appropriate governance. We will ensure that progress on the monitoring of the consultation will be undertaken.	*Elaine Richardson*	*Ongoing*

Signature of Contract / Commissioning Manager	**Date**
Elaine Richardson	**6th March 2018**
Signature of Assistant Director / Director	**Date**

EIA Appendices

Appendix 1	Service User Demographics
Appendix 2	Travel Time Maps
Appendix 3	Travel Time Maps (2)
Appendix 4	Derbyshire and High Peak Public Transport
Appendix 5	Buses to Tameside Hospital
Appendix 6	TFGM Public Transport routes map, Tameside
Appendix 7	First Bus Disability Access
Appendix 8	Stagecoach Disability Access
Appendix 9	Rail-network map
Appendix 10	North Neighbourhood Profile
Appendix 11	West Neighbourhood Profile
Appendix 12	Glossop Neighbourhood Profile
Appendix 13	South Neighbourhood Profile
Appendix 14	East Neighbourhood Profile

Urgent Care Proposals Appendix Contents

The census population tables show the percentage and count of Tameside and Glossop residents within the time bands of 15, 30, 45, 60 and 60 + minutes of both Ashton Primary Care Centre and Tameside and Glossop Integrated Care NHS Foundation Trust. The percentage and count figures are calculated for each mode of transport and time bracket that are displayed on the APCC and T&G ICFT maps.

21 Census Population Percentage Table

22 Census Population Count Table

Ashton Primary Care Centre and Tameside and Glossop Integrated Care NHS Foundation Trust Key Location Travel Time Tables

The key location travel time tables show the time in minutes between 14 key location points and both Ashton Primary Care Centre and Tameside and Glossop Integrated Care NHS Foundation Trust. The travel times are calculated for each mode of transport and time bracket that are displayed on the APCC and T&G ICFT maps.

23 Drive Key Location Centre Travel Times

24 Public Transport/Walk Time Key Location Travel Times

25 Walk Time Key Location Travel Times

APCC, Drive Time, Monday - Friday, 0700 - 0900

N

T&G ICFT

APCC

T&G ICFT

APCC

Time Bands

0-15 Minutes

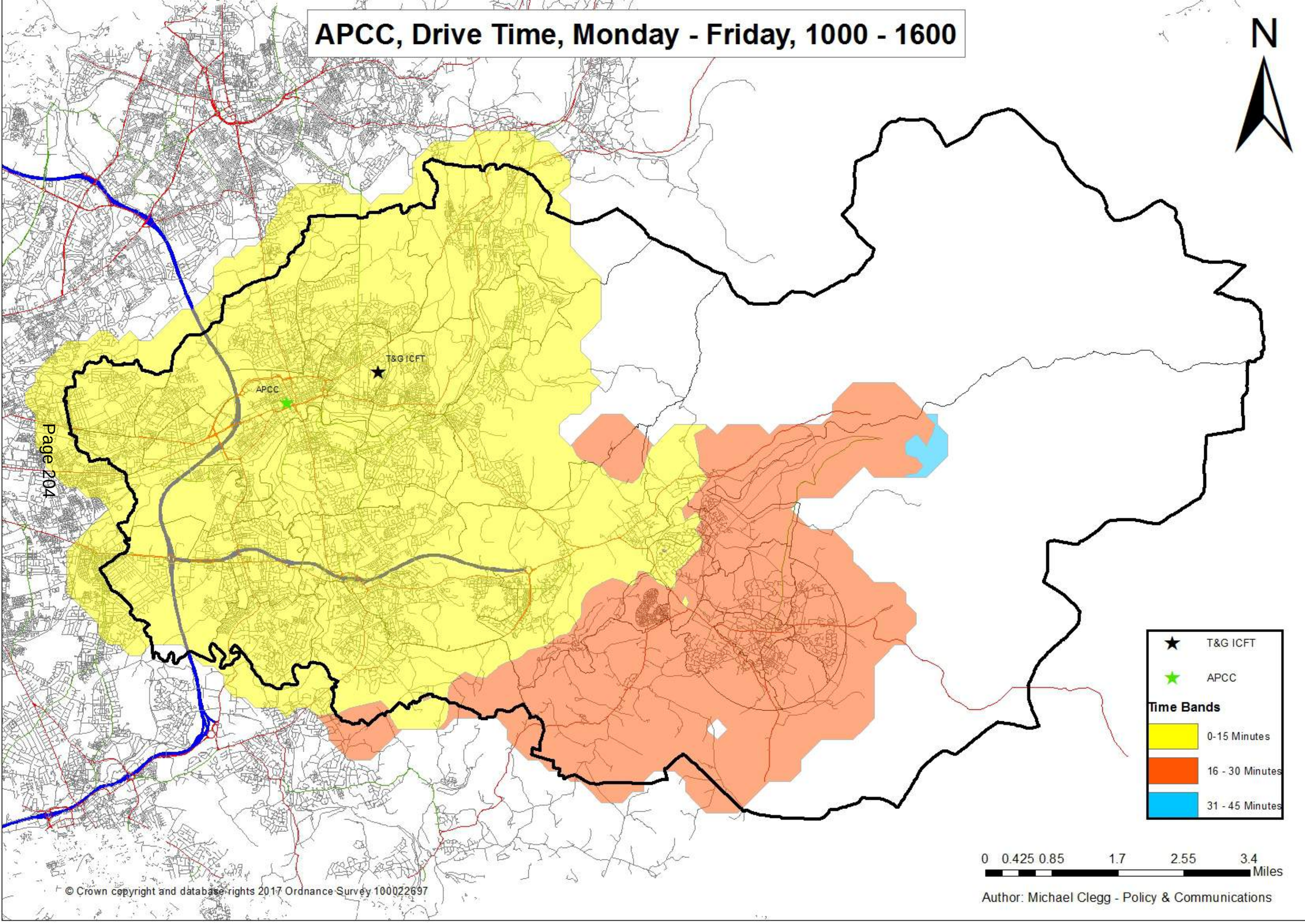
16 - 30 Minutes

31 - 45 Minutes

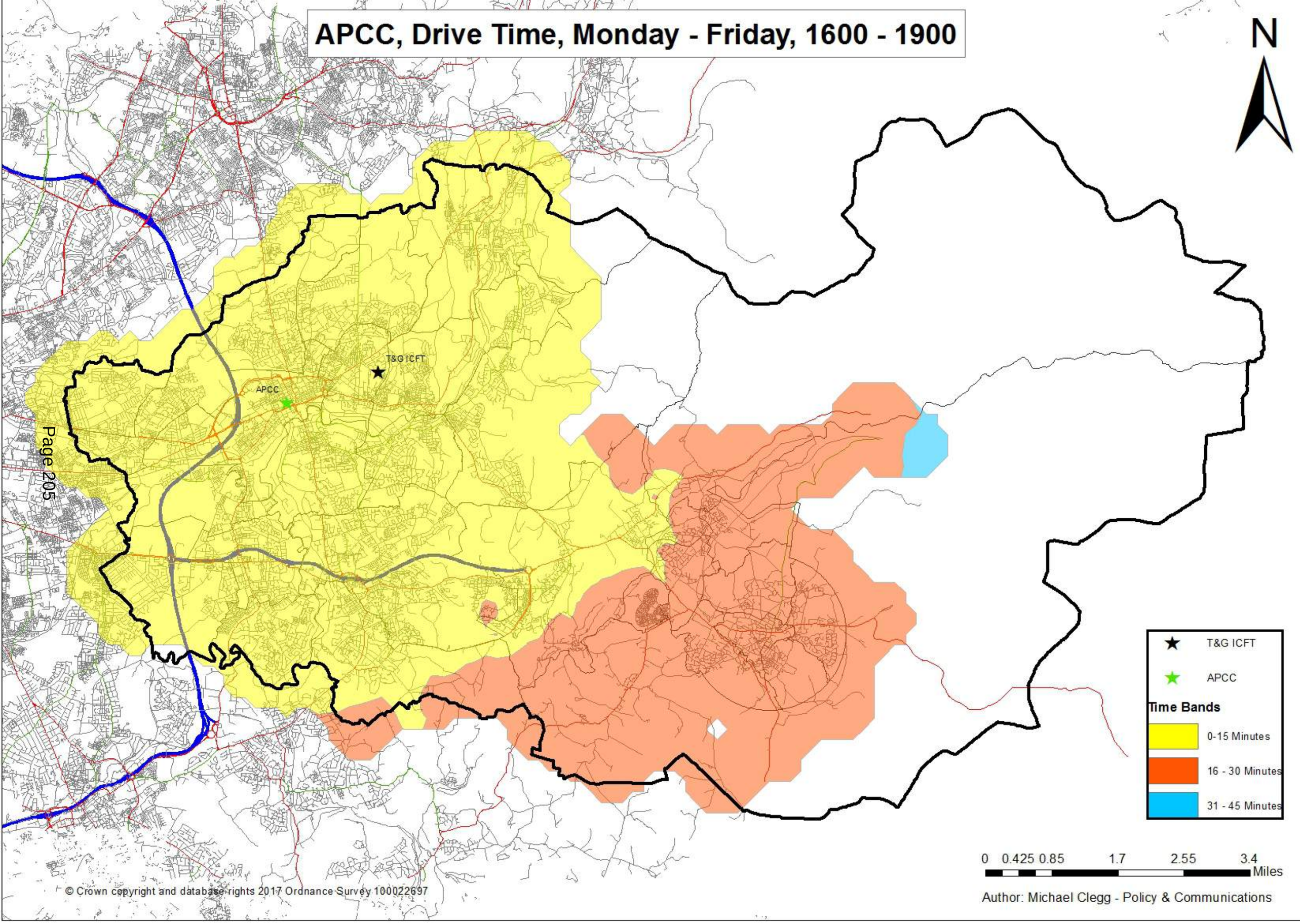
0 0.425 0.85 1.7 2.55 3.4 Miles

Author: Michael Clegg - Policy & Communications

APCC, Drive Time, Monday - Friday, 1000 - 1600



APCC, Drive Time, Monday - Friday, 1600 - 1900



APCC, Drive Time, Weekend, 0700 - 1900

N

T&G ICFT

APCC

T&G ICFT
APCC
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles

Author: Michael Clegg - Policy & Communications

APCC, Public Transport/Walking Times, Tuesday 0700-0900

N

T&G ICFT

APCC

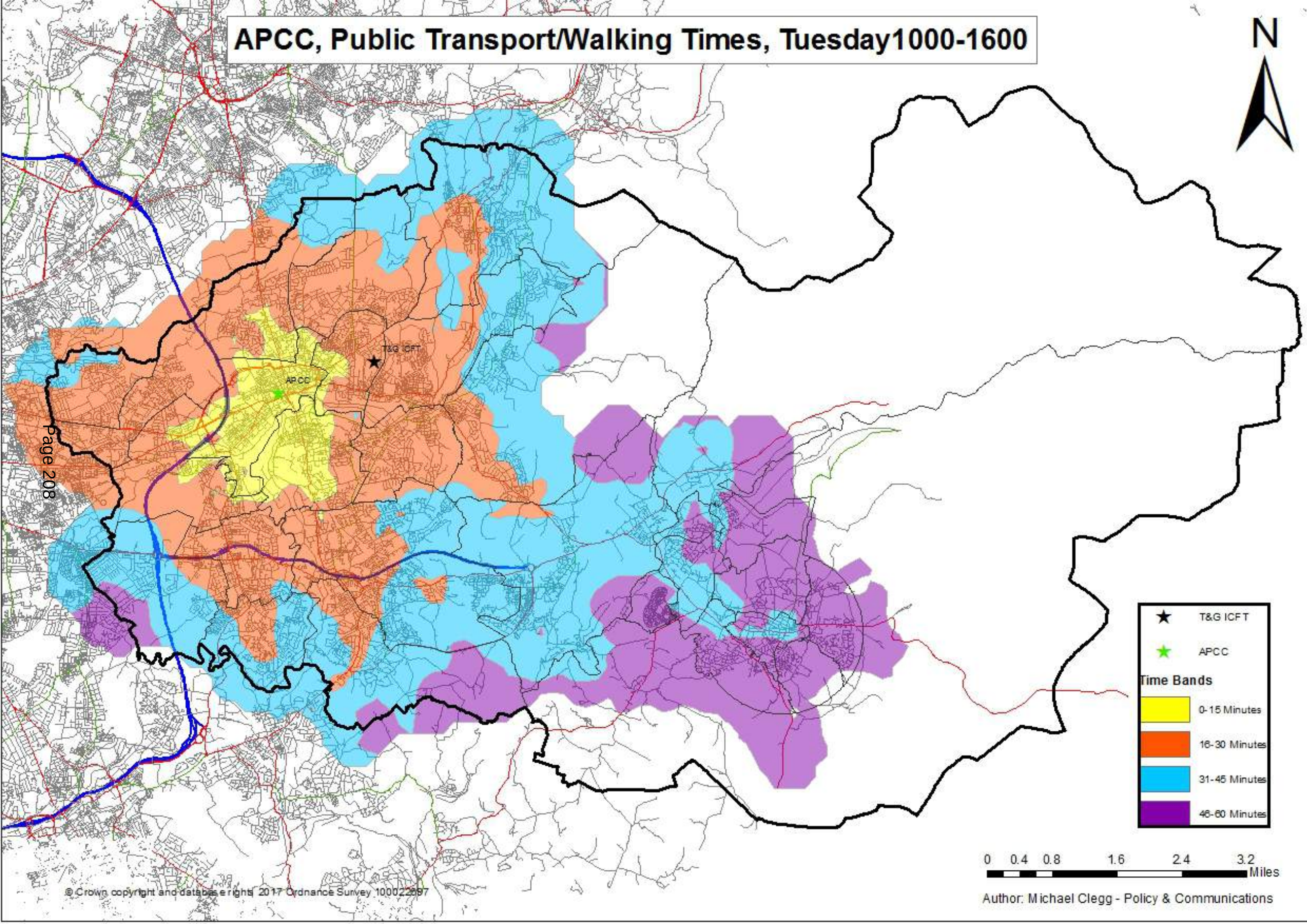
Time Bands

- 0-15 Minutes
- 16-30 Minutes
- 31-45 Minutes
- 46-60 Minutes

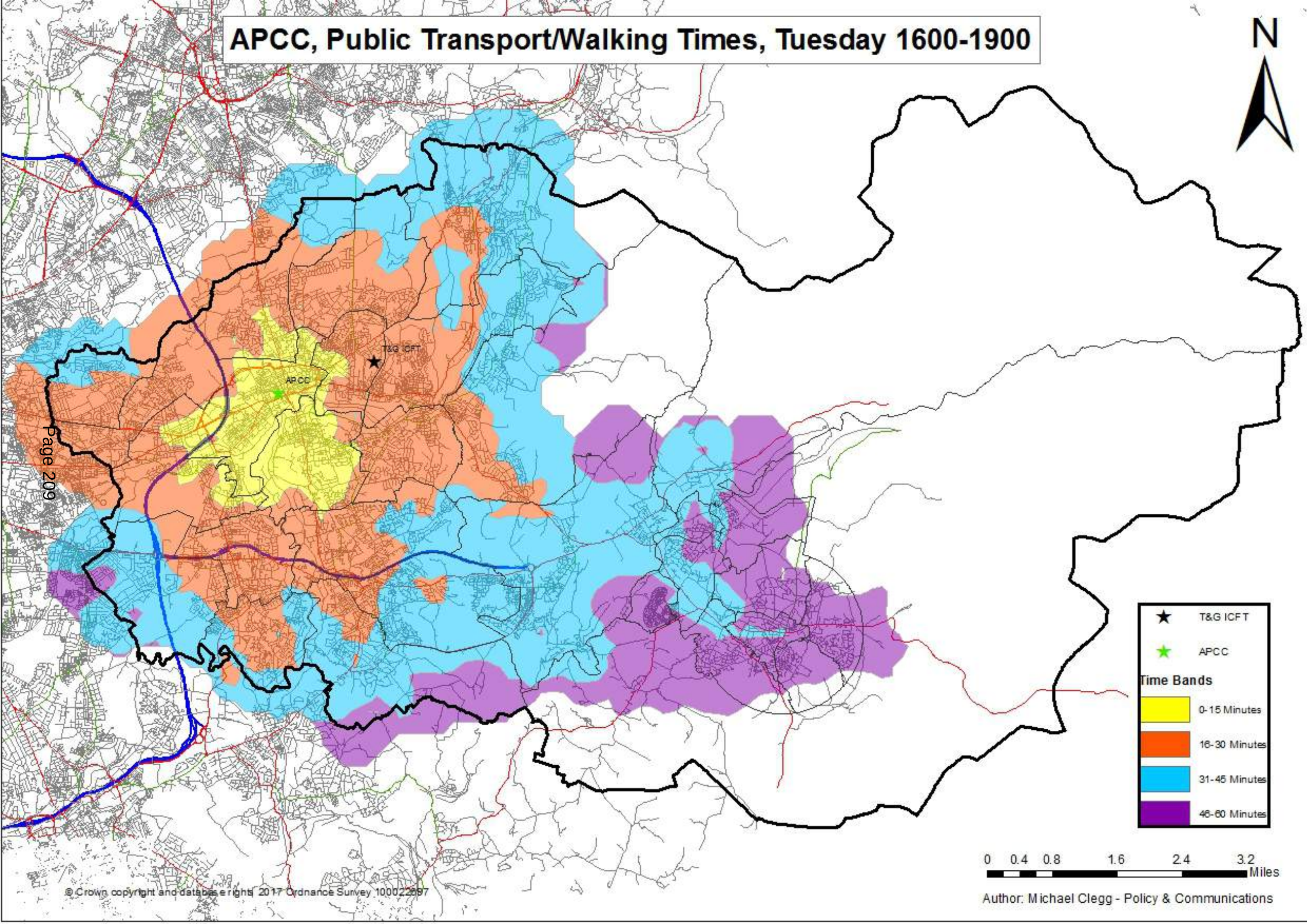
0 0.4 0.8 1.6 2.4 3.2 Miles

Author: Michael Clegg - Policy & Communications

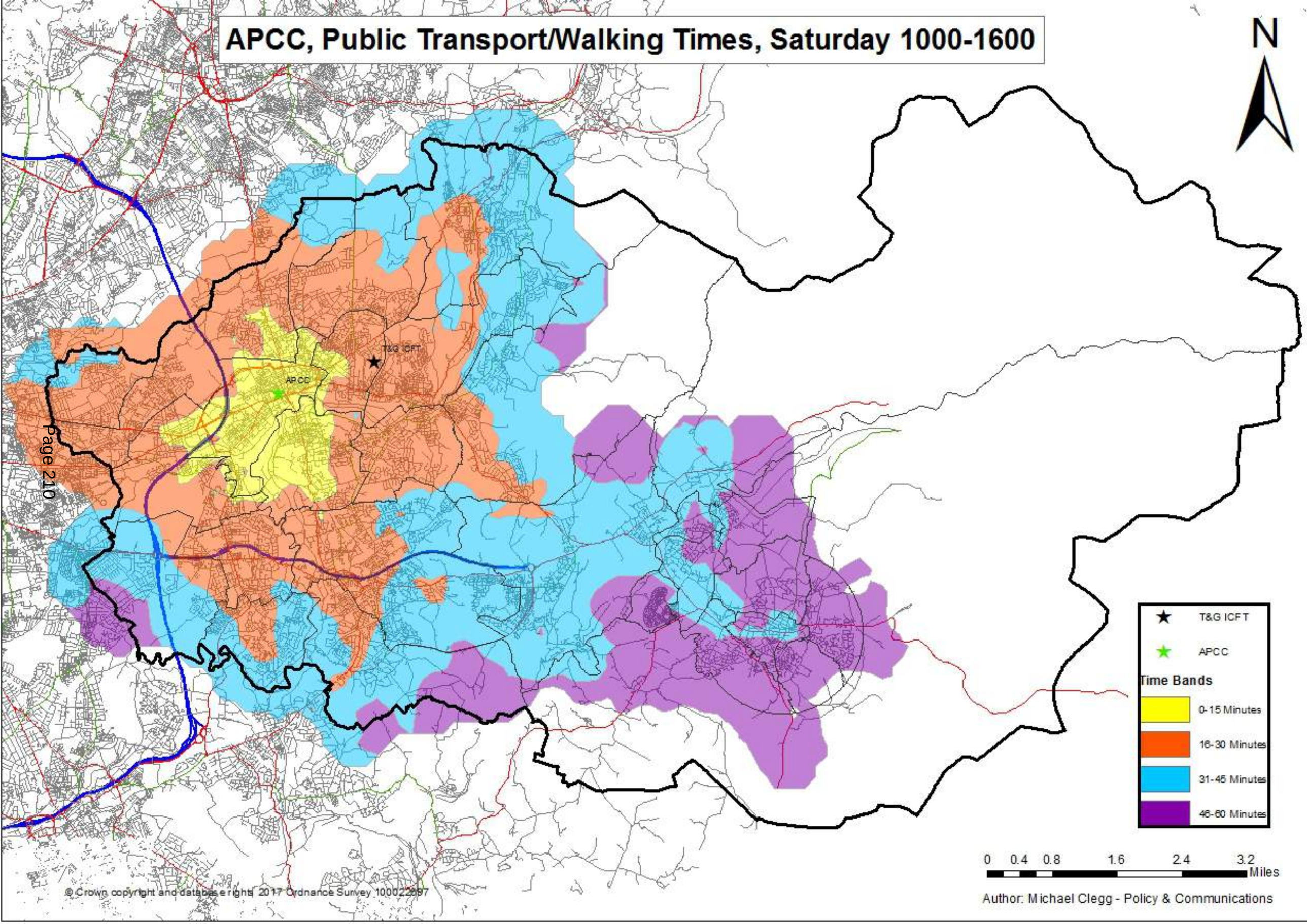
APCC, Public Transport/Walking Times, Tuesday1000-1600



APCC, Public Transport/Walking Times, Tuesday 1600-1900



APCC, Public Transport/Walking Times, Saturday 1000-1600



APCC Walk Time

N

T&G ICFT

APCC

Time Bands

- 0-15 Minutes
- 16-30 Minutes
- 31-45 Minutes
- 46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles

Author: Michael Clegg - Policy & Communications

T&G ICFT, Drive Time, Monday - Friday, 0700-0900

N

T&G ICFT

APCC

T&G ICFT
APCC
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles

Author: Michael Clegg - Policy & Communications

T&G ICFT, Drive Time, Monday - Friday, 1000 - 1600

N

T&G ICFT

APCC

T&G ICFT
APCC
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles

Author: Michael Clegg - Policy & Communications

T&G ICFT, Drive Time, Monday - Friday, 1600 - 1900

N

T&G ICFT

APCC

T&G ICFT
APCC
Time Bands
0-15 Minutes
16 - 30 Minutes

0 0.425 0.85 1.7 2.55 3.4
Miles

Author: Michael Clegg - Policy & Communications

T&G ICFT, Drive Time, Weekend 0700-1900

N

T&G ICFT

APCC

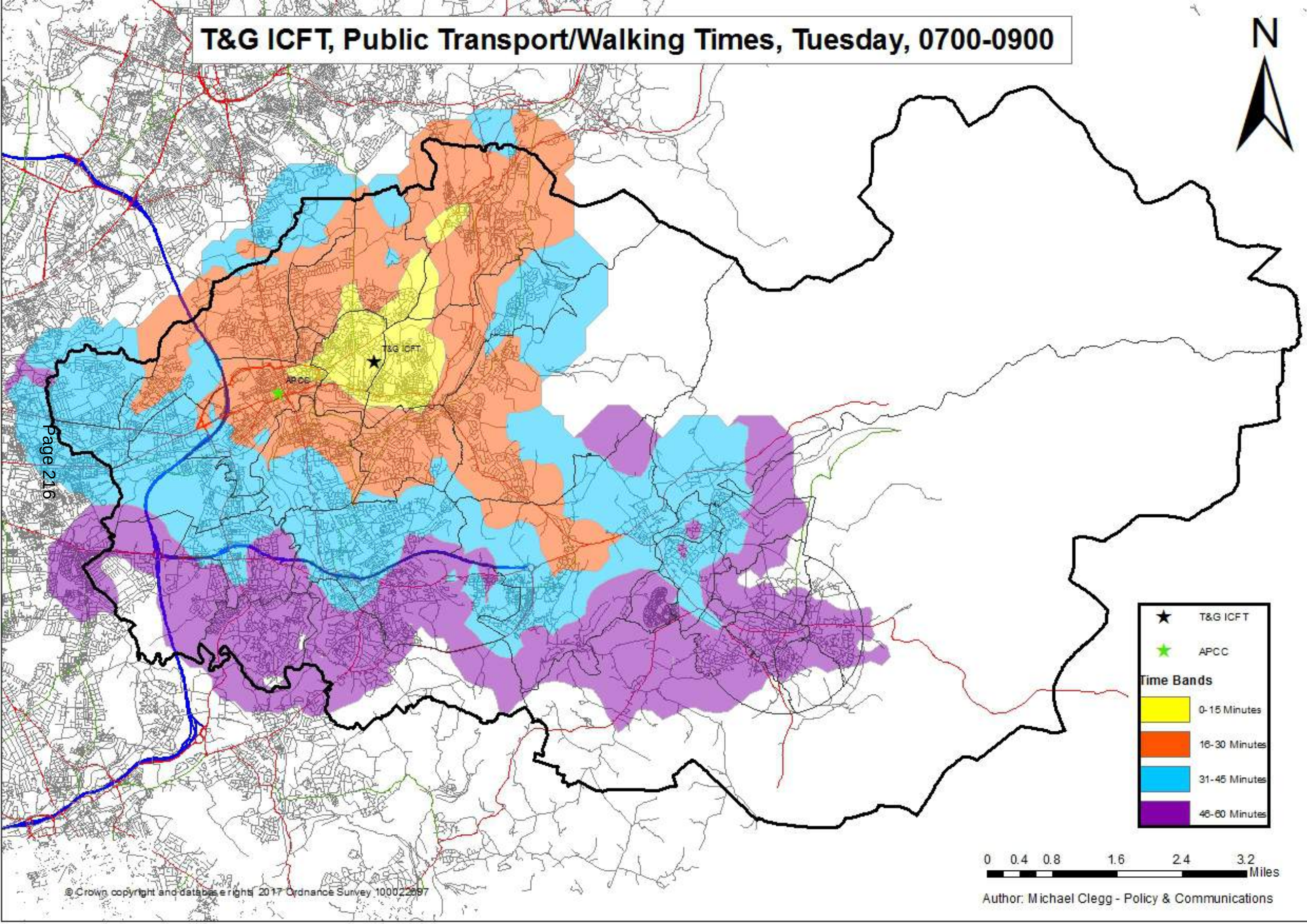
Page 215

T&G ICFT
APCC
Time Bands
0-15 Minutes
16 - 30 Minutes

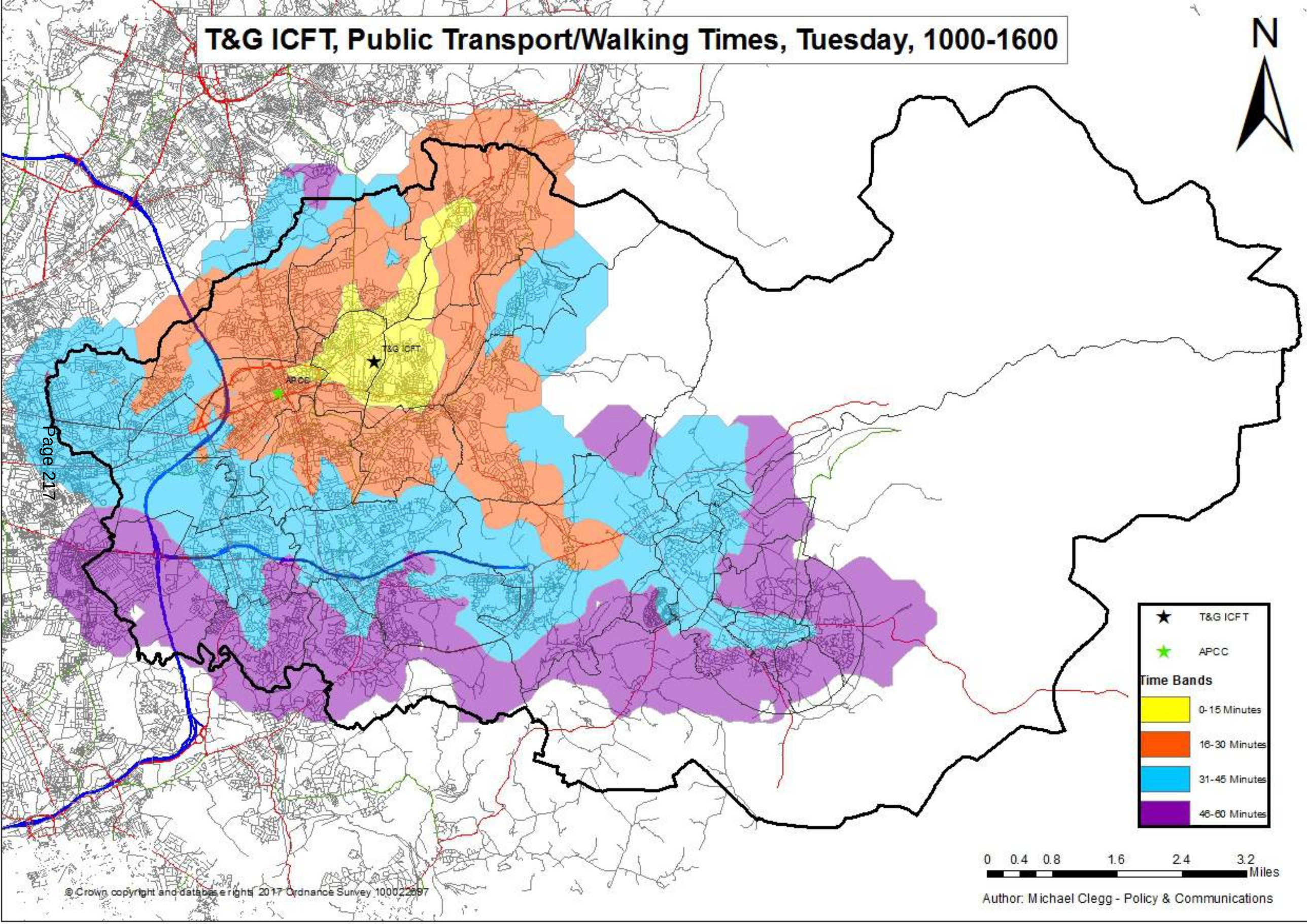
0 0.425 0.85 1.7 2.55 3.4
Miles

Author: Michael Clegg - Policy & Communications

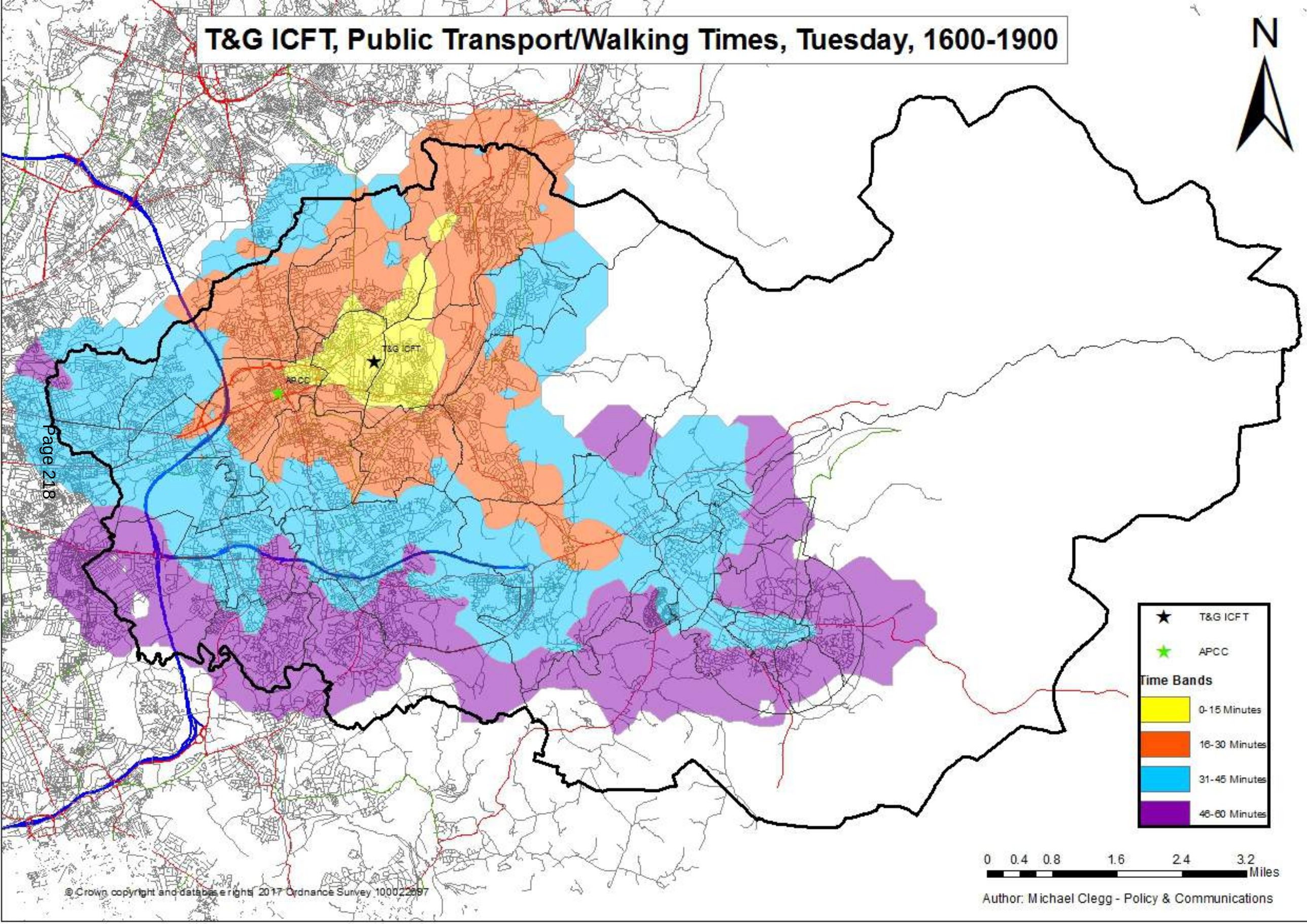
T&G ICFT, Public Transport/Walking Times, Tuesday, 0700-0900



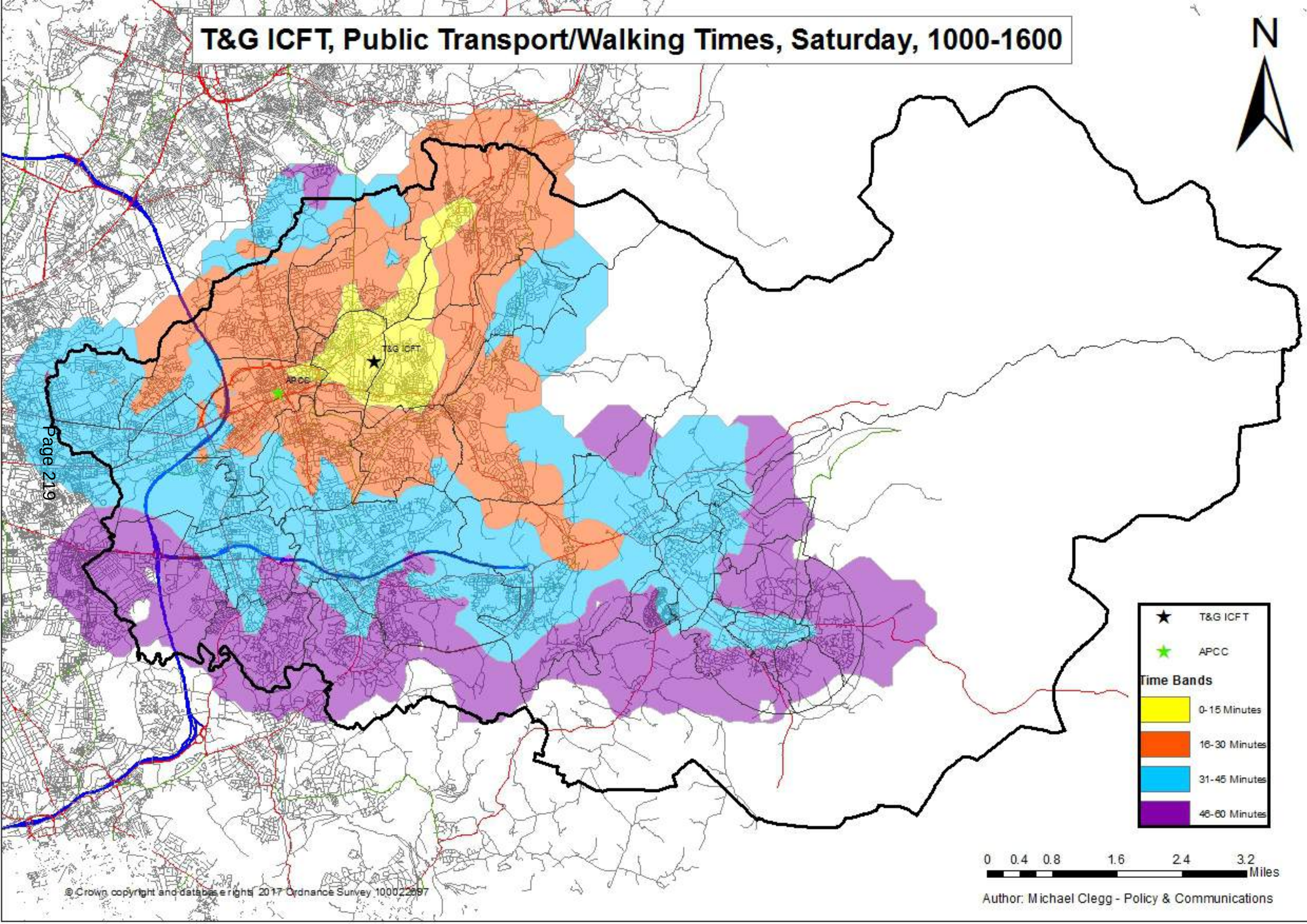
T&G ICFT, Public Transport/Walking Times, Tuesday, 1000-1600



T&G ICFT, Public Transport/Walking Times, Tuesday, 1600-1900



T&G ICFT, Public Transport/Walking Times, Saturday, 1000-1600



Author: Michael Clegg - Policy & Communications

T&G ICFT Walk Time

N

T&G ICFT

APCC

Time Bands

- 0-15 Minutes
- 16-30 Minutes
- 31-45 Minutes
- 46-60 Minutes

0 0.4 0.8 1.6 2.4 3.2 Miles

Author: Michael Clegg - Policy & Communications

APCC and ICFT Census Population Data

Mode of Transport/Time Period	Location	% of Population within 0-15 Minutes	% of Population within 0-30 Minutes	% of Population within 0-45 Minutes	% of Population within 0-60 Minutes	% of Population 60 Minutes +
Drive Time Monday-Friday 0700-0900	APCC	87.2	99.8	99.8	99.8	0.2
	ICFT	86.3	99.8	99.8	99.8	0.2
Drive Time Monday-Friday 1000-1600	APCC	88.4	99.8	99.8	99.8	0.2
	ICFT	89.3	99.8	99.8	99.8	0.2
Drive Time Monday-Friday 1600-1900	APCC	86.5	99.8	99.8	99.8	0.2
	ICFT	86.2	99.8	99.8	99.8	0.2
Drive Time Weekend 0700-1900	APCC	90.5	99.8	99.8	99.8	0.2
	ICFT	92.0	99.8	99.8	99.8	0.2
Public Transport Tuesday 0700-0900	APCC	11.9	58.1	86.5	97.1	2.9
	ICFT	9.0	39.1	71.6	96.4	3.6
Public Transport Tuesday 1000-1600	APCC	11.5	62.4	89.4	99.4	0.6
	ICFT	9.2	40.3	79.6	99.2	0.8
Public Transport Tuesday 1600-1900	APCC	13.5	62.4	88.7	99.2	0.8
	ICFT	8.5	37.8	77.7	99.0	1.0
Public Transport Saturday 1000-1600	APCC	11.8	62.4	89.4	99.4	0.6
	ICFT	9.2	40.1	78.7	99.0	1.0
Walk Time	APCC	4.1	18.1	37.8	54.5	45.5
	ICFT	3.6	15.7	31.8	43.5	56.5

All Census Population Data

Mode of Transport/Time Period	Location	Count of Population within 0-15 Minutes	Count of Population within 0-30 Minutes	Count of Population within 0-45 Minutes	Count of Population within 0-60 Minutes	Count of Population 60 Minutes +
Drive Time Monday-Friday 0700-0900	APCC	220178	251903	251913	251913	505
	ICFT	217865	251913	251913	251913	505
Drive Time Monday-Friday 1000-1600	APCC	223033	251903	251913	251913	505
	ICFT	225274	251913	251913	251913	505
Drive Time Monday-Friday 1600-1900	APCC	218448	251903	251913	251913	505
	ICFT	217582	251913	251913	251913	505
Drive Time Weekend 0700-1900	APCC	228389	251913	251913	251913	505
	ICFT	232161	251913	251913	251913	505
Public Transport Tuesday 0700-0900	APCC	30047	146571	218286	244984	7434
	ICFT	22684	98597	180776	243314	9104
Public Transport Tuesday 1000-1600	APCC	28943	157521	225696	250861	1557
	ICFT	23323	101624	200858	250422	1996
Public Transport Tuesday 1600-1900	APCC	34106	157455	223817	250331	2087
	ICFT	21526	95450	196140	249866	2552
Public Transport Saturday 1000-1600	APCC	29873	157521	225520	250861	1557
	ICFT	23187	101098	198558	249998	2420
Walk Time	APCC	10424	45621	95310	137466	114952
	ICFT	8960	39705	80157	109868	142550

APCC and ICFT Key Location Travel Times

Location	Drive Time Mon-Fri 0700-0900 (Time in Minutes)		Drive Time Mon-Fri 1000-1600 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT
Ashton	2.69	4.67	2.8	4.5
Mossley	9.19	7.11	9	7.18
Stalybridge	5.96	4.71	5.95	4.71
Dukinfield	3.37	5.98	3.87	5.79
Hyde	9.08	12.4	9.22	12.33
Broadbottom	16.03	14.45	15.63	14.14
Hattersley	14.12	12.54	13.51	12.02
Mottram	11.53	9.96	11.03	9.54
Denton	7.32	10.64	7.21	10.41
Audenshaw	4.8	8.12	4.24	7.44
Droylsden	6.54	9.29	6.52	9.16
Hadfield	16.01	14.44	15.38	13.89
Gamesley	16.13	14.55	17.11	15.62
Glossop	19.12	17.55	19.62	18.13

Location	Drive Time Mon-Fri 1600-1900 (Time in Minutes)		Drive Time Weekend 0700-1900 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT
Ashton	2.78	4.66	2.7	4.27
Mossley	9.39	7.09	8.37	7.02
Stalybridge	6.47	4.87	5.47	4.58
Dukinfield	3.97	6	3.31	5.46
Hyde	9.43	12.8	8.59	11.3
Broadbottom	16.2	14.43	14.54	13.41
Hattersley	14.28	12.51	12.7	11.57
Mottram	11.95	10.18	10.34	9.22
Denton	7.36	10.73	6.68	9.77
Audenshaw	4.43	7.8	3.9	6.99
Droylsden	6.69	9.54	6.35	8.89
Hadfield	16.44	14.67	14.52	13.4
Gamesley	17	15.23	15.18	14.05
Glossop	20.74	18.98	18.59	17.47

Location	Public Transport Tuesday 0700-0900 (Time in Minutes)		Public Transport Tuesday 1000-1600 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT
Ashton	3.7	12.13	3.7	12.13
Mossley	22.81	15.5	24.81	14.5
Stalybridge	18.23	14.58	18.23	14.58
Dukinfield	8.92	28.06	8.25	25.32
Hyde	24.76	39.2	21.76	38.83
Broadbottom	39.83	45.81	36.83	47.93
Hattersley	42.41	32.79	39.41	34.79
Mottram	30.12	26.38	30.12	26.51
Denton	20.35	40.39	19.35	36.37
Audenshaw	14.73	33.92	15.73	31.77
Droylsden	15.97	31.14	17.97	31.14
Hadfield	45.24	41.63	45.24	41.63
Gamesley	55.83	48.65	46.83	43.21
Glossop	45.88	48.49	42.88	41.06

Location	Public Transport Tuesday 1600-1900 (Time in Minutes)		Public Transport Saturday 1000-1600 (Time in Minutes)	
	APCC	ICFT	APCC	ICFT
Ashton	3.7	10.96	3.7	12.13
Mossley	24.81	17.5	24.81	14.5
Stalybridge	18.23	14.58	18.23	14.58
Dukinfield	7.25	27.14	8.25	25.32
Hyde	22.76	39.2	21.76	38.83
Broadbottom	36.24	44.93	36.83	47.93
Hattersley	41.41	34.79	39.41	34.79
Mottram	30.12	26.51	30.12	26.51
Denton	17.35	37.37	19.35	37.37
Audenshaw	15.73	32.42	15.73	31.77
Droylsden	16.97	33.34	16.97	31.14
Hadfield	45.24	41.63	45.24	41.63
Gamesley	46.83	43.21	46.83	43.21
Glossop	44.67	41.06	42.88	41.06

Location	Walk Time (Time in Minutes)	
	APCC	ICFT
Ashton	8.6	25.9
Mossley	77.12	56.05
Stalybridge	41.9	22.49
Dukinfield	15.2	37.22
Hyde	59.17	69.83
Broadbottom	122.77	101.61
Hattersley	98.44	89.88
Mottram	95.96	74.8
Denton	50.52	80.28
Audenshaw	30.61	60.69
Droylsden	42.61	73.01
Hadfield	134.99	113.82
Gamesley	136.32	115.16
Glossop	158.48	137.32

This page is intentionally left blank

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 March 2018

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

Subject: **PRIMARY CARE ACCESS SERVICE (THE URGENT CARE ELEMENT); PROPOSED COMMISSIONING INTENTIONS AND PROCUREMENT**

Report Summary:

This report sets out the need to consider the future commissioning of the proposed Primary Care Access Service (the Urgent Care element). The Urgent care element is the name of new service which combines three previous services, all of which were separate, stand alone contracts; Extended Access Service (EAS), Out of Hours (OOH) and Alternative to Transfer (ATT).

The report outlines the rationale for a single contract for these three services to continue our drive for an integrated service model and financial efficiencies in line with our Urgent Care strategy. It identifies the benefits and risks for commissioning this new model through a formal competitive tender process rather than via a direct award.

The report should be read following the Urgent Care consultation paper also at this Strategic Commissioning Board. The Strategic Commissioning Board will need to be cognisant of any decision reached on this previous report before making any decisions based on the recommendations below.

Recommendations:

The Strategic Commissioning Board and the Clinical Commissioning Group is recommended;

1. To note the benefits of bringing three current services (Enhanced Access Service, Out of Hours and Alternative to transfer) together into one single contract.
2. To approve the procurement for this single contract for the Urgent Care aspects of the Primary Care Access Service.
3. To approve the utilisation of procurement expertise (NECS) to ensure procurement is in line with all relevant regulations and guidance, including the cost of accessing such expertise.

Financial Implications:

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

ICF Budget	S 75 £'000	Aligned £'000	In Collab £'000	Total £'000
TMBC Adult Services	-	-	-	-
TMBC Children's Social Care	-	-	-	-
TMBC Population Health	-	-	-	-

TMBC **Other Directorate**	-	-	-	-
CCG	2,811	-	-	2,811
Total	**2,811**	**-**	**-**	**2,811**

Section 75 - £'000 **Strategic Commissioning Board**	Out of Hours (£1,744k recurrent), Extended access (£807k recurrent) and Alternatives to Transfer (£260k non recurrent) are all included in the Section 75 pool.

Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison

The precise value of savings delivered from the recommendations within this paper would be dependent upon market response to the proposed procurement exercise.

However, savings of at least 15% against the current funding envelope are expected should a procurement exercise take place.

Legal Implications: **(Authorised by the Borough Solicitor)**	The procurement must be undertaken in accordance with the constitutional requirements of commissioning body and comply with national and international procurement legislation
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The urgent care proposals are in line with the locality plan and the Care Together model of 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, including improving access to primary care across the locality.
Public and Patient Implications:	This report follows on from the Urgent Care Consultation paper which details the 12 week period of public consultation and engagement with communities in Tameside & Glossop, for which there is a full equality impact assessment.
Quality Implications:	The proposed model of a single service and contract delivery will improve quality of provision through clearly communicating the new model and how it can be accessed, reducing duplication, reducing pressures on the workforce and streamlining access.
How do the proposals help to reduce health inequalities?	The proposal will streamline the delivery of urgent care services across the locality and address health inequalities.
What are the Equality and Diversity implications?	This report follows on from the Urgent Care Consultation paper which details the 12 week period of public consultation and

	engagement with communities in Tameside & Glossop, for which there is a full equality impact assessment.
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation. The contract for the Neighbourhood Care Hub element of the services will also include the GM Safeguarding Standards.
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. The commissioner will seek assurance from all parties involved in the delivery of urgent care that appropriate arrangements are in place. The locality's Information Governance Working Group will sense check the data flows and Information Governance requirements relating to this project.
Risk Management:	This transformation programme will be managed via the Care Together Programme Management Office. The risks will be reported and monitored via this process.
Access to Information :	The background papers relating to this report can be inspected by contacting Janna Rigby, Head of Primary Care: Telephone: 07342056001 e-mail: janna.rigby@nhs.net

1. INTRODUCTION AND BACKGROUND

1.1 This report sets out the proposed future commissioning of the Urgent Care element of the Primary Care Access Service. The Primary Care Access Service (Urgent Care) aims to bring together 3 separate contracts to reduce duplication, streamline services making them easier for our population to navigate and deliver financial efficiency. The 3 current contracts are the Extended Access Service (EAS), Out of Hours (OOH) and Alternative to Transfer (ATT).

1.2 The report outlines the vision for a combined service model with a single contract for the future and sets out the relative benefits and risks for commissioning the new model through a formal competitive tender process.

1.3 The EAS has been commissioned in pilot form since July 2016 and has been delivered by Orbit, the GP Federation for Tameside and Glossop and Go To Doc (gtd), the local out of hours provider. This service delivers pre-bookable appointments in the evenings and weekends and the current contract expires on 30 September 2018. OOH has been commissioned from gtd since 2010 and has been subject to a number of variations to extend the contract period during this time but has not been market tested during this time. Both of these need to be market tested to ensure the Strategic Commission is achieving high quality, value for money provision.

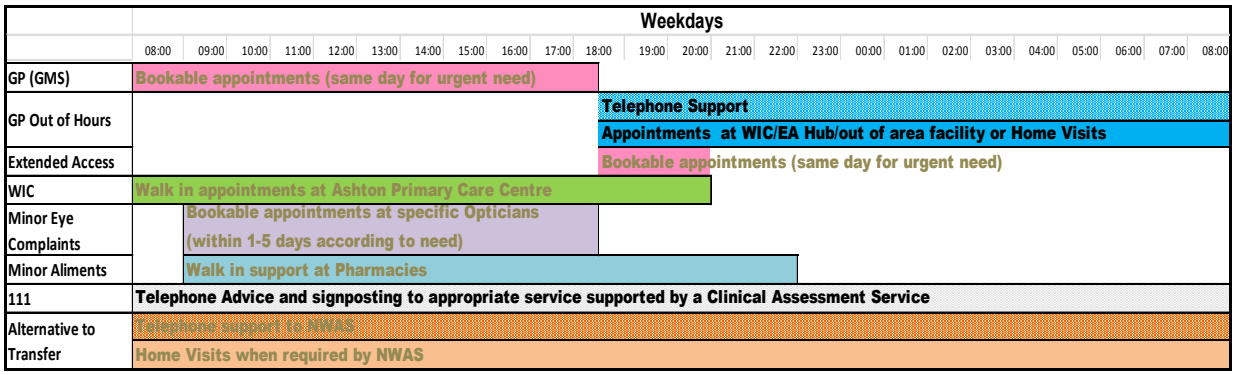
1.4 In addition, the ATT service has been operational for 5 years but is funded on a non-recurrent basis. This service is also provided by gtd and the contract for this expires on 30th September 2018.

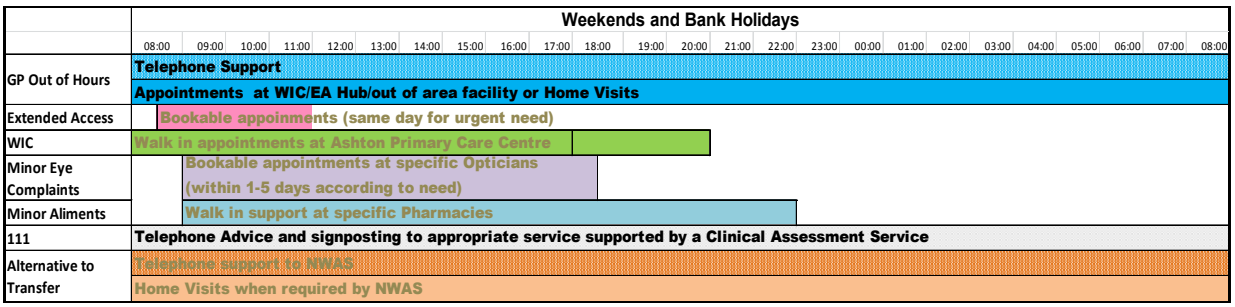
1.5 In the context of the recent public consultation on Urgent Care, a decision likely from the Strategic Commissioning Board on the number of extended access hubs enables the Strategic Commission to procure EAS, OOH and ATT under one contract and from the appropriate number of locations within the locality to meet the expectations of the public.

2. THE EXISTING MODEL OF DELIVERY

2.1 A key aim of the Care Together programme is the reduction in duplication and simplification of access whilst improving the level of service available. This is particularly pertinent in Urgent Care. There are currently multiple access points as demonstrated in Table 1 below.

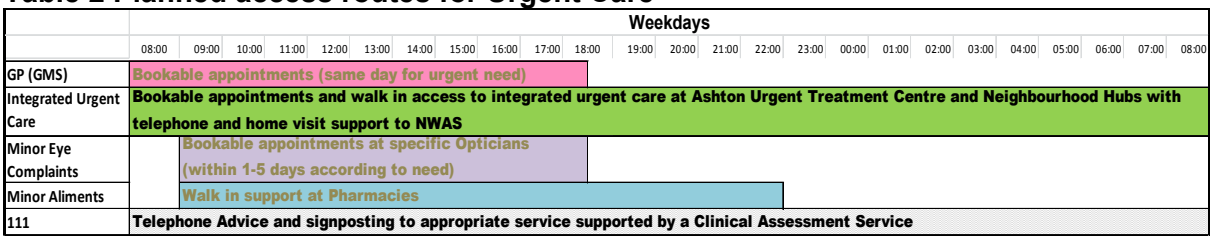
Table 1 Current access routes for Urgent Care

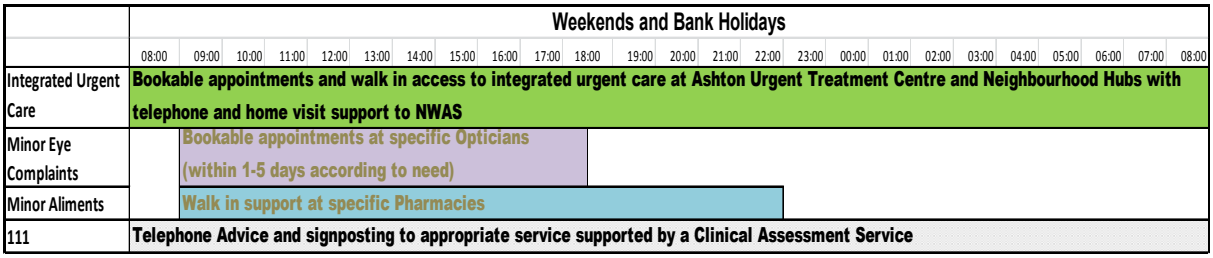




2.2 Our planned model simplifies the access points and is summarised in Table 2 below.

Table 2 Planned access routes for Urgent Care





2.3 The detail of the model is not included within this paper but can be found in the agenda for the Strategic Commissioning Board for March 2018; http://tameside.moderngov.co.uk/ieListDocuments.aspx?CId=303&MId=1511&Ver=4 This paper focuses on what the overall model of care is in regards to Primary Care Access.

3 COMMISSIONING CONSIDERATIONS

3.1 Due to the length of time these contracts have been in situ and the fact that none have been effectively market tested, we believe the time is right to formally procure the Urgent care elements of the Primary Care Access service.

3.2 Before recommending procurement however, certain considerations need to be evaluated:

- Legal requirements
- Financial considerations
- Quality of service
- Commissioning for outcomes

Legal requirements

3.3 The procurement policy requirement is that all public procurement must be based on value for money, defined as "the best mix of quality and effectiveness for the least outlay over the period of use of the goods or services bought". This should be achieved through competition, unless there are compelling reasons to the contrary.

3.4 Public sector procurement is subject to a legal framework which encourages free and open competition and value for money, in line with internationally and nationally agreed obligations and regulations. https://www.gov.uk/guidance/public-sector-procurement-policy 10/11/17)

3.5 A 12 week public consultation relating to the proposed new model for urgent care has concluded with a decision on the number of Extended Access hubs. The consultation included a comprehensive Equality Impact Assessment and appropriate mitigations have been agreed to address the effect of the impacts raised.

3.5 In order to drive effective and integrated delivery of the new model of urgent care, a new contracting form is required. The aim is to bring the EAS, OOH and ATT current contracts into one and thereby simplify commissioning arrangements, reduce transaction costs, reduce overheads and test the market to ensure value for money.

3.6 Direct award rather than procurement may be applied in cases where it is shown that there are no suitable alternative providers able to deliver the proposed service. This is not the case in this instance as a number of providers would be qualified and suitable to deliver.

Financial considerations

3.7 The 2017-18 financial value of EAS, OOH and ATT is £2.811million. The ATT contract is non-recurrently funded so if the procurement exercise does not deliver sufficient savings to bring this service within the required cost envelope, either additional resources will need to be identified or a decision on the future affordability of the service will be required.

3.8 The new model is expected to deliver significant cost efficiencies as a result of a successful provider being able to create economies of scope and scale in the delivery of service. The procurement process will ensure value for money due to an opportunity to give weighting to the financial, quality and service outcomes and ensure the optimum service provision within the cost envelope.

Quality

3.9 A series of quality elements will be explicit requirements of the proposed model. These will incorporate national and local requirements and be intrinsically linked to commissioned outcomes. The process for procurement will enable transparent and direct comparison between providers of how they propose to deliver a service with the required quality standards, whilst direct award will secure these contractually through a process of negotiation.

3.10 National Quality Requirements (2007) within Out of Hours (OOH) contracts contain performance metrics for the quality and timeliness of the call handling element of the service. Performance reports are provided on a monthly basis, and demonstrate that these are being met.

3.11 Two of the national service improvement priorities for the NHS that relate to urgent care are;

- Improving A&E performance - This also requires upgrading the wider urgent and emergency care system so as to manage demand growth and improve patient flow in partnership with local authority social care services.
- Strengthening access to high quality GP services and Primary Care, which are far and away the largest point of interaction that people have with the NHS each year.

3.12 The proposed model addresses these priorities which are also key priorities for the Greater Manchester Health and Social Care Partnership (GMHSCP) and will be subject to a number of clinical and non-clinical quality standards to ensure that an agreed minimum threshold is maintained and can be performance managed through the contract.

Outcomes

3.13 Consistent outcomes across the urgent care system will instil minimum standards for all providers to deliver to and ensure equity of service offer to all residents of Tameside and Glossop. The commissioned outcomes will be embedded within both the Urgent Treatment Centre and the Primary Care Access Service to ensure patients receive the same standard

of care regardless of where they attend. Services at all sites will be expected to meet standards set out nationally and deliver effective high quality and safe care.

3.14 Overarching outcomes will include:-

- People are supported to navigate the system to receive effective care first time and do not represent to other services for the same issue;
- People are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams;
- People whose need can be met within a Neighbourhood do not attend A&E;
- People are equipped to reduce the risk of the same need arising in the future.

3.15 As the specification for procurement is finalised, the detail of the required outcomes will be defined and include national, Greater Manchester Health and Social Care Partnership led and local outcomes.

4 MARKET TESTING

4.1 It is important to understand the provider market in advance of considering the need and value of carrying out procurement. The current contracts for EHH, OOH and ATT are delivered by Orbit, GP Federation and gtd healthcare, an out of hours provider, of which there are four within the Greater Manchester footprint.

4.2 Due to national requirements and Greater Manchester Health and Social Care Partnership focus to the introduction of Urgent Treatment Centres within each locality, other GM commissioners are also planning or in the process of similar procurements. This has resulted in a precedent being set with regards to the procurement process in commissioning these services. Bolton CCG is currently out to procurement for their Primary Care Locality Service and Oldham CCG are developing a service specification with provider engagement, including a market event with both current and potential providers present. This was attended by the local GP Federation, an out of hours provider and for profit providers including Virgin Healthcare. This is an indicator of the level of market interest within the GM footprint.

4.3 The project plan to commission these services will include market engagement activity to ensure that potential providers fully understand the Tameside and Glossop commissioning intentions and outcomes required.

5 RISKS AND BENEFITS

5.1 The risks and issues identified in association with procurement and direct award are set out in Table 3 below.

Table 3 – Risks and benefits

	Procurement	**Direct award**
RISKS	• Potentially destabilise the existing local provider market • Project management timescales to be delivered to ensure contract start is on time	• High likelihood of challenge from provider market due to significant change in delivery model, contracting form and financial value • Challenge to demonstrate legal basis of not following a formal competitive process
BENEFITS	• Open and transparent competition in line with procurement law	• Move directly to contract negotiation with existing providers hence saving

	• Demonstrate value for money • Clear demonstration and assurance of provider quality • Commissioner-led process	time and process costs

5.2 This report has set out the intention to recommission the current provision of EAS, OOH and ATT as a single contract, in line with the urgent care model that is described in the related item on the Strategic Commissioning Board agenda. The Urgent Care model has been comprehensively consulted upon. Through the process of reviewing the existing provision, areas for improvement on the existing service have been identified including improvements to patient experience, access, quality and value for money.

5.3 Commissioning this provision under a single contract will change the contracting arrangements currently in place. In order to demonstrate transparency of process and ensure appropriate market testing, a formal procurement is believed to be the most appropriate way in which to achieve this. The information provided in this paper describes the relative risks and benefits of commissioning through procurement to enable Strategic Commissioning Board to make a considered decision.

6 CONFLICT OF INTEREST

6.1 There are well understood conflicts of interest within the Governing Body GPs relating to connections with gtd, Orbit and ICFT. This will affect which members are able to provide clinical advice and support within the procurement process. All conflicts of interest will be managed in accordance with NHS regulations which can be visited https://www.england.nhs.uk/ourwork/coi

7 RECOMMENDATION

7.1 As set out on the front of the report.

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	20 March 2018
Reporting Member / Officer of Single Commissioning Board	Cllr Brenda Warrington – Executive Leader Stephanie Butterworth – Director of Adult Services
Subject:	**ADULTS SOCIAL CARE FEES (EXCLUDING CARE HOMES) for 2018/19**
Report Summary:	The purpose of this report is to outline proposals in relation to revised prices to meet the increasing cost of providing adult social care services for 2018/19
Recommendations:	That the Board notes the content of the report and approves: • The proposed new rates for home care/support at home, with a standard rate of £14.77 per hour and enhanced rate for the new support at home service of £17.20 per hour; • The proposed new rate for Extra Care of £13.68 per hour; and • The proposed sleep-in rate of £103.26 per night, and £137.65 per night for waking nights, across all adult services contracts; • The revised supported accommodation contract prices highlighted in Section 4 of this report, summarised at **Appendix 3**; • The revised direct payment rates as follows: hourly rate of £11.09 for personal assistant; hourly rate of £14.77 for support provided through a care agency; day services day rate of £31.37; • The revised contract prices for the Day Services highlighted in Section 4 of this report. • The revised contract price for the Community Recovery Service (LD Respite) highlighted in Section 4 of this report; • The revised fees for Shared Lives in section 4 table 3 of this report; • That all the above proposed new rates will be effective from 1 April 2018.
How do proposals align with Health & Wellbeing Strategy?	The proposals and strategic direction are consistent and aligned.
How do proposals align with Locality Plan?	The proposals and strategic direction are consistent and aligned. The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Enabling self-care;

- Locality-based services;
- Urgent Integrated Care Services;
- Planned care services.

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

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

Recommendations / views of the Health and Care Advisory Group

Not Applicable. It was determined by Strategic Leadership Team that the report would not be presented at Health and Care Advisory Group.

Public and Patient Implications:

These proposals look to secure the future provision of essential support to vulnerable people and their families/ carers within an increasingly fragile market. The health and social care economy is facing increasing numbers of older people and younger adults with complex and life limiting conditions and disabilities which in turn is adding further pressure to the services provided. The people who are now receiving care and support are those with more complicated and complex care and support needs that often need more expensive packages of care to meet their assessed eligible needs. Success in the treatment and care of adults with severe illnesses and disabling conditions has also meant that many more people in the borough are living longer; however they are living with one or more health issues that require help and support.

Quality Implications:

It is acknowledged that the current service models are at breaking point offering little financial incentive to attract the quality of staff to deliver such crucial services to vulnerable people living in the community. Service redesign proposals aim to increase the value and standing of workers in the care industry, improving pay and conditions and developing a clear career path for individuals to progress further their care careers such as into nursing, social work etc. Recruitment is increasingly problematic in the field of health and social care and has had a bearing on the quality and consistency of services delivered over the last few years – the increased costs are the start of driving improved quality in service delivery from committed and skilled workers delivering a wider range of service interventions.

Financial Implications:

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

The proposed fee increases detailed in this report will lead to an estimated increase in net expenditure in the Section 75 pooled budget of the Integrated Commissioning Fund (ICF) in 2018/19.

Care Type	**ICF Section 75 Estimated 2018/19 Net Cost (£ m)**
Home Care	0.157
Supported Accommodation	0.543
Total Estimated Net Cost	0.700

	This is in line with the cost modelling included within the Council's Medium Term Financial Plan (MTFP) for 2018/19. In addition the increased costs modelled within this report (table 1, section 4.4) for the new Support at Home model (£0.738m) will be wholly resourced by non-recurrent GM Transformation funding in 2018/19. Work is ongoing to establish alignment of this new model of care with home care support procured by the CCG. Financial implications will be confirmed once further details are known. It should be noted that Finance and Commissioning officers of the Strategic Commission have worked closely with Supported Accommodation providers to understand the true cost of care delivery in order to determine 2018/19 contract rates which are aligned to the Council's financial planning and the financially sustainability of providers. The proposed contract rates will ensure that providers are able to manage a number of financial pressures including; National Living Wage payments of £7.83 per hour, increased rates for Sleep In's in Supported Accommodation facilities, increases in regulatory inspection costs and general inflationary increases on utilities and other overheads. The Council will continue to work closely with providers to explore new and innovative models of care delivery (including increased use of technology and assistive equipment) in order to ensure provision of a cost effective, financially sustainable care market in 2018/19 and beyond.
Legal Implications: **(Authorised by the Borough Solicitor)**	Provided fees and charges are set and implemented in accordance with the Care Act 2014, and its own Charging Policy developed in accordance with the 2014 Act, any challenge through the courts or the complaints process will be successfully met by the Council. The Charging Policy makes clear that the Council will not charge more than the cost that it incurs in meeting a person's assessed needs. Those costs must be reasonably and properly assessed in line with cost of care factors as set out in the report, including the National Living Wage (NLW). The legal framework for charging is set out in s 14 (power of a Local Authority to charge) and 17 (assessment of financial resources) of the 2014 Act. Charges should be reviewed annually to ensure they remain compliant with the Act, statutory guidance and any secondary legislation.
How do the proposals help to reduce health inequalities?	It is widely recognised that the social conditions in which they each live (poverty, disability, damp or overcrowded housing, poor diet and so on) all have a negative impact upon health and wellbeing. These service areas all seek to address the social conditions within which people live their lives and therefore make a key contribution to reducing health inequalities and improving social outcomes among the communities in which they work.
What are the Equality and Diversity implications?	It is not anticipated that there are any equality and diversity issues with this proposal. The increased costs will ensure that all workers will be paid at either the national minimum wage or National Living Wage (workers aged 25 and over) and support the service redesign proposals planned over the

	coming 12 months, thereby ensuring that individuals whose eligible assessed needs meet the national eligibility criteria will be offered a quality and diverse service from a highly skilled and valued workforce.
What are the safeguarding implications?	There are no anticipated safeguarding issues. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. Any procured service will include minimum requirements for training and qualification workers which includes standards and requirements for information governance, privacy and respect.
Risk Management:	There are a number of risks associated with this work. These are summarised as: • Contracts need to as a minimum support providers adhere to the introduction of the National Living Wage, national insurance changes, and pension changes and the emerging problem relating to sleep-in payments • Contracts need to support providers in meeting the costs associated with the burden of the increased regulatory and inspection burden • Contracts need to support providers to address the increasing problem of recruiting sufficiently skilled staff, both social care and nursing, which is prevalent not just locally but nationally. These risks will be mitigated through ongoing redesign of the service offer and increased funding across contract prices.
Access to Information :	The background papers relating to this report can be inspected by Contacting; Trevor Tench – Head of Commissioning Telephone: 0161 342 3649 e-mail: trevor.tench@tameside.gov.uk

1. INTRODUCTION

1.1 The focus of this report is the setting of revised prices to meet the increasing cost of providing social care support to vulnerable adults. Work has been progressing over the past three months in relation to the impact of a number of cost pressures imposed nationally on current providers that significantly challenge the financial viability of what the Council and CCG have been paying to deliver these essential services. From a financial perspective the key cost pressures faced by providers are in the main related to the introduction of the National Living Wage and compliance with sleep-in payments.

1.2 Discussions with providers, whilst recognising the expectation that National Living Wage (NLW) and sleep-in rates are met, have been set against the background of the financial pressures faced by the health and social care economy and the challenge posed by the redesign of a whole system that if it doesn't change faces a projected funding gap of £70 million projected over the next four years.

1.3 Much work has been done over the past few years to radically change the way that services are provided. For example, in the Council's Adult Services a total of £23.6m has been taken out of the budget since 2010 (a net budget reduction of 34%) which has been achieved through radical service redesign, a reduction in management capacity, 20% reduction in contract costs.

1.4 These reductions have been happening at the same time as demand for service provision has been rising - the increasing number of older people and younger adults with complex and life limiting conditions and disabilities has added a further pressure to the services provided. Although many people are encouraged to seek help from within their own families or communities many still require help and support. The people who are now receiving care and support are those with more complicated and complex care and support needs that often need more expensive packages of care to meet their assessed eligible needs. Success in the treatment and care of adults with severe illnesses and disabling conditions has also meant that many more people in the borough are living longer; however they are living with one or more health issues that require help and support.

1.5 This report will set out proposals for costs that will constitute the minimum requirements to meet the specific cost pressures imposed on providers following consultation with the provider sector.

2. BACKGROUND

Home Care/Support at Home

2.1 The focus of the home care service is to enable people to remain living in their own home, living as independently as possible, achieving and maintaining their potential in relation to their physical, intellectual, emotional and social capacity.

2.2 To achieve this, the current home care contract focuses on the provision of good quality outcome focused support appropriate to the needs identified in an individual support plan and to demonstrate this through assistance with the personal, practical and social/emotional tasks associated with ordinary living.

2.3 The local home care market is delivered exclusively via the external (independent) market with the in-house service focus being on the delivery of the Reablement Service. From March 2006, the delivery of the home care service was reorganised to operate within specified postcode zones across the borough. The borough, and the service, was divided into zones following consultation with the area teams and the home care providers – these four zones are in line with the neighbourhood approach currently being progressed through the Care Together programme.

2.4 The service was tendered in 2016 and contracts were awarded to six organisations with zoned contracts covering the four neighbourhoods - this however is supplemented by a further twenty one organisations approved to pick up the work the six zoned providers are not able to cover. On the week commencing 05 February 2018 a total of 9,706 hours were commissioned for 968 service users (covering both social care and CHC packages). Payments are made on actual hours delivered and this tends to be approximately 100 less than the commissioned hours each week.

2.5 In 2016 as part of the annual fee setting process a revised cost framework was approved and the current rate of £13.67 per hour was agreed. The 2017-18 approved rate of £14.20 per hour was centred on updating the cost framework to reflect the revised NLW rate of £7.50 per hour along with other increases across other cost domains.

2.6 Work has centred on updating the revised cost framework for the standard homecare service which reflects the revised NLW rate of £7.83 per hour. The proposal on the revised fees for 2018-19 is explored in detail at Section 4 of this report.

2.7 As has been reported widely, the traditional Home Care model is seriously outdated in a modern health and social care system and it is widely recognised that we need to do something different – the plans in Tameside are in line with the thinking across Greater Manchester. Work with GM partners has produced clear principles in relation to what we would want from a new service offer. It is clear that there aren't that many examples to follow either locally or nationally – however with the existing home care contracts coming to an end on 30 October 2016 a tender was launched to attract a group of providers who will work closely together with us to deliver a dramatically different service. Six contracts have been awarded across the four Tameside neighbourhoods with a clear message that whilst the traditional model of home care will continue to operate for the first year work will commence with providers to develop a new service model that will include:

- Commissioning on the basis of outcomes allowing the provider to look not only at directly delivering care but opening up a whole range of options for meeting need such as
  - Negotiating with service users' families, friends, neighbours, communities what they can offer in terms of support to people to meet the individuals needs
  - Encouraging the greater use of technology (such as medication dispensers to reduce the number of physical calls required to ensure medication is taken),
  - Encouraging the use of adaptations and equipment;
  - Supporting people to access community activities available in their local neighbourhoods to ensure people can continue their interests whilst replacing where possible the for direct staff visits;
  - The use of telephone calls to replace a physical check call (but have the flexibility to call to the house in the absence of a response).

- The model of delivery will have a strong ongoing reablement emphasis in service delivery which would enable providers to reduce individual packages to ensure that they can deliver support for new referrals as well as respond flexibly to fluctuations in care needs of existing users in their zone.

- Commissioners working with providers to blend health and social care roles where it makes sense to do so and thereby design a 'therapeutic workforce'.

- Assessments will be outcome based and will indicate to providers an allocation of hours as a guide – there will be a move away from the current practise of detailing calls, tasks and time that support should be delivered.

- The provider will arrange with the services users and carers directly to agree support plans to meet the identified need with providers providing evidence to commissioners that outcomes continue to be met as the guide hours are reduced across individual packages.

- A further angle to this is that providers will be charged with becoming actively involved in positively promoting care as a career of choice and offering this as a stepping stone into careers including nursing, social work and all associated caring options.

2.8 In recognition of the enhanced service offer described above, which requires additional duties and increased staff skills, an enhanced rate has been agreed that ensures staff are paid a minimum of £9.00 per hour. This rate of pay has been applied to the established cost framework to provide an hourly rate of £17.20 through 2018/19.

Extra Care Housing Support

2.9 The Council currently have four extra care housing schemes which are –

Fairfield Court is situated in Droylsden and is owned by Anchor Trust.
Melbourne Court is situated in Stalybridge and is owned by Contour Housing.
Hurst Meadow is situated in Ashton-Under-Lyne and is owned by Hanover Housing.
Beatrix House is situated in Dukinfield and owned by New Charter Housing Trust.

2.10 Extra Care Housing Support was tender in 2016 as part of the larger support at home contract described above with four of the six zoned providers having the contract for the scheme which is in their locality.

2.11 The current model is based on a number of indicative hours per scheme and includes waking nights and sleep-ins where assessed. The cost of care model used for the support at home model was adapted to support an hourly rate within the extra care schemes.

2.12 Full details of proposed contract values for 2018/19, together with comparisons to current values can be found at Appendix 3

Sleep-in and Waking Night Rates

2.13 As reported in the fees report in March 2017 discussions had taken place throughout 2016/-17 relation to the rates paid for sleep-in duties as Case Law had established that “sleep-ins” should be covered by the National Minimum Wage (NMW) regulations – the implication being that even if a worker is allowed to sleep at work but are required to stay at their workplace then all their hours are covered by NMW regulations.

2.14 Whilst this was a very complex area of the law it was clear that different approaches to the issue were being taken based on the individual organisations taking their own legal advice. However, legal advice was changing and the Council agreed to pay sleep-ins based on hourly rates to all but one of the providers providing 24 hour supported accommodation via contracts. In addition a revised spot purchase rate for sleep-ins was introduced for domiciliary services and Direct Payments.

2.15 The discussions also centred on how any additional costs of sleep-ins could be mitigated against and providers were asked to review the need for sleep-ins at every property, particularly where a waking night is also in place. The potential for this surrounded alternative options and new approaches using the technology available with robust on-call arrangements to eradicate the need for a physical presence overnight.

2.16 Work on mitigating the costs of sleep-ins has proved very difficult as the sleep-ins in place have proved essential in all cases – and the tragedy of Grenfell Tower and the growing revisions and guidance in relation to the fire has put a stop on this piece of work.

2.17 The final provider of sleep-ins who continued to pay a standard rate for sleep–ins as opposed to payments on the basis of an hourly rate have now received updated legal advice to the effect that they need to move the basis of payment to an hourly rate. The additional cost implications of this are detailed in Section 4 of this report.

2.18 In relation to the sleep–in payments it is clear that legally staff can put in claims for the past six years. Discussions with external providers have not commenced in relation to any claims for back pay and there are no plans at this stage to consider doing so – the impact of any claim on this level would be significant from a financial point of view. Discussions are taking place within the in-house service and Human Resource colleagues are working with AGMA to analyse this issue and the potential impact of back pay which as highlighted can be claimed for the past 6 years.

Supported Accommodation including Learning Disability Respite

2.19 Supported accommodation largely refers to people requiring 24 hour support to meet their complex needs in their own homes. Support is primarily delivered to people living in group homes, or larger blocks of self-contained individual flats, and only to a small extent some people living on their own in their own house. The balance of provision has changed over the years with larger schemes of self-contained flats being developed in place of some group home settings, thereby increasing the number of people enjoying self-contained accommodation rather than having to share their living space whilst providing savings as economies of scale of supporting higher numbers in one location are realised with a reduction in support provision.

2.20 Care and support is provided either by the Council's in-house Homemaker Service or by one of a number of external providers. The Council generally provides services in-house where needs are more complex as the Council can provide this support at a lower cost than the private sector. Where needs are less complex, generally the Council's costs are higher than external providers.

2.21 External provision has been procured from the independent sector over the past 20 years via open tenders with awards made using a combination of cost and quality considerations.

2.22 The contracts have been affected in cost terms with the introduction of the NLW from April 2016 along with increased contributions in relation to pensions and National Insurance. The NLW rate for 2018-19 is £7.83 per hour which is reflected in the contractual vales proposed in Section 4 (Summarised at Appendix 3) of this report.

Direct Payments

2.23 Direct Payments are money people can receive from us to buy care and support services, rather than having the council arrange them. This puts people in charge of their own care or support arrangements, giving more choice, control, independence and flexibility over the care they receive.

2.24 Some people choose to use their Direct Payment to commission care directly from a domiciliary care agency and the amount calculated for this is the standard home care fee that is detailed earlier in this report. This was £14.20 in 2017/18 and a proposed rate of £14.77 2018/19

2.25 Care costs for people wishing to pay for their care from other sources either by acting as a direct employer themselves are calculated as a Personal Assistant (PA) Rate. This was £10.82 in 2017/18 and a proposed rate of £11.09 in 2018/19.

Wilshaw House

2.26 Adult Services commissions a specialist day service for people with dementia at Wilshaw House. The overall aim of the service is to enable people to live as independent and fulfilling a life as possible in the community. The service is focused on a number of key objectives: enhancement of physical, mental, social and life skills; the provision of reliable practical emotional or psychological support to increase people's choice and control over their daily lives; enriching the range of experiences in a service user's daily life through the opportunities and social contact offered; reducing social isolation and supporting carers in their caring role.

2.27 Creative Support have are the current provider at Wilshaw House and have been engaged in ongoing dialogue regarding the impact of costs related to changes in NLW, pension contributions and revised NI payments.

2.28 The discussions in relation to revised cost for the Wilshaw House Dementia Day Service are presented at Section 4 (Summarised at Appendix 3) of this report.

Approved Day Service providers

2.29 The key aims and objectives of day services are to provide day time support/activities for people who are eligible for publically funded care and support. This includes older people and people with learning disabilities.

2.30 Day Services are delivered via an approved list of day services to enable the delivery of day services in a diverse and innovative way, giving people choice and control over how personal needs and assessed outcomes could be met.

2.31 No guarantees are given on the number of placements. Commissioners, care co-ordinators and service users have access to the list of approved day services from which to choose.

2.32 The rate per person per day in 2017/18 is £30.60 and the proposed rate in 2018/19 is £31.37. The proposed additional hourly rate for complex clients is £10.99, this is where double ups are required and 2 members of staff are required to deliver appropriate care for a period of time.

2.33 There is a different rate approved for HC-One older people day care this is due to the service open an hour longer than the other day services due to our in-house transport needing to pick service users up at 4pm (rather than 3pm in the other services) and the provision of a hot meal at lunchtime. The 2017/18 rates are £35.00 per person per day, £50.00 per person per day on a bank holiday (other day services on the approved list are not open on a bank holiday) and a £20 charge for showering/bathing service. The proposed rates for 2018/19 are £35.88 per person per day, £51.25 per person per day on a bank holiday and a £20.50 charge for showering/bathing service

Community Day Services

2.34 The aims of the service is to provide community-based support for people with a learning disability and people recovering from mental ill-health through the delivery of a model based on the principles of recovery and rehabilitation that enables individuals to move through the service and reduce hospital admission. The 2017/18 budget was £157,342.

3. POLICY CONTEXT

3.1 The national framework governing care and support in England has undergone fundamental reform. The Care Act 2014, in effect as from 1 April 2015, replaced the piecemeal legislation across the previous sixty years. The Care Act 2014 gives effect to, amongst other things, the following provisions:

- Requiring the council to promote individual wellbeing and apply the wellbeing principle in all cases where a local authority is carrying out a care and support function, or making a decision, in relation to a person.
- The council is responsible for preventing, reducing or delaying care and support needs.
- Requires that the council must promote the efficient and effective operation of a market of services for meeting care and support needs. The Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways.
- Specifies the requirements of a personal budget prepared for each adult needing care or support itemising the cost of meeting assessed need and individual financial assessment in terms of actual payment.

- Entitles an adult to express a preference for particular accommodation.

3.2 The duty on councils to assess any citizen who requests an assessment of their social care needs remains as a fundamental part of the Care Act as does the introduction of a new national minimum eligibility criteria for receiving adult social care services.

3.3 Once an assessment is completed the Council must determine whether a person is eligible to receive services provided by or commissioned by the Council. Previous to the Care Act local councils had discretion regarding the level of need they deemed eligible using the Fairer Access to Care Services (FACS) eligibility criteria. In Tameside services provided to those people meeting category 1 and 2 of the FACS criteria, that is those people with critical and substantial needs.

3.4 The FACS eligibility criteria was replaced with the introduction of the Care Act's National Minimum Eligibility Criteria which means that all councils must now assess people and provide services to those people who meet the national criteria.

3.5 In addition to these provisions, the Council has a new responsibility for market shaping as prescribed by the Act. Supplementing the Care Act 2014, there is further legislative provision and statutory guidance which has been issued by the Department of Health. The relevant regulations are Care and Support and Aftercare (Choice of Accommodation) Regulations 2014 (the Choice Regulations") which state that a local authority has to meet the provision of preferred accommodation. The effect of the Act, regulations and guidance, is to require the Council to facilitate and shape their market for adult care and support as a whole.

3.6 The statutory guidance issued under the Care Act 2014 states that local authorities must focus on outcomes when pursuing market shaping and commissioning. This is set out in the guidance. These include:

- Councils should have regard to guidance on minimum fee levels
- Councils must not undertake any actions which may threaten the sustainability of the market as a whole
- Council should assure themselves and have evidence providers deliver services through staff remunerated so as to retain an effective workforce.

3.7 Under the Care Act 2014 and the Choice Regulations, the Council needs to have regard to the Department of Health guidance "*Building Capacity and Partnership in Care*" it refers, more than once, to the need for consultation and cooperation between commissioners and providers of care. It states that fee setting must take into account the legitimate and current future costs faced by providers as well as the factors that affect those costs and the potential for improved performance and more cost effective ways of working. Local authorities should not use their position to drive down fees. Contract prices should not be set mechanistically but should have regard to providers' costs and efficiencies, and planned outcomes for people using services, including patients.

3.8 Under the National Assistance Act 1948 (NAA 1948) the Council was under a requirement to have regard to the actual costs of providing care so that it could have regard to those costs in setting the fees it pays to care providers (known as the usual costs). The Care Act 2014 and guidance does not require this. The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. However, the usual costs process remains lawful and a useful tool in market shaping and complying with regulations about choice.

3.9 Therefore, in seeking to identify a usual cost the Council is under very similar obligations as it was under the previous regime to consider the cost of care and engage with the providers to understand as far as possible their financial models.

4. FINANCIAL INFORMATION

Home Care/Support at Home

4.1. In setting the hourly rate for Home Care, a model was developed that took account of the implementation of the NLW in April 2016 where typically the staff costs accounted for 77% of the total rate. Calculations which underpin the proposed rate for 2018/19 have inflated direct staffing costs by the increases in NLW and NMW reflecting the age mix of home care staff in Tameside.

4.2. Taking account of these factors the proposed hourly rate for 2018/19 is £14.77, an increase of 4% Appendix 1 contains details of the model used to arrive at the proposed hourly rate.

4.3. Throughout 2018-19 the new Support at Home model will be implemented on a phased approach across various geographical zones. This means that in 2018/19 the Council will commission both the existing model of homecare provision and the new Support at Home model, this will result in two different rates payable to providers. A detailed modelling exercise has been undertaken to ascertain the scale of delivery for the respective models. Based on current data it is estimated that a total of 276,100 hours will be delivered using the existing model of homecare and 245,980 via the Support at Home model.

4.4. The proposed fee payable for delivery of the new Support at Home model is £17.20, the increased rate reflects the upskilled role being undertaken by the Support at Home workers and allows for a starting pay rate of £9 per hour for front line staff to provide a more attractive career proposition for prospective care workers and consequently lead to a more sustainable provider market. The increased cost fully funded by GM Transformation monies in 2018/19. The financial impact is summarised in table 1 below;

Table 1 – Increased costs of Homecare / Support at Home

	Current Homecare model £	New Support at Home model £
2017/18 Hourly Rate	14.20	14.20
2018/19 Proposed Hourly Rate	14.77	17.20
Estimated hours of delivery in 2018/19	276,100	245,980
Additional Gross Cost	157,377	737,940
GM Transformation Funding		-737,940

4.5. People in receipt of home care are expected to pay towards the cost of that care. People with savings and assets (not including their home) in excess of £23,250 will be expected to pay the full cost of their care which will incorporate the rise in fees proposed. Others will be expected to pay a proportion according to their income and assets. A full financial assessment is carried out for all users of social care services and this is reviewed on an annual basis to ensure that people continue to have the ability to pay and are not left unable to meet their day to day living costs at home

Extra Care Housing / Supported Accommodation including Learning Disability Respite

4.6. In reviewing the contract sums paid to providers operating supported accommodation recognition has to be given to a range of staff cost pressures, where staff costs account for up to 90% of the costs of operating these services. Particular cost pressures on the contracts are the ongoing costs of the NLW first introduced in April 2016 and a new pressure where the payments to staff providing night cover at premises has changed following recent employment tribunal rulings which have been confirmed by HMRC. Traditionally night cover in supported accommodation been met by "sleep ins" and/or "waking nights", the former has

been traditional paid as an allowance, where typically £40 might be the going rate for a 9 hour shift. The decision of recent Employment Tribunal cases, *Esparon T/A Middle West Residential Care Home v Slavikovska and Whittlestone v BJP Home Support Ltd*, have held that where an employee is contracted to "Sleep In" the time should be treated as working time and paid at the prevailing hourly rate. The consequence of employers not paying sleep ins at the prevailing rate are punitive charges levied by HMRC.

4.7. To understand the potential financial liability that might fall on the Council from providers changing payment methodology for sleep ins, costs of providers have been shared with the Council on an open book basis.

4.8. The proposed contract sums for 2018/19 are based on paying the full cost of paying any additional cost associated with the NLW uplift at 1 April 2018 and paying the current level of sleep ins at an hourly rate.

4.9. Details of the supported accommodation contracts are contained in Appendix 3 with the proposed cost across all contracts for 2018/19 is expected to be £11.357m a 5.02% increase of £0.543m on 2017/18 values.

Wishaw House - Dementia Day Service

4.10. The annual contract price for the Dementia Day Centre at Wilshaw House for 2017-18 is £367,176

4.11. Uplifts have been applied in relation to staff rates of pay to meet the revised National Living Wage with the additional on costs relating to this hourly rate (NI, Pensions etc). This led to a revised annual contract cost for 2018-19 of £376,644 which represents an increase £9,468 (2.6%).

Community Recovery Service

4.12. Discussions with the provider have concluded no increase is required for 2018/19 as there has been a review of management input that has brought efficiencies to the cost of the service for the new financial year. The contract price for 2018/19 will therefore remain at £157,342

Direct Payments Personal Assistant Rates

4.13. Once a package of care has been agreed with a service user a personal budget is calculated which takes account of the cost of the care and in particular how the care will be provided. Users can choose to take their personal budget as a Direct Payment which allows the person to have their personal budget paid into their account and for them to determine how to spend the money to meet their needs in a more flexible way.

4.14. Some people choose to use their Direct Payment to commission care directly from a domiciliary care agency and the amount calculated for this is the standard home care fee that is detailed earlier in this report.

4.15. Care costs for people wishing to pay for their care from other sources either by acting as a direct employer themselves or using a brokerage agency such as Pay Partners are calculated as a Personal Assistant (PA) Rate.

4.16. Table 2 outlines the proposed Direct Payment Personal Assistant fees for the forthcoming financial year.

4.17. Payments for personal assistants and other associated payments that are made through the Direct Payments system are relatively high in comparison to other local authorities in Greater Manchester and across the North West and it is proposed that these payments are frozen for the coming year to bring them closer in alignment with Greater Manchester neighbours.

Table 2 – Proposed Direct Payment Rates

DIRECT PAYMENTS			
Fee/Charge		**2017/2018**	**2018/2019**
Personal Assistant	Per hour	£10.82	£11.09
Provider	Per hour	£14.20	£14.77
Direct Payment	Sleep in	£56.41	£57.82
Direct Payment	Night Sit	£95.87	£98.27
Respite	Respite weekly rate	£423.59	£434.18
Managed Account	Weekly	£28.00	£28.70
Day Care	Day rate	£30.60	£31.37

Shared Lives Scheme

4.17 The Shared Lives Scheme offers placements to adults in need of long term, respite and day care. The care is offered by trained carers in their own homes in a similar way to fostering schemes for children.

4.18 The fees uplift was included in section 11 of the Council's budget report on 27 February at 2.5%.

4.19 Table 3 indicates the new rates for Shared Lives for 2018/2019;

Table 3 – Proposed Shared Lives Fee Rates

SHARED LIVES			
	Fees	**2017/2018**	**2018/2019**
Respite	Per night	£44.45	45.56
Long Term	Per week	£395.65	405.54
Day Support	Per 5 hrs or part thereof	£6.89 (5 hours £34.45)	£7.06 (5 hours £35.30)

5 EQUALITIES

5.1 It is not anticipated that there are any equality and diversity issues with this proposal. The increased costs will ensure that all workers will be paid at either the National Minimum Wage or National Living Wage (workers aged 25 and over) and support the service redesign proposals planned over the coming 12 months, thereby ensuring that individuals whose eligible assessed needs meet the national eligibility criteria will be offered a quality and diverse service from a highly skilled and valued workforce.

5.2 There are fundamental principles inherent in all proposals for delivering health and social care support to vulnerable adults:

- The receipt of health and social care services is based on eligibility. All adults over the age of 18 have the right to request an assessment of their need either as a potential service user or as a carer of someone who needs care and support. Once an assessment has been completed a decision will be made as to which needs someone has that are eligible to be met according to the national eligibility criteria laid out in the Care Act.
- That wherever possible identified eligible need is met by family, friends, neighbours and the wider community.

- That whatever eligible needs are left unmet by other parties must be met by either providing services directly to meet the need or by commissioning services from elsewhere. In doing so every effort should be made to use the most cost efficient service available to meet the eligible needs identified including the use of assistive technology and appropriate equipment.
- That people are expected to pay what they can afford to pay for the services that they are in receipt of taking full account of any income, savings and assets that they have.

5.3 Applying the national eligibility criteria robustly will ensure that only those people who have identifiable needs will receive help and support. This will ensure that all people will be treated fairly and equitably according to the needs that they have. People who have needs that are not deemed eligible will be offered other advice and signposted to other organisations who may be able to help.

6 RISK MANAGEMENT

6.1 There are a number of risks associated with this work. These are summarised as:

- Contracts need to as a minimum support providers adhere to the introduction of the National Living Wage, national insurance changes, and pension changes and the emerging problem relating to sleep-in payments.
- Contracts need to support providers in meeting the costs associated with the burden of the increased regulatory and inspection burden.
- Contracts need to support providers to address the increasing problem of recruiting sufficiently skilled staff, both social care and nursing, which is prevalent not just locally but nationally.
- There is a risk of challenge from providers that in setting the fees for Care Homes, Home Care and Supported Living that they do not adequately reflect the local cost of delivering these services.

6.2 A further risk is that the uplifts being proposed in this report are not sufficient to stabilise the current markets, particularly home care, and that providers make a decision to exit the local market. The proposed fee increases have been calculated using local market and provider intelligence in an attempt to determine a local fee that is reasonable to both the commissioners and the providers.

6.3 These risks will be mitigated through ongoing redesign of the service offer and increased funding across contract prices.

7. SUMMARY

7.1 The health and social care economy has seen unprecedented reductions in funding over the past five years.

7.2 As a result of these reductions all services have been subject to review to establish where efficiencies can be achieved and/or where services can be provided differently. This includes consideration of services where there are statutory and non-statutory duties and responsibilities.

7.3 The demand to meet savings targets have progressed at a time when providers have in the main been facing increased operating costs. The most significant increase in costs have been those recently experienced specifically in relation to the introduction of the National Living Wage to a sector that has for many years been operating on wage levels at or close to minimum wage levels, but also in relation to increased pension contributions.

7.4 Work has been progressing over the past three months to work with providers to reflect these additional costs in realistic prices that can continue the delivery of what are essential services for the vulnerable adults concerned. The methodology adopted has included revising cost of care framework that reflect local factors, whilst in the case of the supported accommodation has adopted open book accounting methodology to establish the impact on costs of these additional requirements.

7.5 This work has resulted in the proposed uplifts that are presented in this report. The estimated net costs of which amount to £0.157m for Home Care , with a further increase for the supported accommodation contracts of £0.543m.

8 RECOMMENDATIONS

8.1 As presented at the front of the report.

APPENDIX 1

Homecare Model					Comments and assumptions
Hourly Pay Rate			£ 7.73		National Living Wage payable for all workers 25+, average based on known data of 88.73% of workforce being eligible
Weekend Rate	plus 0.00%		**£ 7.73**		No enhancements for weekend working
Travel Time allowance	11.4	minutes	50.4	**£ 9.19**	based on national historical information that home care workers contact time was only 84% of every hour, and travel accounted for the balance, being equivalent to 11.4 minutes of every hour.
Bank Holiday Premium	plus 50.00%			**£ 0.10**	Based on paying the eight bank holidays at x1.5
Gross Pay				**£ 9.29**	
ADD					
National Insurance	9.50%			**£ 0.88**	based on current NI employer rates
Pension	1.00%			**£ 0.09**	
Holidays	10.74%			**£ 1.00**	employees have a statutory entitlement of 5.6 weeks paid leave per annum that needs to be covered by other means, 5.6/52.14
Training & Supervision	1.73%			**£ 0.16**	In line with industry average
Direct Pay Costs				**£ 11.42**	
Travel Payments	0	miles	£ 0.35	**£ -**	HMRC's rate for use of private vehicles is £0.45, though a rate of £0.35 is deemed reasonable by UKHCA, how much travel is allowed is dependant on the geography of the area and most importantly whether travel is paid. As Tameside is a small geographical area and contract areas are small travel payments will be negligible.
Sub-total before Overheads				**£ 11.42**	
Overheads	25.50%			**£ 2.91**	sickness cover, recruitment, uniforms, local office expenses, head office expenses, supervision and management
Sub-total before Profit				**£ 14.34**	
Profit Margin	3.00%			**£ 0.43**	typical margin of 3-5%, assumed the lower end, consistent with UKHCA
Chargeable Rate per hour				**£ 14.77**	

Appendix 2

Support at Home Model						Comments and assumptions
Hourly Pay Rate			£9.00			Apply the Living Foundation Wage who have been fully trained and move to the new service delivery model
Weekend Rate	plus	0.00%	**£9.00**			No enhancements for weekend working
Travel Time allowance		10.8 minutes	50.4	**£**	**10.62**	based on national historical information that home care workers contact time was only 84% of every hour, and travel accounted for the balance, being equivalent to 9.6 minutes of every hour. Geographically Tameside is a fairly condensed area with rural pockets - this leads to slightly higher contact time than the national average of 81%
Bank Holiday Premium	plus	50.00%		**£**	**0.12**	Based on paying the eight bank holidays at x1.5
Gross Pay				**£**	**10.74**	
ADD						
National Insurance		9.50%		**£**	**1.02**	based on current NI employer rates
Pension		1.00%		**£**	**0.11**	workplace pension schemes start at 1% rising to 3% by 2018, applying to staff 22+ and earning 10k+ per annum, assumed to 1% from 1st April
Holidays		10.74%		**£**	**1.15**	employees have a statutory entitlement of 5.6 weeks paid leave per annum that needs to be covered by other means, 5.6/52.14
Training & Supervision		2.63%		**£**	**0.28**	Assumes training of 2% forexpanded role and 0.63% for supervision based on industry standards
Direct Pay Costs				**£**	**13.30**	
Travel Payments		0 miles	£0.35	**£**	**-**	HMRC's rate for use of private vehicles is £0.45, though a rate of £0.35 is deemed reasonable by UKHCA, how much travel is allowed is dependant on the geography of the area and most importantly whether travel is paid. As Tameside is a small geographical area and contract areas are small travel payments will be negligible.
Sub-total before Overheads				**£**	**13.30**	
Overheads		25.50%		**£**	**3.39**	sickness cover, recruitment, uniforms, local office expenses, head office expenses, supervision and management
Sub-total before Profit				**£**	**16.69**	
Profit Margin		3.00%		**£**	**0.51**	typical margin of 3-5%, assumed the lower end, consistent with UKHCA
Chargeable Rate per hour				**£**	**17.20**	Proposed rate per hour in paying the Living Foundation Wage for the Help to Live at Home Service

Supported Accommodation Fees 2018/19					
Provider	**Contract**	**Current Contract 2017/18**	**Proposed Uplift**	**Proposed Contract Value 2018/19**	**Comments**
Creative Support	Intensive Support Contract	£ 841,374	£ 26,665	£ 868,039	The increas £26,665. Th addition, the workers to r adequate re £868,039 fo x 9 hour slee (2 properties Stamford St Sycamore C
Affinity Trust	Supported Accommodation Learning Disability	£ 1,567,737	£ 43,000	£ 1,610,737	To meet inc effect to NI f
Alternative Futures Group	Supported Accommodation Learning Disability East Locality Contract	£ 1,924,609	£ 100,600	£ 2,025,209	9 properties
Alternative Futures Group	Supported Accommodation Learning Disability North Locality Contract	£ 2,208,654	£ 101,700	£ 2,310,354	10 propertie by the provi 18 contract
Alternative Futures Group	Transition St Ann's House	£ 351,516	£ 13,000	£ 364,516	1 property, 5
Turning Point	Supported Accommodation Learning Disability	£ 1,911,385	£ 197,000	£ 2,108,385	Sleep Ins fo 18 following unsustainab Support Acc uplift.
Turning Point	Mental Health Supported Accommodation	£ 523,625	£ 2,000	£ 525,625	2 properties,
Turning Point	Recovery Mental Health	£ 157,342	£ 0	£ 157,342	currently 56 uplift require
Liberty Support Services	Lomas Court	£ 200,000	£ 9,000	£ 209,000	National Livi per hour wh being incurr • Fee by 175% in 2 future. • Insu the last two • A re can continue are a contin The estimat commission costs and th approximate
Anchor Trust	Extra Care Housing - Fairfield Court, Droylsden	£ 189,301	£ 10,465	£ 199,766	
Contour Housing	Extra Care Housing - Melbourne Court, Stalybridge	£ 215,411	£ 11,810	£ 227,221	
Hanover Housing	Extra Care Housing - Hurst Meadows, Ashton-under-Lyne	£ 235,694	£ 13,152	£ 248,846	
New Charter Housing Trust	Extra Care Housing - Beatrix House, Dukinfield	£ 267,183	£ 14,809	£ 281,992	
Community Integrated Care	Respite Cumberland St Learning Disability	£ 220,320	£ 0	£ 220,320	Provider has to achieve a have also fo to a change been able to as such hav The provide a respite se
Total		**£ 10,814,151**	**£ 543,201**	**£ 11,357,352**	
Total % Uplift across all Supported Accomodation Contracts		**5.02%**			

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	20 March 2018
Officer of Strategic Commissioning Board	Stephanie Butterworth, Director of Adult Services
Subject:	**NEW CARE HOME MODEL AND FEES FOR 2018/19**
Report Summary:	The report seeks approval for the proposed fees for the 2018/19 financial year, both for if the On/Off Framework arrangement is removed or if it will remain the same (to be agreed by Executive Cabinet on the 21 March 2018). Subject to Executive Cabinet agreeing to remove the On/Off Framework arrangement there are a small number of service users who will be directly financially disadvantaged by the change of policy, for which it is proposed the Council will be pick up the difference. As this change in policy will be to assist the care homes market any ensuing disadvantage to service users currently contracted with the Council and care homes should be picked up by the Council. Failure to do so would result in successful challenge through the courts and/or the Local Government Ombudsman. The report also notes the need to use the NHS Shorter Form contract as the basis for the continuing contractual relationship with the care homes and seek approval for the proposed Enhanced Payment criteria. The report will also seek approval to the way the approved list operates, i.e. to change the mechanism to a Dynamic Purchasing System (DPS), whilst recognising service users' rights to choose any care home provider that is registered with the Care Quality Commission and meets the conditions as laid out in the Care Act Guidance 2017.
Recommendations:	1. To agree to the fee structure for 2018-19 as set out in Section 8. 2. To agree that current service users will not be disadvantaged by the change in contractual policy arrangements and any financial difference will be met. 3. To agree the criteria for the Enhanced Payment. 4. To agree the transitional period of 12 months for those providers currently receiving the enhanced payment but, due to the inclusion of the CQC rating of 'Good' or 'Outstanding' in the new criteria, cannot now meet this criteria. 5. To recognise the requirement to use the NHS Shorter Form contract as the basis for the contract with the care homes. 6. To acknowledge that there will be service users financially disadvantaged by the proposal, and agree that the Section 75 Pooled Budget will meet the difference between the Off & On Framework rates for those service users.

Financial Implications:

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

The funding and associated costs of Care Home fees forms part of the Section 75 Pooled Budget. The proposals outlined in this report will result in cost increases to the Strategic Commission as outlined below in 2018/19:

	£'000		
	TMBC	T&G CCG	Total Strategic Commission
Net Cost Increase as a result of rate increase(s)	766	214	980
Movement from Off to On Framework	152	36	188
Rate differential for 17 Self Funders affected by removal of Off Framework rates	29	0	29
Total Net Cost increase	**947**	**250**	**1,197**

The cost increases linked to the rate increase are included in the Strategic Commission's Medium Term Financial Plan, although it should be noted that provision has not yet been made for the movement from Off to On Framework rates.

Legal Implications:

(Authorised by the Borough Solicitor)

Councils must not undertake any actions which may threaten the sustainability of the care home market as a whole, for example, by setting the fee levels below an amount which is not sustainable for the provider in the long term, as set out in Care Act statutory guidance.

It is very important therefore that policies reflect this, and that fees are set appropriately, and their effect monitored and kept under regular review.

Further, under section 5 of the Care Act 2018 Councils must promote the efficient and effective operation of a market in services for meeting care and support to ensure that a person has a variety of providers to choose from who provide a variety of services; a variety of high quality services to choose from; and sufficient information to make an informed decision about how to meet those needs.

The proposed change in contracting policy to be considered by Cabinet on 21 March 2018 is dependent on a decision by the Strategic Commissioning Board to agree the fee structure set out in this report which is designed to assist the care homes market. Any ensuing disadvantage to service users currently contracting with the Council and care homes should be picked up by the Council. Failure to do so could result in successful challenge through the courts and/or the Local Government Ombudsman.

	Any change to Council policy brings with it a risk of judicial challenge and/or complaint. It is therefore very important to ensure the Council has engaged on a meaningful and effective consultation exercise, and carried out a full equality impact assessment which is of particular significance where vulnerable people are concerned, as in this case. Members must therefore ensure they have read and understood the EIA attached at appendix F of this report. The Council has previously been challenged by the Local Government Ombudsman when it changed its policy on contracting with care homes in 2012, and so it has been careful to ensure the concerns raised in that challenge have been met during this exercise. This will be achieved by ensuring service users who currently contract with the Council are not financially disadvantaged by the decision to change the basis on which the Council contracts with the care homes. The care homes should not be financially disadvantaged by this change which is designed assist them in their future planning and quality improvements under the CQC inspection regime which is a key requirement for their business. Clearly there is the potential for challenge in any contractual arrangement, but this type of contract is now governed nationally by the NHS and their standard contract terms and conditions, and so the scope for such challenge more limited. Where local conditions create variations this will need to be carefully managed locally through individual negotiations. It will be important to ensure any change in policy is fully understood and properly implemented, and that the Council's Charging Policy is amended should this be necessary in the light of the same.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care • Locality-based services • Planned care services
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commission for the 'whole person' • Create a proactive and holistic population health system
Recommendations / views of the Health and Care Advisory Group:	Not required for this piece of work
Public and Patient Implications:	If the Executive Cabinet agrees to the proposal to remove the On/Off Framework arrangement there are financial implications for some service users who are assessed as paying the full contribution to their care as well as those

	currently paying top-up contributions in Off Framework care homes. The former (the residents) will be adversely affected, i.e. their contribution will increase by approx. £32.30-35/week (depending on the category of care), whilst the third party contributors will be in a financially better position as their contribution will decrease by the same amount (on the assumption that the provider's gross fee stays the same).
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness. It is anticipated that the current Off Framework providers will have additional resources to invest back into the business and improve the quality of the service delivered.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	There are no anticipated safeguarding issues. Where safeguarding concerns arise as a result of the actions or inactions of the provider and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. Any contracted service will include minimum requirements for training and qualification workers which includes standards and requirements for information governance, privacy and respect. A privacy impact assessment has not been undertaken.
Risk Management:	Is detailed in Section 10.
Access to Information :	The background papers relating to this report can be inspected by contacting Tim Wilde  Telephone: 0161 342 3746  e-mail: tim.wilde@tameside.gov.uk

1. INTRODUCTION

1.1 The current contractual relationship with the care homes is coming to an end and there is a need to continue with this relationship to allow the Council to fulfil its statutory duty to provide care and support to meet service user's needs.

1.2 The Commissioners have been contracting with the sector under an On/Off Framework arrangement following a Key Decision in August 2012 (and subsequent tender). The On/Off arrangement carries slightly different contract terms and conditions for On and Off Framework providers, as well as different fee levels, and it is proposed that this arrangement is no longer fit for purpose in 2018, and all care homes should start from the same base with the same contract, be paid the same fees for the service and have the same opportunity to apply for the enhanced payment.

1.3 The change of policy will have an adverse financial impact on some residents in Off Framework care homes. There are 17 service users identified that the Council contracts for, but who are recharged to full contribution towards to cost of care, and the change of policy will adversely affect them. Any increase in fees (over and above any applied inflationary increase) will be directly charged to the service user. Conversely, there are a number of relatives of residents in Off Framework care homes (who may be paying a third party top-up) who will benefit from the change of policy, i.e. any increase in fees by the Council will reduce the amount of third party top-up paid by the relative (on the assumption that the gross fees remain the same).

1.4 As the proposal is a change in policy a consultation exercise has been undertaken to seek the views of those affected by the change, as well as with wider stakeholder. The outcomes of this consultation is considered later in the report (Section 5)

1.5 Historically, the Council has contracted with providers using Council developed contract terms and conditions, which includes the current agreement with the providers, albeit they were modified to meet the conditions required by the NHS as the local health commissioner (the Primary Care Trust as it was then) is a signatory to the contract.

1.6 However, instructions from NHS England state that where healthcare services are being purchased (which includes nursing care in care homes) then the NHS contracts must be used and agreement to use the NHS Shorter Form contract is sought.

1.7 Changes in the Public Contracts Regulations (latest version was published in 2015) and the way in which the Council undertakes tenders (using The Chest for electronic tendering) has opened up other ways to establish 'Approved Lists'. It is proposed that the Commissioners use a Dynamic Purchasing System to establish a new list of providers, which will also be used should the Commissioners need to tender for any specialist services for care home provision in Tameside. Glossop will be excluded from this process as, whilst the local CCG covers Glossop and will continue to be party to the contract, Derbyshire County Council remains responsible for the care homes in the Glossopdale neighbourhood.

2. BACKGROUND

2.1 In 2012 the Council, along with the then Tameside & Glossop Primary Care Trust (PCT), worked closely with the care home market to develop a new contract as well as a standard methodology to calculate the usual cost of care (taking account of the providers' costs) to determine fee rates across the various bed types.

2.2 A Key Decision dated 15 August 2012 approved that:

- The Council should procure a framework of approximately 1,200 care beds (750 residential & 450 nursing) with the fee structure as set out in the report and other matters as set out in the report.

- Where the Council commissions care from care homes in Tameside which are not on the Framework:
    - Placements should retain their existing fee for a transitional period of three months following commencement of the Framework
    - After that period, the fees will be as set out [in the report]
- With effect from commencement of the Framework the Council should allow top up fees as set out in section 13 of the report
- With respect to all new placements following the commencement of the Framework, the Council should withdraw from any placement or not accept a duty where a resident is assessed as being able to meet the full cost of the care and either able to manage the placement or having access to the resources to do so) as set out in [the report].
- The placements in Glossop Care Homes should be treated as being out of Borough placements.

2.3 Following the Key Decision a tender was undertaken with the care home sector, with the outcome being based purely on quality (following representation from the sector and the significant amount of work put into the cost of care methodology). This tender was evaluated by representative from both health and social care and the creation of the On/Off Framework Care Home list was established. The contract started on 10 December 2012 and was for a 5 year period (ending on 9 December 2017).

2.4 Prior to the policy change (which created the On/Off Framework arrangement) the Council had never tendered for the service as all providers had the same contract; which was established with providers to facilitate the service users' choice as determine by the National Assistance Act 1948. It was only the establishment of the On/Off Framework arrangement that required a tender as there was a difference between the fees and the contract between On/Off Contracts, hence the need for a fair, open and transparent process to determine which providers were awarded which contract.

2.5 Following an additional tender (required to increase the number of nursing beds on the On Framework) the number of homes/beds On/Off Framework as at May 2013 is noted below:

Category of care	Off Framework		On Framework	
	No. of Homes	Total beds	No. of Homes	Total beds
Residential	13	391	16	778
Nursing	3	122	11	476
Totals:	16	513	27	1254

Note: Two care homes had only a proportion of the beds included On Framework (Hyde NH & Riverside Care Centre) and only single beds are paid at the On Framework rate hence the discrepancy in the total bed numbers noted above (1,767 in total) and the number of registered beds of 1,838.

2.6 At the time the decision was taken the care home market in Tameside was different than the present time, i.e.:

August 2012			January 2018		
Type of Home	Number	No. of Beds	Type of Home	Number	No. of Beds
Residential	29	1106	Residential	27	1091
Nursing	14	683	Nursing	11	548
Total	43	1789	Total	38	1639

2.7 During the time of the current contract five care homes have closed, one care home completely deregistered from nursing care to provide residential care only (and following an extension increased the number of beds) and another home changed the registration of one unit (20 beds) from nursing to residential. The overall impact of these changes has reduced the residential capacity by 15 beds and the nursing capacity by 135 beds.

2.8 Of the five care homes that closed, one was an On Framework home with the remaining four being Off Framework.

2.9 At the start of the contract period the vast majority of providers were compliant with the Care Quality Commission (CQC); however, during the contract period the CQC amended the way they regulated registered services and started to rate providers based on the essential standards, which was later replaced by the fundamental standards. The current compliance ratings of the providers are noted later in this report.

3. CURRENT SITUATION

3.1 The market has evolved and changed during the course of this contract, with the loss of beds in the borough, specifically nursing beds. This is impacting in Tameside (and surrounding areas) in facilitating timely discharges from hospital.

3.2 In August 2012 there were significant vacancy levels in Tameside, i.e. 158 (14.3%) residential and 118 (17.3%) nursing vacancies. As of February 2018 these figures are 90 (8.2%) residential and 38 (6.9%) nursing vacancies.

3.3 The placement profile for the Council and Tameside and Glossop Clinical Commissioning Group (CCG) has reduced over the last 5 years, e.g. 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 is 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.

3.4 The fact that vacancy levels are decreasing yet the Commissioners are purchasing fewer beds is down to a number of factors, i.e. reduced capacity in the market (specifically nursing beds), increased level of self-funders and increased purchasing in the borough by other authorities (due to paucity of placements in those localities). In January 2018 approximately 18% of the local bed base was commissioned by other local authorities.

3.5 It was noted earlier that the CQC introduced a revised rating system approximately 3 years ago. The rating profile of homes in the borough as at 21 February 2018 is presented below:

Rating	No. of Homes	% of Homes	No. of Beds	% of Beds
Outstanding	0	0%	0	0%
Good	19	50%	748	46%
Requires improvement	18	47%	873	53%
Inadequate	1	3%	18	1%

3.6 The above can also be broken down into Off, On Framework & Enhanced Payment providers:

Rating	Off Framework		On Framework		Enhanced Payment	
Outstanding	0	0%	0	0%	0	0%
Good	5	42%	3	75%	11	50%
Requires Improvement	6	50%	1	25%	11	50%
Inadequate	1	8%			0	0%
Total:	12		4		22	

3.7 Off Framework Providers are struggling to perform to the expected standards (as required by the CQC), with only 33% of the homes demonstrating compliance. The majority of these homes do not charge top-ups to residents, with the notable exception of one provider (currently rated 'Good') who charges a top-up in the region of £70-80 per resident per week.

3.8 The small numbers of On Framework (without enhanced payment) homes makes any statistical analysis difficult, but the majority of these providers are performing well with none rated 'Inadequate'.

3.9 The Enhanced payment providers are performing better than the Off Framework providers, with 50% of them achieving a CQC rating of 'Good'.

3.10 The care home market in Tameside is dominated by a single national provider - HC-One owns 16 care homes in Tameside (745 beds or 45.5%). All of HC-One homes are On Framework, with the majority attracting the enhanced payment premium. This equates to 61.5% of the 1212 On Framework beds in the borough.

3.11 The CQC rating profile of HC-One is not as good as the overall profile in Tameside, i.e. 37.5% (6 homes) are rated 'Good', 56.3% (9 homes) rated 'Requires Improvement' with 6.3% (1 home) rated 'Inadequate'.

3.12 The fees in Tameside have increased in line with the agreed methodology (contained within the August 2012 Key Decision), which takes account of the providers actual costs in delivering the service. The increase in the National Minimum Wage and the introduction of the National Living Wage are key factors that have driven the increase in the fees. The methodology for calculating care home fees changed in 2016 as the Council was required to take account of the National Living Wage to calculate the impact of this in advance of the implementation (rather than in retrospect). The methodology slightly changed to make the process more efficient and built on the information received over the previous years.

3.13 The levels of need of the residents in care homes is also increasing, which can be partly attributed to the Commissioners commitment to supporting people to remain in their own homes for as long as possible, i.e. when service users do require to be in a care home their needs are greater now than they have been in the past.

3.14 The staffing ratios have not changed dramatically during this time as, although they should be determined by the levels of need of the residents, the care homes are also constrained by the available budget (whilst still maintaining financial viability). Historically (under the Registered Homes Act 1984) providers were required to have staffing ratios of 1:8 (care workers: residents) in residential homes. The model that has been used to calculate the fees for 2017/18 allowed for staffing ratios of 1:7.

3.15 Providers have, for some time, noted that the recruitment and retention of competent nursing staff has been challenging. This is not just a local issue but is continually reported nationally. The reduction in the numbers of nursing beds is a symptom of the challenges in recruiting nurses. The large increase in FNC paid to providers (£110/resident/week in 2012 to £155/resident/week in 2017) was in recognition of this issue and that providers are now relying more on agency workers (and staffing agencies charge substantially more per hour than directly employed staff).

3.16 Latterly, the providers have also stated that it is difficult to recruit and retain care workers. This is due to other local providers (not the care sector) paying staff more for work that has far less responsibility.

3.17 The need for providers to use agencies to ensure they have enough staff to meet residents' needs is putting more financial pressure on providers, with one provider paying 25% of the staffing bill on agency staff (primarily nurses).

3.18 The present contract – a joint contract with the Council and the CCG - is based upon the Council's standard Adult Social Care Contract with modifications to ensure it is broadly compliant with the NHS Standard Terms and Conditions (as agreed by Hempsons who were commissioned by Tameside & Glossop PCT to ensure this was so).

3.19 The current contract was extended from 10 December 2017 until 31 March 2018 to allow the Commissioners to undertake appropriate consultation about the proposed change of policy (see the Consultation section at point 5 and Appendix B).

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

3.21 One of the drivers affecting the future direction of the care home sector is the policy to ensure people remain at home for as long as possible/safe to do so. This is affecting the market and will impact on the future provision required, i.e. it is envisaged that more resources will be community based and when service users do require 24 hour support they will require more specialist residential or nursing care (rather than standard residential care).

3.22 The Council and CCG have also been working closely to build on current practice and to develop new processes and documentation to provide assurance that the service is being delivered in accordance with the contract and to support providers to be CQC compliant. This development of new documentation has taken account of existing good practice, good practice from neighbouring authorities, NHS England Vanguard schemes and the Independent Age eight quality indicators, as well as the CQC Key Lines of Enquiry. The new documentation/process has now been agreed with the care home providers and is being implemented from February 2018.

3.23 Given the current agenda to fully integrate health and social care the Council and CCG has, for some time, been exploring the option of using the NHS Standard Terms and Conditions as the basis for contracting with the care sector. The initial thought was to 'future proof' the contractual arrangement in readiness for any transfer of the contracting function to the NHS Tameside & Glossop Integrated Care Foundation Trust. However, as the fees were based on the existing contract, and some of terms and conditions in the NHS Vanguard model of good practice contract (Nottinghamshire Council & Nottinghamshire CCG) were more onerous than the current contract, it was agreed that the basis for consultation would be the current contract.

3.24 Subsequent to this consultation NHS England published instructions for the new NHS Standard Contract ("NHS Standard Contract 2017/18 & 2018/19 Technical Guidance") in which it states that "14.2 …*In a situation where NHS commissioners and a local authority are intending to sign the same single contract with a provider, however, and where the service being commissioned involves a healthcare service, then the NHS Standard Contract must be used"*. This was also confirmed in discussion with the NHS England National Care Home Lead on 19 January 2018. On this basis (as the CCG is a signatory to the contract) it is proposed that the NHS Shorter Form contract is used as the contractual framework, incorporating the local specification and other relevant policies, e.g. safeguarding.

3.25 Tameside is unique in in the North West with its current approach to working with the care home market, i.e. we are the only authority to have an On/Off Framework arrangement and to place limitations on the ability for providers to charge top-ups. Rationalising the approach in the way envisaged in this report will therefore bring the Council in line with the North West.

4. STRATEGIC FIT

4.1 The service will meet the current objectives as outlined in the Care Act 2014 - under the Care Act, local authorities have taken on new functions. This is to make sure that people who live in their areas:

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- Can get the information and advice they need to make good decisions about care and support;
- Have providers offering a choice of high quality, appropriate services.

4.2 The Council's Community Strategy supports the delivery of the six Sustainable Community Strategy aims listed below:

- Prosperous Tameside
- Supportive Tameside
- Learning Tameside
- Attractive Tameside
- Safe Tameside
- Healthy Tameside

4.3 The Commissioners are also working closely with the Greater Manchester Health & Social Care Partnership and is leading on the workstream to improve the quality of care homes services. The new contract will include provision for the development of the services during the contract period. Such developments currently being considered include:

- Maximising the use of technology (including the continued use of the local Digital Health service)
- 'Teaching Care Homes' (designed to empower and embolden the workforce in care homes, with a desire to harness and promote care, knowledge and skills development)

5. CONSULTATION

5.1 Given that the proposal is a change of policy that was approved by a Key Decision in August 2012, and a number of residents may be financially disadvantaged by this policy change, the Commissioners undertook a consultation exercise to obtain views of people using the service, care homes and the wider public. This consultation started on 11 December 2017 and took a number of forms to give people the best opportunity to provide feedback:

- A questionnaire included on The Big Conversation (attached as Appendix A)
- The same questionnaire was sent to providers for distribution within the care homes (for residents and relatives) and also for completion by the providers themselves
- A request that providers invite a representative from the Joint Commissioning & Performance Management Team to a resident/relatives meeting
- Direct contact with the residents who would be financially disadvantaged by the change of policy (facilitated by the Neighbourhood Teams).

5.2 The end of the consultation period was 31 January 2018, which allowed 7½ weeks for comments to be returned (the minimum duration is 6 weeks).

5.3 The Council commissions an advocacy service which is available should Service Users require some support to understand/make decisions. At the start of the consultation period a representative from the Joint Commissioning & Performance Management Team attended their team meeting to brief them on the proposals should that have any queries from residents/relatives.

5.4 At the time of writing this report 34 questionnaires were returned (either electronically or on paper versions). A representative from the Joint Commissioning & Performance Management Team attended 3 residents/relatives meetings (please note that this would have been more but some homes had outbreaks of diarrhoea & vomiting which prevented meetings taking place), however, all residents & relatives did have the opportunity to respond by completing the questionnaires.

5.5 The Neighbourhood Teams made contact with 4 residents and/or their relatives to discuss the proposals (it was noted that 17 residents would be financially disadvantaged by the change of policy). The main reason for the Council contracting on behalf of a Service User, where they have assets in excess of £23,250 (the upper financial limit), is that the Service User lacks the capacity to enter into a contract for themselves nor do they have any other support available to them to assist them in contracting with the provider.

5.6 Appendix B shows all the responses to the consultation and a summary of these responses is noted below. Please note that whilst 34 questionnaires were returned not all questions elicited a response. The percentages noted below relate to those responses received rather than the number of questionnaires received.

Removal of the On/Off Framework arrangement

5.7 50% of the respondents agreed with removing the existing arrangement on the understanding that it should help to increase the quality of the provision. Some people gave a very positive response to the proposal, i.e. those who would be financially better off (relatives currently paying top-ups).

5.8 The Council endeavoured to speak to the service users (who would be affected) themselves, however, one of the criteria for the Council to contract on behalf of service users is that they lack the capacity to contract directly with the care provider. The response from the service users themselves was not obtainable.

5.9 However, there were a number of service users' who did have relatives to advocate on their behalf and all of those who could be contacted (4 relatives) were against the proposal.

5.10 Concerns were raised about the quality of the service in care homes, that provider should comply with standards and that the CQC/Commissioners should do something about improving standards.

5.11 2 responders (9%) do not agree with the proposals. One responder did not give a reason whilst the other noted they didn't believe that allowing 'Off Framework' homes to "*increase fees for unspecified reasons giving them carte blanche to print money*". It is believed this response was in relation to the removal of restrictions on top-ups rather than the removal of the current framework arrangement as the fees would be set rather than allowing the providers to set whatever fee they wish.

5.12 The Commissioners agree that the removal of the off-framework arrangement could be beneficial to allowing off framework providers to invest in their service to improve standards. The Commissioners also take on board the comments about being more proactive to ensure that standards are met and to this end have also invested in a Quality Improvement Team (currently funded for 3 years) to help providers raise standards.

5.13 A large proportion of service users (or relatives) identified as being assessed as paying the full contribution towards the cost of their care did not respond. In any event any financial concerns they may have going forward will be negated by the proposal that the Council meets the shortfall.

Removal of the restrictions to third party top-ups

5.14 There were mixed views from respondents with regards to the removal of restrictions for third party top-up (for new residents). Some were in favour (22% or 4 responders) with 11% (2 responders) categorically stating that they don't agree with the proposed policy change.

5.15 Other views, which appear to disagree with the proposed policy change include:

- People shouldn't have to pay top-ups for care (22%)
- Top-ups should be for additional facilities (6%)
- Might have an adverse impact on [service user's] finances (6%)
- Concerns that all homes will charge top-ups if proposal accepted (11%)

5.16 Overall, it is deemed that 56% of responders did not agree with the proposed policy change hence the proposal not to change.

5.17 HC-One gave a response to the proposed removal of restrictions, i.e. "*we do not feel that this will make a substantial difference to providers in Tameside and shouldn't been seen as a way of bolstering provider's financial stability*". No other providers commented on the proposal.

5.18 Some responders were critical that this could cause problems in the longer term for new residents/families and make some care homes unaffordable.

5.19 Longer term there could be a financial risk for the Commissioners, i.e. where a resident has been living in a care home for a number of years (privately funded) and they seek financial support due to their finances dropping below the upper threshold, the Commissioners will need to assess the person. The Commissioners will need to take into account where they are living to determine where their needs can be met. In some circumstances, especially if a service user has been living in a home for a number of years, the care home is the only place that can meet the service user's needs. In these instances the Commissioners would need to meet the gross cost of the placement (without charging top-ups) irrespective of what the usual cost of care is (following a Best Interest Assessment to determine if the service user needs to stay at the home).

5.20 Taking account of the responses to the consultation, and the potential for increased financial risk to the Commissioners this proposal will not be taken forward and the new care home contract will continue to include the restrictions on top-ups.

Use of a Dynamic Purchasing System in lieu of the current approved list

5.21 Only one provider has commented on this and they expressed views about how this would be used by the Commissioners, i.e. they are fearful that this could be used by the Commissioners to have providers engage in bidding for service users with ever decreasing costs being put forward to increase occupancy levels.

5.22 It is not the Commissioners intention to use the DPS framework in this way, i.e. the Commissioners will have published (and agreed with providers) a set of rates that are deemed acceptable (the usual cost of care). There are no plans to use the DPS framework to undermine these published rates.

5.23 The Commissioners may use the DPS framework to aid future tenders for specific services that care homes in Tameside can bid for, e.g. should the Commissioners look to commission a specific service (for example a specialist mental health provision) the DPS framework will be used to request tenders.

6. OPTIONS CONSIDERED

6.1 A number of options have been considered for working with the care home sector.

6.2 Not contracting with the care homes at all – this was discounted for the following reason:

- The Council has a statutory duty to assess service users and meet those assessed needs. One of the services required to meet those assessed needs is 24 hours residential care provision and therefore not contracting with the care home is not an option as this would breach a stautory duty.

6.3 Continuing with the current arrangements, i.e. the On/Off Framework – this was considered but discounted for the following reasons:

- the CQC rating profiles of the off framework providers is poorer than other homes and continuing to pay the off framework providers a lessor fee than others would potentially continue this trend – this would not benefit those residents in the home and would result in a lessor quality service;
- there are fewer vacancies in the borough now than 5 years ago when the framework was introduced and, given the need to ensure 'patient flow' from the hospital into a care home of choice, the economy needs good quality care home beds to achieve this;

- one provider (who owns 2 off framework care homes) believes that the time and effort he puts in, given the level of risk and reward, is not viable and has considered selling the care homes. It is not known whether these would be sold as a going concern or whether those beds would be lost to the economy (58 beds) and would mean that a large number of residents would need to be relocated, which will have a detrimental impact on their health and well-being.
- Should an off framework provider decide to close there may not be enough vacancies in Tameside to accommodate all the residents of that home.

6.4 Removing the On/Off framework arrangement and contracting with all providers on the same basis, including the option for all providers to apply for the enhanced payment - this is the prefered option for the following reasons:

- The care home market has evolved and so is different than 5 years ago when the On/Off framework arrangement was established. The number of vacancies is significantly less than that time even though the Commissioners are purchaing approx 150 beds less and there is a need to ensure there are enough beds in the system to meet need;
- The increased investment into the off framework homes will assist to maintain their financial viability and allow the owners the opportunity to invest in the business to improve services;
- It is a simpler system to understand for all stakeholders (service users, families, assessment staff, finance, etc.) and so should reduce any confusion;
- As all care homes will be paid the same fees, with a consequent reduction in top-ups, service users (and their families) will have a greater choice of which care homes they can choose from. This will benefit the service users (and their families) and assist flow in the system;

6.5 Removing the restrictions on top-up charges and allowing all providers to charge whatever fee they wish and let market conditions determine whether the fees are appropriate – this was considered but discounted for the following reasons:

- Feedback from the consultation exercise has identified a negative response to this proposal with people stating that this could adversely affect placements in the future;
- One main provider has stated that this will make little difference in Tameside and shouldn't be seen as a way of bolstering a provider's financial stability.

7. PROPOSAL

To remove the On/Off Framework arrangement

7.1 As already stated within this report 58% of the registered beds in Off Framework care homes are rated either Requires Improvement or Inadequate. This equates to 264 beds and, whilst the Commissioners do not fund all of these placements, the Commissioners have a responsibility to ensure that the care provision is of a reasonable standard to meet needs ("Care and Support Statutory Guidance 12 February 2018 at paragraph *4.2 says The Care Act places new duties on local authorities to promote the efficient and effective operation of the market for adult care and support as a whole. This can be considered a duty to facilitate the market, in the sense of using a wide range of approaches to encourage and shape it, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways*.")

7.2 The removal of the On/Off Framework arrangement will provide additional funds to those Off Framework providers to give them the opportunity to reinvest in the services to make the appropriate improvements.

7.3 It is acknowledged that the removal of the On/Off Framework arrangement will financially disadvantage a small number of services users. To mitigate any disadvantage, the commissioners will pay the difference between the Off & On Framework rates and the proposed rates.

Recommendation to use the NHS Contract

7.4 Should the approval be given to remove the On/Off Framework the next logical step is to contract with the care homes using the same terms and conditions (currently there are some differences between the On and Off Framework contracts).

7.5 As the CCG will be co-signatories to the contract NHS England has stated that the NHS contract is used, i.e. information on the NHS website states "*The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care*" (source: https://www.england.nhs.uk/nhs-standard-contract/). Care homes are not primary care and therefore the NHS contract must be used.

7.6 The Commissioners therefore have the option of using either the full-length NHS Standard Contract or the NHS Shorter-form Contract. Following assessment of both forms of contract, discussions locally, with NHS England and the vanguard site in Nottinghamshire CCG, the NHS Shorter-form Contract is deemed to be the most suitable.

7.7 Following consultation with NHS England and confirmed in discussions with the lead commissioner in Nottinghamshire CCG (a vanguard site for a shared contract based on NHS terms) it has been agreed that CQUINs are not applied to the care homes contract. This is reflected in the 'Particulars' element of the contract.

7.8 Should the NHS standard contract be adopted this would enable other commissioners (CCGs) to use the agreement as 'associate commissioners', reducing the administrative burden on the provider and other commissioners, i.e. the providers would not have to contract separately with each CCG but would use our agreement as the basis for the contractual relationship.

7.9 Given the current agenda to integrate health and social care, including the aspiration that services transfer the Integrated Care Foundation Trust at some stage, it would also seem reasonable to 'future proof' the agreement for a future transfer.

7.10 It is proposed that the contract period will be for 5 years (1 April 2018 until 31 March 2023).

The Enhanced Payment criteria

7.11 The existing agreement includes an Enhanced Quality Scheme, which was designed to reward those providers that put extra investment into the workforce, as well as demonstrating community engagement and using 'life stories' to enhance the quality of the service. The measures included in the contract are 'proxy' quality measures

7.12 The proposed new measures would also be 'proxy' measures and the measures are noted below (full details can be seen in Appendix C):

- The Provider has organised 3 (three) or more events that involve the wider community in the previous 12 (twelve) months.
- 70% of Residents with life stories completed within 2 (two) months of admission. This relates to those Service Users who are:
  - Funded by the Commissioner
  - Are intended as Permanent Service Users
  - Have been in the Home for longer than 2 (two) months

- 85% of Staff are QCF qualified to level 2 (two) and/or are registered on a QCF level 2 (two) course (excluding modern apprentices). Registered manager qualified at level 4 (four).
- Completion of 6 (six) steps or Gold Standard Framework Accredited
- The Provider will have an overall rating of 'Good' or 'Outstanding'
- The Provider attends 75% of the Care Home Provider Forum meetings
- 80% of the monthly monitoring forms are returned

7.13 The above measures are based on the previous contract but have been amended to reflect the following:

- The Providers are having difficulties with recruitment and selection, and particularly retention of the workforce – previously 85% of the workforce had to be qualified but the new measure includes qualified and those registered to undertake a qualification;
- Providers now have to pay for qualifications at the start of the course and Workforce Development Funding is only available when the candidate has completed the course, whereas previously other funding was available on completion of the various modules – the last Skills for Care statistics noted that 40% of new starters leave care within the first year;
- Providers that have engaged with Commissioners have tended to meet the relevant standards and provide a better quality of service;
- The removal of Investors In People Silver (IIP) as providers have stated the fees for IIP have increased significantly and they believe it doesn't necessarily improve the quality of care delivery . As the Council decided not to continue investing in IIP it is proposed to remove this.
- The quality of care in care homes has received a lot of publicity and is of strategic importance to the Council. One of the public ratings of quality is the CQC rating, so this has been added to the criteria.

7.14 All other measures have remained the same, i.e. life story work, community involvement and completion of Gold Standard Framework or the 6 steps (for palliative and end of life care).

7.15 The proposed Enhanced Criteria has been circulated to the providers and, generally the feedback received has been positive. The only exception to this is the inclusion of the CQC ratings as this is beyond the control of the providers.

7.16 The Commissioners have included the CQC Rating within the criteria for the following reasons:

- The Commissioners have been criticised for paying an enhanced premium to providers that are rated either Requires Improvement or Inadequate by the CQC. The questions raised is how, as Commissioners, can we continue to pay an enhanced rate when the provider cannot meet the fundamental regulatory standards?
- The Commissioners have recently amended the contracts performance process to better reflect the CQC Key Lines of Enquiry (KLoE). This will enable the Commissioners to have a better understanding of likely CQC inspection outcomes and to better support the providers (on the assumption that they will be open and honest when completing the pre-visit questionnaire and submitting the monthly data returns). If they are honest about the current service the Commissioners can better support them to improve.
- The Commissioners have recently invested in a new Quality Improvement Team, who will be focussing on working with the providers to improve the service.

The transitional process from the current Quality Payment Scheme to the new Enhanced Payment scheme

7.17 It is proposed that care home providers are afforded 12 months to comply with the revised Enhanced Criteria with respect to a CQC rating of Good or Outstanding.

7.18 During the recent contract negotiations, including the proposal to remove the On/Off Framework arrangements, the providers were concerned about the fee levels, i.e. the providers are aware of the Commissioners financial challenges and the levels of savings required and they felt that the Commissioners, whilst removing the Off Framework element (and increasing the fees) would reduce the higher fees currently paid (for the Quality Payment Scheme) to offset the increase.

7.19 Some providers noted that, based on the current business models they are working to, any reductions in fees may necessitate a review of the business to see whether they could continue.

7.20 The Commissioners are mindful of the balance between destabilising the care homes, the number of beds required in the system and providers wishing to take advantage of the current pressures on beds required.

7.21 However, as the proposed enhanced criteria has not yet been approved, and one of the elements would be reliant on an external source to undertake assessment, it is proposed that those providers currently receiving the Quality Payment, but don't have a Good or Outstanding CQC rating, have a 12 month transitional period before any enhanced payments are reduced (albeit they would need to comply with the other elements).

Proposed fees for the 2018/19 financial year

7.22 The proposed fees are detailed in Section 8 and .are subject to a separate report to SCB on 20 March 2018.

Restrictions to third party top-ups

7.23 The Council is currently an outlier in the Northwest in the way in which it contracts with providers (notwithstanding the On/Off Framework arrangement) in that there are contractual restrictions on what top-ups can be charged for, i.e. environmental factors.

7.24 The original rationale for this (as noted in the Key Decision Report in August 2012) was that, in undertaking the rigorous usual cost of care exercise, the Commissioners believed that all reasonable costs in providing the care and support had already been taken account of (for On Framework fees) and therefore no additional charges were required by the provider. Providers could however charge for environmental factors that service users chose prior to the point of admission.

7.25 As the On/Off Framework arrangement was being reviewed it seemed logical that the restrictions for top-ups were also considered

7.26 Following the consultation exercise, and the responses received from the public and providers, it is proposed that the Council's stance remains unchanged from that agreed in the Key Decision Report in August 2012, top-ups can only be charged for environmental factors that the service users choose prior to admission.

To establish a framework agreement using the 'light touch regime' provided by Regulation 76 of the Public Contracts Regulations 2015 based upon a dynamic purchasing system

7.27 The Commissioners have operated a list for care homes for many years to ensure that service users preference for a care home can be met. The list confirms the care homes (and contact details) in Tameside, along with the On/Off Framework status of the home, and is designed to assist service user to choose a care home by providing basic details.

7.28 New care homes that open up in Tameside have been able to apply for inclusion on the list as an Off Framework provider as and when they open.

7.29 Under Regulation 34 of the Public Contract Regulations 2015 there is a mechanism to establish a Dynamic Purchasing System (DPS) from which goods and services can be procured. This is via a wholly electronic system which is open to new entrants into the market. The establishment, and maintenance, of a DPS involves the publication of a notice in the Official Journal of the European Union (OJEU). Any provider who meets minimum standards is invited onto the DPS and there is a call for competition each time goods or services are required.

7.30 Under Regulation 76 of the Public Contract Regulations 2015 which applies to Social or Other Services (also known as 'light touch services') into which care home services fall, the Commissioners are allowed to determine the procedures that are to be applied in connection with the award of contracts. In doing so they must ensure compliance with the principles of transparency and equal treatment of economic operators.

7.31 It is proposed that the Commissioners will undertake a procurement in reliance of Regulation 76 of the Public Contracts Regulations 2015 and establish a framework agreement similar in operation to a Dynamic Purchasing System. The award of contracts under the DPS will be determined by service user preference. The minimum standard criteria for access onto the DPS shall be any CQC registered care home in Tameside who is willing to sign the Commissioner's contract. The DPS will be open to new entrants that pass the minimum standard criteria. The Commissioners will ensure that an OJEU notice will be published for the duration of the arrangements.

7.32 It is further proposed that the use of the light touch regime will include flexibility to include commissioning opportunities pertaining to the local care home market e.g. for a specialised mental health service within a home in Tameside. Participants on the framework will have already been 'pre-approved' and therefore removing a stage from the procurement process.

7.33 The establishment of this list for Tameside care homes will not exclude service user choosing care homes outside of Tameside, for example, to be closer to family, in accordance with the Care Act 2014 and Statutory Guidance.

7.34 Legal Services will be consulted prior to establishing this process to ensure that the Commissioners are compliant with the Public Contract Regulations 2015.

Implications for the CCG

7.35 The CCG are a signatory to the existing contract and will continue to be signatory for the new contract, and changes in policy/arrangements are being considered in line with their governance procedures, i.e. Strategic Commissioning Board.

8. FINANCIAL IMPLICATIONS

KEY POINTS OF CONSIDERATION

Employee related costs

8.1 The National Living Wage (NLW) rate was confirmed at £7.83 on 20 November 2017 (lower than the previously assumed £7.90)

8.2 The cost of care model continues to reflect a differential rate for those workers under the age of 25 (currently representing 17% of the workforce – slightly higher than national average of 14%) – NLW guidance stipulates that this is an appropriate methodology to follow.

8.3 If the above mentioned age differential was removed it has a significant impact on the fees proposed with most bed categories increasing in excess of 12%.

8.4 Nationally approved Funded Nursing Care (FNC) rates are included at £158.16 per week following the announcement of 2018/19 rates on 6 March 2018.

8.5 Staffing ratios per bed remain unchanged in the existing fee level methodology. However these will need to be reviewed with the introduction of telehealth and assistive equipment within care homes.

8.6 A 1% sickness allowance has been included in line with CIPFA good practice.

Accommodation / Other overheads

8.7 General inflationary uplifts of 2.4% have been applied in line with the latest Office for Budget Responsibility (OBR) inflationary outlook report (November 2017) – whilst inflation is expected to peak at around 3% during Quarter 4 2017/18, it is forecast to reduce to 2.4% by March 2018, reducing further to 2.2% over the subsequent 12 month period.

8.8 The current draft fee proposal includes an element of headroom for providers.

8.9 Areas of exception to the above rate are utility costs, against which an inflationary uplift of 5% has been applied in line with forecast trends and also medical supplies against which 4% uplift has been applied.

8.10 The proposed allowances in the cost of care model for each of the other areas under this group are broadly in line with the CIPFA / ADASS report previously referenced – the main omission to the Council model is that we do not include an allowance for uniforms and this hasn't been challenged previously by providers (good practice states £16 per bed week which would impact fairly significantly on the proposed fee)

Returns / Profit Margin

8.11 Return on Land and Buildings remains at 7% based on recent Care Home Sales in GM

8.12 Profit margin remains unchanged from the previous year's assumption at 10% - this is in line with market averages and is deemed to be a reasonable allowance to allow continued investment in Care Home improvement projects.

PROPOSED FEES

8.13 Benchmarking of existing weekly rates payable inclusive of any top-up arrangements is provided at Appendix D. This analysis demonstrates that the Commissioners are in the lower quartile, with only Bolton and Salford currently paying lower fee rates. Information from other NW / comparator authorities will continue to be collected to provide a detailed understanding of differentials between actual rates paid and published base rates. Appendix E contains information regarding Derbyshire County Council's fees, although it is not possible to benchmark these in the same way as they follow a different fee structure.

8.14 The table below provides indicative details of the draft rates proposed from 1 April 2018, with a comparison of existing rates in 2017/18, should it not be agreed to remove frameworks. It is proposed that, from 1 April 2018, providers will be paid the standard rate, unless they apply for and achieve the Enhanced rate. On and Off Framework fee rates have been provided at this stage as, whilst proposed, it has not been agreed to remove the On/Off Framework arrangement.

	Residential & Dementia £	Specialist Dementia £	Nursing only £	Nursing + Dementia £
Current Rates 2017/18				
Off Framework	444.00	481.90	603.95	641.85
On Framework	480.00	521.00	640.25	681.25
Enhanced	516.00	560.00	676.55	720.55
Proposed Rates - April 2018 onwards				
Standard Rate	496.00	538.00	673.11	716.11
Enhanced Rate	528.20	572.90	716.61	762.41
Percentage change in Rates				
On Framework	3.33%	3.26%	5.13%	5.12%
Enhanced	2.36%	2.30%	5.92%	5.81%

Shared Rooms

8.15 Under the On/Off Framework arrangement only single rooms were allowed On Framework. The proposed removal of this arrangement means the shared room rate will need to be considered. Any financial impact in considering a rate increase will be minimal as it was identified (in November 2017) that only 2 residents occupied shared rooms in Tameside (out of 12 shared beds (in 6 rooms)).

8.16 The shared room rate has historically been lower than the single room rate and it is proposed that this price differential is maintained for the new fee structure. The current difference in the shared & single room rates (Off Framework fees) is:

Bed Type	Off Framework Rate – Shared Room	Off Framework Rate – Single Room	Price Difference
Residential	£389.60	£444.00	£54.40
Nursing	£517.00	£603.95	£86.95

8.17 To maintain the above price difference it is proposed that the shared room rate increases as noted in the table below:

Bed Type	Proposed Single Room Rate	Current Price Difference	Proposed Shared Rate
Residential	£496.00	£54.40	£441.60
Nursing	£673.11	£86.95	£586.16

Implications of all providers accessing the Enhanced Payment

8.18 If the proposals are accepted then all care homes will have the opportunity to apply for the Enhanced Payment. In the first year of the contract this could have the following impact:

Care Home	Anticipated start of Enhanced Payment	Full Year Impact (£)	2018-19 (£)
Home 1	01-Jul-18	28,142	21,107
Home 2	01-Oct-18	52,767	26,384
Home 3	01-Oct-18	49,249	24,625
Home 4	01-Jul-18	48,077	24,038
Home 5	01-Jul-18	51,594	38,696
Home 6	01-Jul-18	23,452	17,589
Total		253,282	152,438

8.19 Conversely, there are currently ten providers who currently receive the enhanced payment who are rated 'Good' or 'outstanding' by the CQC and could therefore lose this payment after the first twelve months of the contract.

9. EQUALITIES

9.1 In removing the On/Off Framework policy it is deemed that this would not adversely affect anyone protected by a relevant characteristic within the Equality Act 2010.

9.2 As the majority of funded residents in care homes are female (due to longer life expectancy for females) the proposed policy change would have a disproportionate impact on women (13 of the service users assessed as paying the full contribution towards their care are female and 4 are male). This is an indirect impact due to the life expectancy differential between men & women.

9.3 An Equalities Impact Assessment has been undertaken to support the proposed new arrangements and is included at Appendix F.

10. RISK MANAGEMENT

10.1 A risk appraisal has been undertaken on the recommendations in this report.

10.2 The table below sets out the risk considerations.

Risk	Consequence	Impact	Likelihood	Action to Mitigate Risk
Care homes will not agree to the NHS Shorter form contract as the basis for the new contract	Impact on the ability to contract with the care homes should they decline to sign the agreement This would mean the Commissioners cannot place service users in that home as the Commissioners have no choice but to use this contract	High	Low	Providers were informed about this in December 2017 so have been aware for a few months. A draft contract has been circulated to the care homes for their information & input Open & transparent discussions with the providers about how this contract will be managed in the short to medium term.
Providers do not agree to the removal of the On/Off framework arrangement	The contract framework would continue in its current format.	Low	None	All stakeholders have agreed to change the framework so the risk is negated.
Providers do not agree the proposed fees	The Commissioners would only be able to pay at the 2018/19 rates until further governance was obtained.	Low	Low	Providers have been made aware that the fees would be calculated using the same methodology which has been used for the previous 2 years, and providers haven't challenged this outcome.
Providers may not agree with the new enhanced rate criteria	The Commissioners would review all providers based on the current criteria whilst negotiating to amend them	Low	Medium	A transitional period of 12 months has been proposed to allow providers to comply with the revised criteria.

Risk	Consequence	Impact	Likelihood	Action to Mitigate Risk
Providers do not agree to keep to the environmental restrictions on third party top-ups	Providers will not sign any new contract that includes this criteria Commissioners will not therefore place service users at the care home.	High	Low	Providers have been consulted on the removal of restrictions and their responses have indicated it will have very little impact on their business The agreed usual cost of care methodology allows the Commissioners to purchase the majority of placements with the need for top-ups.
Providers do not agree to use the DPS framework	Providers will not sign any new contract that includes this criteria Commissioners will not therefore place service users at the care home	High	Low	Providers have been made aware of this proposal since December 2017 and been given the opportunity to voice their concerns. Support will be offered to providers to ensure they can sign up to 'The Chest' and complete the necessary tasks.
				.

11. CONCLUSION

11.1 The Commissioners have had a joint 5 year agreement in place with the local care home providers since December 2012. The fee structure used for this contract has been based on information provided by the care home owners to take account of the actual cost of care delivery.

11.2 The cost of care methodology followed the agreed methodology for the majority of the contract but latterly, and to ensure that the impact of the National Living Wage was accounted for, a number of indices were used to increase the fees (based on the original data supplied by the providers).

11.3 The proposed change in contracting with the care home providers is based on the changing market conditions and the impact of regulatory changes made by the Care Quality Commission, i.e. providers not being able to demonstrate they are meeting the fundamental standards – more so with the Off Framework providers.

11.4 Following the consultation the majority of respondents had no objections to the removal of the On/Off Framework arrangement, with the exception of those who would be financially disadvantaged. The proposal to mitigate will remove this objection.

11.5 The Council has reconsidered its proposal to remove restrictions on third party top-ups following the consultation and will keep this within the new contract.

11.6 Some concerns have been raised by providers about the new enhanced payment scheme, specifically the inclusion of the CQC rating. However, Commissioners cannot continue to pay an 'enhanced' payment when providers have not been able to demonstrate they are complying with the regulators fundamental standards. To ensure that providers are not financially destabilised in the short term a transitional period of 12 months is proposed.

12. RECOMMENDATION

12.1 As set out at the front of the report.

Residential and Nursing Care Homes in Tameside – Consultation on the proposed removal of On / Off Framework and Restriction on Top-Ups

In 2012, it was agreed that the Council would work with the care home providers differently and carried out a procurement exercise. This resulted in the borough's care homes being allocated to one of two lists, those that are "on framework" i.e. those who were successful in the procurement exercise and "off framework" being those who either didn't apply to be on the framework or who were unsuccessful in the procurement exercise.

What is the difference between an 'On Framework' and 'Off Framework' care home provider?

The providers 'on framework' were able to demonstrate (as part of the procurement exercise) that they met the quality standards required by the Council/NHS. This is not to say that the 'off framework' providers cannot meet the needs to the residents, but that they weren't able to sufficiently demonstrate this as part of the exercise or that they didn't apply to be on the framework.

There are three main differences between "on framework" and "off framework" providers:

1. The contract:

The core purpose of both contracts (on and off framework) is the resident receives the appropriate level of care and support to meet their needs. 'On Framework' care homes demonstrated they could meet the quality standards required by the Council/NHS and have more onerous terms and conditions to meet to ensure that the appropriate standard of care and support is given.

2. The fees that the Council will pay:

The Council pays a higher fee to 'on framework' providers than it does to 'off framework' providers. The fee levels were agreed following substantial consultation with the care home sector. The higher fee paid to 'on framework' providers is in recognition that they demonstrated they could meet the quality standards required by the Council/NHS as part of the tender.

The "off framework" fee although lower, represents a level that residential care can still be provided at. The lower fee, however, has in some way contributed to the fact that many 'Off Framework' care homes in Tameside have struggled to meet Care Quality Commission standards.

3. Additional charges that the care homes can charge for (third party top ups):

On framework' providers are only able to charge additional fees (or top-ups) for environmental factors that you have expressed a preference for, e.g. an en-suite, a larger room, etc. There should be no top-up for meeting the assessed needs of the resident unless you wish to pay privately for services rather than accept the free provision that the care home provides/arranges for the resident.

Off Framework' providers are free to set whatever fee they wish to and can charge top-ups for the basic service provision. As the Council will pay providers 'off framework' less than those 'on framework' the level of top-up may be greater in these homes.

Proposal
We are proposing to change the way in which we contract care homes in Tameside. There are two outcomes of this proposed change that we are seeking your views on.

1. **Removal of 'On / Off Framework' arrangement**

Removal of the 'On / Off Framework' will mean each care home in Tameside is contracted on the same basis, adhering to the same quality standards and paying the same amount for each resident. This will mean that the fees paid to the current 'Off Framework' providers, where the Council holds the contract, will increase by approximately £36 - £39 per person per week (depending on whether they are in residential or nursing homes). A list of all Off Framework Care Homes in Tameside can be found at Appendix A.

The majority of people who live in a Tameside care home will not be directly affected by this change as their contribution to the cost of their care is capped. However, there are a small number of care home residents who pay the full contribution to the cost of their care (under a council contract) who would be directly affected by this change, i.e. they will be charged an additional £36 - £39 per week depending on the care setting.

Overall, it is anticipated that a significant amount of care home residents (in Off Framework homes) will benefit from this as the care homes will have more money to improve the quality of service.

There is another group of people who could directly benefit from this change in policy. They are family and / or friends who are currently paying top-ups for their loved ones in 'Off Framework' care homes. It is anticipated that the cost of the top-up payment would reduce by the increase that the Council pays (e/g. £36/week), meaning that they will pay less.

2. **Removal of restrictions on third party top-up charges**

We are also considering another change for those care homes who are 'On Framework' which would remove restrictions of third party top-up charges. Currently 'On Framework' care homes can only charge extra for environmental factors that care home residents choose in relation to their facilities e.g. an en-suite bathroom or a larger than average room (similar to choices made when booking hotels).

Following discussions with care home providers we are considering removing this restriction for new residents and that the care home will be able to charge a top-up without having to state it is for anything specific. **This will only affect new care home residents as we will instruct care home providers not to impose this charge on existing residents.**
(Please note that 'Off Framework' homes have been able to charge unrestricted top-ups since 2012.)

We are inviting your views on how our proposals impact on you. Please tell us your thoughts by no later than **31 January 2018**. You can complete the questionnaire online at http://www.tameside.gov.uk/tbc/residentialandnursingcare

In case of any queries or to request more paper copies please contact commissioningteam@tameside.gov.uk.

Appendix A: List of Off Framework Care Homes (in Alphabetical Order)

AUDEN HOUSE
473 Audenshaw Road
Audenshaw
Manchester
M34 5PS

BALMORAL
29 Old Road
Mottram
Hyde
SK14 6LW

BOWLACRE HOME
Elson Drive
Stockport Road
Hyde
SK14 5EZ

CARSON HOUSE CARE CENTRE
30 Stamford Street
Stalybridge
SK15 1JZ

CLARKSON HOUSE RESIDENTIAL CARE HOME
56 Currier Lane
Ashton-U-Lyne
OL6 6TB

DOWNSHAW LODGE NURSING HOME
Downshaw Road
Ashton-U-Lyne
OL7 9QL

FIRBANK HOUSE
24 Smallshaw Lane
Ashton-U-Lyne
OL6 8PN

HATTON GRANGE
Oldham Street
Hyde
SK14 1LN

OAKWOOD CARE CENTRE
400a Huddersfield Road
Stalybridge
SK15 3ET

POLEBANK HALL RESIDENTIAL CARE HOME
Stockport Road
Hyde
SK14 5EZ

ST LAWRENCE'S LODGE
275 Stockport Road
Denton
Manchester
M34 6AX

THE VICARAGE RESIDENTIAL CARE HOME
109 Audenshaw Road
Audenshaw
Manchester
M34 5NL

Consultation

1. Are you a care home resident in Tameside? (Tick one box only)

- ☐ Yes (If yes, go to question 3)
- ☐ No (If no, go to question 2)

2. Is a family member or friend a care home resident in Tameside? (Tick one box only)

- ☐ Yes (If yes, go to question 3)
- ☐ No (If no, go to question 4)

3. Will the proposed changes to the 'On/Off Framework' impact you or your family member or a friend who is a resident of a Tameside care home directly? (Tick one box only)

- ☐ Yes
- ☐ No

4. Do you have any comments you wish to make about the proposed changes to the 'On/Off Framework'? If you, or your family member or friend who is a resident of a Tameside care home is directly impacted by our proposed changes to the 'On/Off Framework' please explain how? (Please state below)

5. Do you have any comments you wish to make about our proposal to remove the restrictions for third party top-up charges? (Please state below)

6. Do you have any other comments you wish to make about our care home proposals? (Please state below)

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

- ☐ A care home resident
- ☐ A relative or friend of a care home resident
- ☐ A care worker in a care home
- ☐ A member of the public
- ☐ A Tameside Council employee
- ☐ A community or voluntary group
- ☐ A partner organisation
- ☐ A business/private organisation
- ☐ Other (Please specify)

About You

8. What best describes your gender?

- ☐ Female
- ☐ Male

9. What is your age? (Please state)

10. What is your postcode? (Please state)

11. 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 Black African
- ☐ White and Asian
- ☐ 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
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (Please specify)

Other ethnic group

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

12. What is your religion?

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

13. What is your sexual orientation?

- ☐ Heterosexual/Straight
- ☐ Gay man
- ☐ Gay woman/lesbian
- ☐ Prefer not to say
- ☐ Prefer to self-describe (Please self-describe below)

14. 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

15. 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

16. Are you a member or ex-member of the armed forces?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Please return consultation to the care home in which you or your friend or relative lives. Alternatively return directly to Tim Wilde, Strategic Commissioning Team, Tameside MBC, The Hub, Stockport Road, Hattersley, Hyde, Tameside SK14 6AF

Appendix B

Commissioner Response to Feedback from the Consultation Exercise

Comments received from the questionnaires (either via The Big Conversation or the care homes)

Area/Theme	Comments/Concerns/Feedback	Commissioner response
Quality of provision	All care homes should be to standard agree by Council /NHS and residential client /family inspected by a governing body with reports posted in the public domain	The Commissioners are working closely with providers to ensure that the quality of care and service offered meets the needs of the residents. The Commissioners undertake planned annual visits and, where necessary, work with care home to improve the service, and new processes have recently been put in place to assist with this. The Commissioners also liaise with the Care Quality Commission (the regulators) to share appropriate information about the quality of the service. All Care Quality Commission reports are in the public domain.
	ALL care /nursing homes should meet the same high standards. We looked at nursing homes for my (late) father and believe me I would not board and animal there. Some were disgusting.	Please see the above comment
	All Tameside care homes should meet the requirements of the NHS/CQC/Council before the Council makes any payments to that home.	Please see the above comment.
	All care homes should meet the NHS/CQC/Council requirements or be closed.	Please see the above comment. The Commissioners do not have any regulatory powers to close a care home and, because it is a home to a number of residents, the Commissioners work closely with the providers to improve services rather than 'evicting' vulnerable people from their place of residence.
Changes to the On/Off Framework arrangement	We are not directly affected by these changes but may be in the future. Overall, they seem to be fair.	No response required
	This will nor [not] impact on my relative's care.	No response required

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	It may mean that the top up fees paid might be less.	On the assumption that providers gross costs remain the same then any top-up paid to an off framework provider would reduce.
	I consider that all residents in care homes in Tameside be treated equally and that the on/off framework be removed and top ups be restricted although I do not have any relative living in care homes I have worked for Tameside in the past and part of my job included monitoring he standards of the care and nursing homes and Ignis [it is] my opinion that all such places meet fully the standards of care.	No response required
	It makes sense to have a level playing field and top up fees to meet the true costs of care.	No response required
	My mum is in [care home] and we have to pay a top up. My husband and I are pensioners and finding another £184/month is asking a lot.	On the assumption that providers gross costs remain the same then any top-up paid to an off framework provider would reduce.
	The new proposal would make it less stressful and uncomplicated to understand, as it can be quite complicated with how much is paid by Tameside and how much the family has to pay toward the cost of the fees.	No response required
	It is a good idea to make it easier	No response required
	Yes improve my money	On the assumption that providers gross costs remain the same then any top-up paid to an off framework provider would reduce.
	We feel an equal playing field will help improve care for residents in all off framework homes	No response required
	As a family member this will relieve me of any top-up charges if this is abolished.	On the assumption that providers gross costs remain the same then any top-up paid to an off framework provider would reduce.
	Whilst I appreciate the cost of care is a problem, I do not think that the outlined proposals are the solution, particularly	At the moment the off framework care homes can charge whatever they wish without the need to justify what any additional fee is (over and above the Commissioner's rate). The proposal was to level the playing field, both with the fees paid by the

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	allowing 'off framework' homes to increase rates for unspecified reasons giving them carte blanche to print money.	Commissioners and by removing and top-up restrictions. However, having given regard to the comments received for this consultation the Commissioners are minded to retain the restriction on top-up charges.
	I agree that the on/off system should be removed so that all care homes would be expected to provide the same high quality of care which is a fairer system for the residents.	No response required
Removal of top-up restrictions	I think it is better that all care homes are on an equal system	No response required
	What are these top up charges for additional facilities A basic stand of en-suite wash basin and toilet for all residents	In current off framework care homes the top-up fee doesn't have to be anything specific, but reflects the fee that the provider wishes to charge. In on framework care homes the top-up fee can only be charged for environmental factors, i.e. en en-suite or a larger room.
	Do not expect family members to meet residential costs	The Commissioners have worked closely with the care providers over a number of years to identify a usual cost of care. This usual cost of care reflects what is believed to be an accurate reflection of how much a residential or nursing placement should be able to be provided for. However, providers have the opportunity to charge more than this, the costs for which would need to paid by a third party. However, this should be made clear prior to a resident choosing to live in a care home so an informed choice can be made.
	There should be no top-ups for basic needs only extras such as larger room/en suite.	No response required
	People pay enough for their care. So shouldn't have to pay top up charges.	Please see the comment above, i.e. providers have the option to charge more than the calculated fee.
	Makes sense	No response required.
	This is very likely to cause problems for people in the future, paying for care	No response required.
	This proposal will eventually lead to all homes charging a top-up fee. In cases where the Council pays the fee and the resident has no means of paying the top-up charge - who will pay it? If the Council doesn't where will the people go for care?	In cases where all care homes charge a top-up the Commissioners would need to revisit the usual cost of care to ensure that they could purchase enough beds to meet the needs of the service users. People would still retain a choice to go into care homes that charge more than the Commissioner's usual cost of care.
	I really don't think there should be any third	The Commissioners have worked closely with the care providers over a number of

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	party top up.	years to identify a usual cost of care. This usual cost of care reflects what is believed to be an accurate reflection of how much a residential or nursing placement should be able to be provided for. However, providers have the opportunity to charge more than this, the costs for which would need to paid by a third party. However, this should be made clear prior to a resident choosing to live in a care home so an informed choice can be made.
	I think this will benefit homes in the future, overall improving the health and wellbeing of all residents in care homes in Tameside	Unsure whether this should be in response to the removal of the On/Off framework arrangement. However, no response required.
	Would be better to remove.	No response required
	If the On/Off Framework is removed, then all care homes should be expected to provide the same quality of care if being paid the same Council fees. I believe then that top-up fees should be accounted for.	The Commissioners should be aware of all top-up arrangements in the borough and to ensure that they are charged for correctly.
	Although the removal would not affect my mother at the moment it may in the future. I would strongly object to being made to pay a top up without any additional benefits for my mother being identified or offered. In normal contract law who pays for something without knowing what they are purchasing? Surely this just gives free license to be charged whatever, without the home having to qualify or explain where monies are to be used in residents care. If a home requires more money to operate commercially & maintain standards then I would argue it is the local authority's responsibility to address this, not a resident or relative. Also I would be worried impact his would have on new residents, or people being upgraded, where no-one is available to pay a third party top-up. The L.A. is responsible for managing the market & ensuring sufficient provision is available. The effect of this proposal would	The proposal to remove restrictions on top-up charges would be for new service users only, who would make an informed decision prior to living in a particular care home. Existing residents would not be affected. The Commissioners have worked closely with the care providers over a number of years to identify a usual cost of care. This usual cost of care reflects what is believed to be an accurate reflection of how much a residential or nursing placement should be able to be provided for. However, providers have the opportunity to charge more than this, the costs for which would need to paid by a third party. However, this would be made clear prior to a resident choosing to live in a care home so an informed choice can be made.

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	be to place the burden on current residents and their families.	
	I think it would be fairer for most people	No response required
	As per point 3 [regarding the removal of On/Off framework] I do not agree with this proposed change.	No response required
Other comments received	Cost of Local authority fund should be topped up by TMBC rate payers	No response required
	Care home proposals should primarily and fully consider the residents and their families	The Commissioners needs to balance a number of factors when considering policies. In this instance the needs of the residents and their families is very important, as is the need to ensure that any proposals are financially viable.
	I think all care homes should charge the same amount to social services funded residents and private funded residents. Also they should all meet Care Quality Commission standards and they should be checked more often.	The Commissioners cannot tell the providers what they can and cannot charge for residents that are not covered under their, i.e. for private funded residents, as they have no jurisdiction to do so. The Commissioners are pro-actively working with the care homes to ensure that all appropriate standards are met. The Commissioners do not cannot influence how often the Care Quality Commission visit providers to check whether they are meeting standards.
	Whilst it does not directly affect me at this moment, it would appear that there are both benefits and disadvantages with these proposals.	No response required.
	Some comments noted that respondents were confused by the questionnaire and some of the language it contained. One respondent expressed a view that this was to bamboozle the public so the Commissioners can just do whatever they like	It was not the intention to use confusing language to bamboozle people so that the Commissioners can make whatever decision they want. Where people were confused and felt they couldn't seek advice/support then an apology is given.

Comments received from Providers as part of the on-going consultation

Area/Theme	Comments/Concerns/Feedback	Commissioner response
Removal of the On/Off Framework arrangement	HC-One understand the desire to harmonise rates across the borough and agree the on/off framework distinction isn't relevant going forward.	No response required
Fees	We estimate however that the value of the "on framework" premium to HC-One is approximately £1.3m. We naturally would need reassurance that any removal of the differential would not result in an overall net loss of income across the 16 homes we operate in Tameside. Any further reduction in income, especially when taken in the context of the FNC discussions in 2017, would have a huge effect on the stability of the market. We understand your desire to incentivise quality improvement. We suggest the best way to do that is to operate a gold, silver, bronze system which really incentivises improvement but in a way that is light touch and easy to administer. We understand the CCG team have a new KPI requirements so perhaps rather than creating a 2nd quality monitoring system, you might want to harmonise arrangements. Again though, the standard fee structure needs to reflect the reality of providing care in Tameside and be cognisant of providers evidenced cost of care submissions. We believe that in order to truly turn the curve of provider performance and CQC quality ratings in Tameside, there needs to be an injection of investment in residential and nursing care sector, co-ordinated with the CCG. The system wide benefits of doing this will be considerable and without a large scale investment we anticipate that the market will shrink which will lead to higher out of area costs.	The Commissioners consider that investing in social care is a priority and are not looking to reduce the amount of money paid to current On Framework providers, but to increase to basic fee paid to Off Framework providers to match that of On framework. The Commissioners will contract with all care homes on the same basis, which will also include an enhanced payment scheme that all providers will be able to apply for (should they meet the criteria), therefore incentivising improvement. It is anticipated that the differential between the standard rate and the enhanced rate will remain the same (subject to any annual uplifts, which may affect each rate differently). By investing more into the market, not just financially, but by the establishment of a Quality Improvement Team to support providers to meet the appropriate standards, the Commissioners hope to see an improvement in the local market. In Tameside, the Council & local CCG have worked closely over several years and was one of the only Council's & CCG's to operate a joint contract for residential & nursing care. This arrangement will not change. The new KPIs introduced by the Commissioners are to assist with overseeing the currently quality of the provision, and have not been designed with the aim of using them to determine payment. To incorporate the two systems could incentivise providers to start 'gaming' and to not necessarily accurately report on all elements and/or modify the service to hit 'targets', which could distort the assessment of quality, which could in turn mean that Commissioner's resources aren't targeted appropriately to improve standards.
	For the past 5 or more years, I have been basing my business plan on the fee levels I receive as an 'on framework	Please see the above comment, i.e. fee levels for current Off Framework providers will increase, rather than a new 'average' fee

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	enhanced' operator. This means that amongst many other things my care staffing levels, my staff pay, my quality control measures and my overall operation is at an enhanced level. I am concerned right now that there is a possibility that I will be put on a par with homes who do not and have not considered over the past 5 years, the importance of the level of quality we do. Also that you are going to pay them the same rate. You mentioned to me that you are considering an enhanced level over and above the new rate. However, we will not get to know how to qualify for this level until the last minute therefore not giving us the opportunity to achieve it, which would be highly unfair and counter- productive. As you know, I have tried to avoid getting into debates over recent years on fee levels. However you need to be aware the we fast approaching the state of affairs that were the case in in the 1990s where it became more viable to sell ones care home to a developer, than to continue to operate whether beds are full or not. If my fee levels going forward are reduced and you expect me to recover them by way of future 'Top Ups', I amongst other could well be forced into that difficult decision. I would urge you and your colleagues to ensure that any enhancement you make is achievable by the homes already achieving it and that it takes into account, the much higher costs homes face alongside the increased expectations and much higher dependency levels of clients available to us, particularly in Tameside.	level being created. The enhanced payment will be broadly based on the old criteria, which has been modified to take account of some providers views. There are also some new criteria added, which has already been shared with providers. As a key new criterion has been added, those providers currently receiving the enhanced payment will have 12 months to ensure they are able to meet the criteria. It is anticipated that by using the current cost of care methodology (albeit reviewed on a periodic basis to ensure its validity) that the Commissioners published usual cost of care should maintain providers viability. Providers continue to choose to charge more for environmental factors (the proposal to change this will not be enacted – based on feedback from the conversation).
Removal of Top-up restrictions	Whilst we acknowledge that 3rd party top-ups are becoming the norm in the majority of local authority areas in England and Wales, we do not feel that this will make a substantial difference to providers in Tameside and shouldn't been seen as a way of bolstering provider's financial stability	It was not the Commissioner's intention that top-ups should be seen as a means to bolster a provider's financial stability. The Commissioner's believe that the methodology used to calculate the usual cost of care is a good reflection of the actual costs required by providers to maintain their financial stability, but the proposed removal of restrictions would bring the Commissioners contract in line with the vast majority of other care home contracts. However, based on the responses to this consultation the Commissioner's will

Area/Theme	Comments/Concerns/Feedback	Commissioner response
		be maintaining this restriction.
Self-funders/private residents	We would like to reiterate that the local authority rate that we allow Tameside to place residents at is only for those residents who are fully funded by the local authority. Any resident or potential resident who is defined as a self-funder in the regulations (including those who are under DPA) are not eligible for the local authority rate and will be charged the full self-fund rate. We reserve the right to serve notice on any placement that has been made incorrectly.	This matches the decision made in August 2012 and the current contract. No change to this provision will be made in the new contract. Prior to notice being served the provider will need to liaise with the Commissioner's as there may be good reason why it continues to contract for, and on behalf of, a service user, i.e. that service user lacks capacity and has no other support available to them to contract on their behalf. In such circumstances the Commissioner's will continue to contract at the published usual cost of care. This is in accordance with the decision made in August 2012 (section 12.11 of the Key Decision taken in August 2012)
New Contract	We welcome the news that there will be a new contract within Tameside. Given our vast experience of contracting with UK commissioners we feel that we could add significant value to be part of the process in developing the new contract. We believe you should use the opportunity of a new framework contract to acknowledge the growing issue of complexity, co-morbidity and acuity as people stay at home for longer and come into residential care later than they might have done in years gone by. We believe the fee structure should be flexible, have new bandings and responsive to when people's situation and care needs change. We would also ask that you use to opportunity create one contract covering all CHC and council funded placements. The rules and regulations on equipment should be clarified and made crystal clear.	The Commissioners thank the provider for their offer of support. The new contract framework will be based on the NHS Shorter Form and has already been shared with providers (albeit in a draft form). The locally agreed specification has not changed from the previous contract, which providers had the opportunity to comment on in August/September 2017, and the Commissioners have taken the view that provider remain satisfied with the content of the specification. The Commissioner's (Council & CCG) already use a joint contract and will continue to do so, albeit the format will change to using NHS terms and conditions rather than locally agreed contract conditions. The latest equipment policy has been circulated to all providers in Tameside and clearly sets out the roles and responsibilities of the provider and Commissioner's
Use of a Dynamic Purchasing System	Again we have a significant amount of experience in using DPS systems and while not against them in principle, we would council against creating a "race to the bottom" where providers are encouraged to undercut each other and submit the lowest price to secure occupancy. Ultimately this will lead to a very unstable market. Where DPS systems work well, they are underpinned by a realistic fee structure and	The Commissioners intention to use a Dynamic Purchasing System (DPS) was a way of creating an electronic 'Approved List' and to be used for any future tenders. It would not be used to determine the cost of individual placements (for those who come under the contract) as these costs will have already been agreed using the cost of care methodology.

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	concentrate on the provider's ability to deliver care based in the individual's needs. To do this effectively, the pen pictures of the individuals need to be consistent and accurate to allow managers to efficiently determine if a face to face assessment is appropriate	Should the Commissioners wish to use the DPS for tendering purposes it will be distinct services that providers will have the opportunity to submit prices and, as with all tender processes, those prices need to reflect the on-going requirement for a provider to maintain profitability. All relevant information will be included within the tender documentation to allow providers to submit prices they believe are realistic.

Feedback from those directly affected by the proposed change of policy, i.e. residents under the Commissioners contract who are assessed as paying the full contribution towards to cost of care (17 service users were identified)

Area/Theme	Comments/Concerns/Feedback	Commissioner response
Removal of the On/Off framework arrangement	Comments from his wife: 'This is frightening and awful' 'I have saving and now I have to pay more and now I have to look at his finance' 'I wish he just has the threshold amount' 'now I have to pay extra out of my money for living' 'I am worried that I am going to be hit with a bill'	The Commissioners have onboard that the initial increase in fees could cause anxiety, but is also mindful of the need to treat all service users equally. However, the Commissioners are proposing to levy the increased charges over a two year period, rather than at the start of the new contract, i.e. on the 1 April 2018 the charges will increase by 30% at the start of the first year, 60% at the start of the second year with the charges matching the full cost by the start of the third year. A worked example of this is shown in section 7.3 above.
	Comments from her Son: 'Yes. It impact on me financially as I am trying to live my life as much as I can.' 'My mum is seriously ill at the minute and I just don't need the stress… I am meeting with the doctor tomorrow as my mum is really ill and not eating.'	See the above Commissioner response.
	The increase cost for off framework home will have a financial impact on [service user] finances. He will have less money to spend on himself and personal items. [Service User's Daughter] also said that all care home should be on framework.	See the above Commissioner response.
	[Service User's Daughter's] view, is that she likes [care home] and is happy with the carers and care delivery. [Service User's Daughter] feels that the cost of 24 hours	See the above Commissioner response. The Commissioners cannot direct the care home provider where to spend the fees, but the increased fees to [current] Off Framework

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	residential is expensive, when you are a full cost payer or home owner and the increase will have an impact on [service user] who still has a property that she is maintaining until it is sold. [Service User's Daughter] would prefer not an increase as this will effect [Service User]'s finances. But [Service User's Daughter] would like to know that the money will go directly to the home and the carers and not take by owner/ organisation. [Service User's Daughter] would like to see with the increase for off framework, will result in staff increase. [Service User's Daughter] would like further information on this matter and the process.	providers will allow them to invest more into the business to improve services.
Removal of Top-up restrictions	'I don't see why it has to come from a family member or friend this should not be there responsibility'	Where providers wish to charge more for care than the Commissioners usual cost of care, and the Commissioner is contributing towards to the cost of the placement, then service users are not allowed to pay a third party contribution themselves (except in exceptional circumstances, i.e. during a 12-week property disregard period of if they are a 'Relevant Resident' (they have a property to sell but have not yet managed to do so).
	[Service User's Daughter] hopes that the increase will mean that the staff at the home get a better pay.	The Commissioners cannot direct the care home provider where to spend the fees, but the increased fees to [current] Off Framework providers will allow them to invest more into the business to improve services.
	[Service User's Daughter] has no comment to make on third party top up, as [care home] does not have a third party top up in place.	No response required

Feedback received during residents/relatives meetings

Area/Theme	Comments/Concerns/Feedback	Commissioner response
Removal of the On/Off framework arrangement	Those present agreed it was a good idea to contract with all care homes on the same basis, but improvements need to be monitored.	No response required
	Agree to contract with all care homes the same	No response required

Area/Theme	Comments/Concerns/Feedback	Commissioner response
	Agree with the proposal to contract with all care homes on the same basis	No response required
Removal of Top-up restrictions	Didn't agree to this and felt that the current restrictions to environmental factors should remain.	No response required

Proposed Enhanced Payment Scheme

ENHANCED PAYMMENT SCHEME

1. ACCESS TO THE ENHANCED PAYMENT SCHEME

1.1 The Provider will need to be able to demonstrate compliance with all the standards noted below to be eligible for an Enhanced Payment.

1.2 The Commissioner will invite the Provider to apply in September of each year.

1.3 The Provider will need to provide evidence that each standard has been achieved.

2. OPERATION OF THE ENHANCED PAYMENT SCHEME

2.1 Invitations for assessment/re-assessment will be sent to Providers in line with the timescales noted below:

2.1.1 mid-September – Letter of invitation for assessment/reassessment and self-assessment forms to be issued;

2.1.2 end of September – applications must be received by the Commissioner;

2.1.3 end of October – assessments completed;

2.1.4 mid November – Providers advised of the outcome of the assessments/reassessments.

2.2 Should the Provider be successful the Enhanced Payment will be applied from the following April.

2.3 Unsuccessful Providers will have up to 3 (three) months to demonstrate compliance with the enhanced criteria. Failure to demonstrate compliance after this time will mean the removal of the Enhanced Payment for the next financial year.

2.4 Should the Provider fail to apply for the Enhanced Payment Scheme or successfully demonstrate the required standard any Enhanced Payments will cease from the following April.

3. ENHANCED QUALITY CRITERIA

3.1 The standards below are the current standards and may be modified from time to time by the Commissioner.

Standard	What we expect to see	Criteria

Standard	What we expect to see	Criteria
Residents are supported to maintain relationships with family, friends and other networks. They are enabled to establish and maintain social networks and access community facilities.	The home works proactively to involve the wider community in the home and makes use of its resources, including for example the involvement of community groups, schools and volunteers	The Provider has organised 3 (three) or more events that involve the wider community in the previous 12 (twelve) months.
Up to date person centred support plans, pen pictures and risk assessments are in place and agreed with residents. These are regularly reviewed, consulted on and used.	Life story work has been undertaken with the majority of Residents and their families/friends and is used by Staff routinely and to inform activity programmes. A life story book should be in place within 2 months of admission. Where this is not possible due to lack of contact with the Resident's family, and the Resident having dementia or a condition which has meant their ability to provide this information is limited, the Provider must demonstrate that steps have been taken by Staff to get as much information as possible. Plans and Staff interaction with Residents reflect life story work undertaken and also that 'visual triggers' have been assessed which Staff have noted through observation of Residents. This demonstrates that care is evolving to become increasingly person-centred as Staff have more observations and more information to develop appropriate care plans with.	70% of Residents with life stories completed within 2 (two) months of admission. This relates to those Service Users who are: • Funded by the Commissioner • Are intended as Permanent Service Users • Have been in the Home for longer than 2 (two) months
Staff in the Home are highly capable with relevant qualifications and experience as well as regular training and investment in their development.	The Staff team has a range of skills, training and experience - QCFs or Diploma in Health and Social Care, level 2 and 3/ Nursing/ qualified first aiders available. All trained nurses should be Nursing and Midwife Council (NMC) registered and keeps up with the NMC requirements. Staff providing personal care and those left in charge of the Home have the appropriate knowledge, skills and experience.	85% of Staff are QCF qualified to level 2 (two) and/or are registered on a QCF level 2 (two) course (excluding modern apprentices). Registered manager qualified at level 4 (four).

Standard	What we expect to see	Criteria
	The Provider demonstrates on-going commitment to enhancing service provision for end of life care at the Home. This can be demonstrated through either GSF accreditation or the completion of the 6 steps process. The home must continue to be re-accredited and re-assessed annually.	Completion of 6 (six) steps or GSF Accredited
The Provider is meeting the requirements of the Care Quality Commission	The Provider is meeting the requirements of the CQC and this is demonstrated in the published reports	The Provider will have an overall rating of 'Good' or 'Outstanding'
The Provider is engaged with the Commissioner	The Provider attends the Commissioner arranged Provider forums.	The Provider attends 75% of the meetings
	The Provider consistently returns the monthly monitoring forms	80% of the monthly monitoring forms are returned

4. WITHDRAWAL OF THE ENHANCED QUALITY PAYMENT

4.1 The Enhanced Payment will automatically cease during any suspension of new placements as detailed in clause [insert clause in new contract].

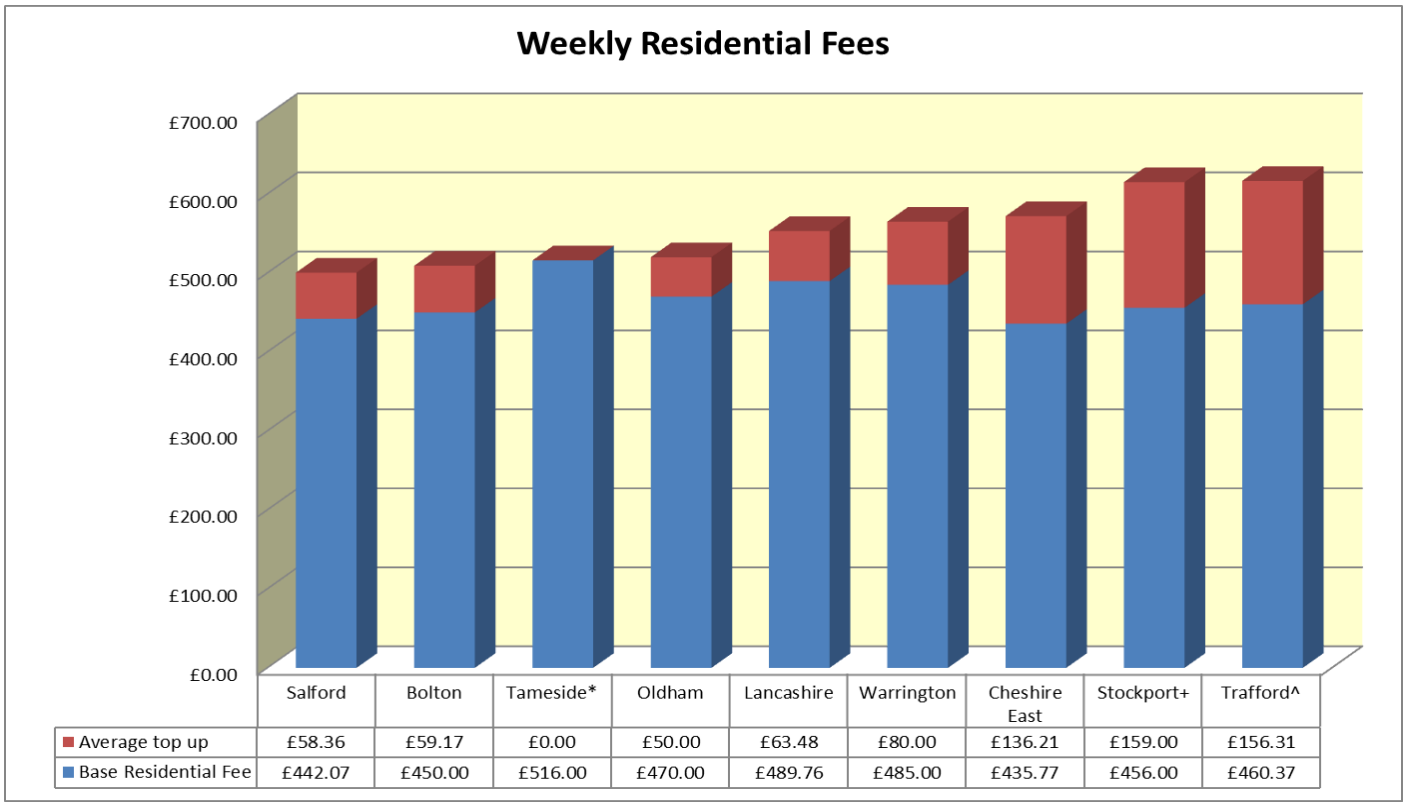
4.2 During the course of the Commissioner's duty to ensure the Provider's performance it may be noted that the Provider is not complying with the Enhanced Standards. Where this is the case the Provider will be given 3 (three) months to rectify the situation. Failure to do so will mean the removal of the Enhanced Payments.

4.3 Notwithstanding clause 4.2 above the Enhanced Payment will cease from the date the CQC publishes a report that states the provider is not rated 'Good' or 'Outstanding' as an overall rating.

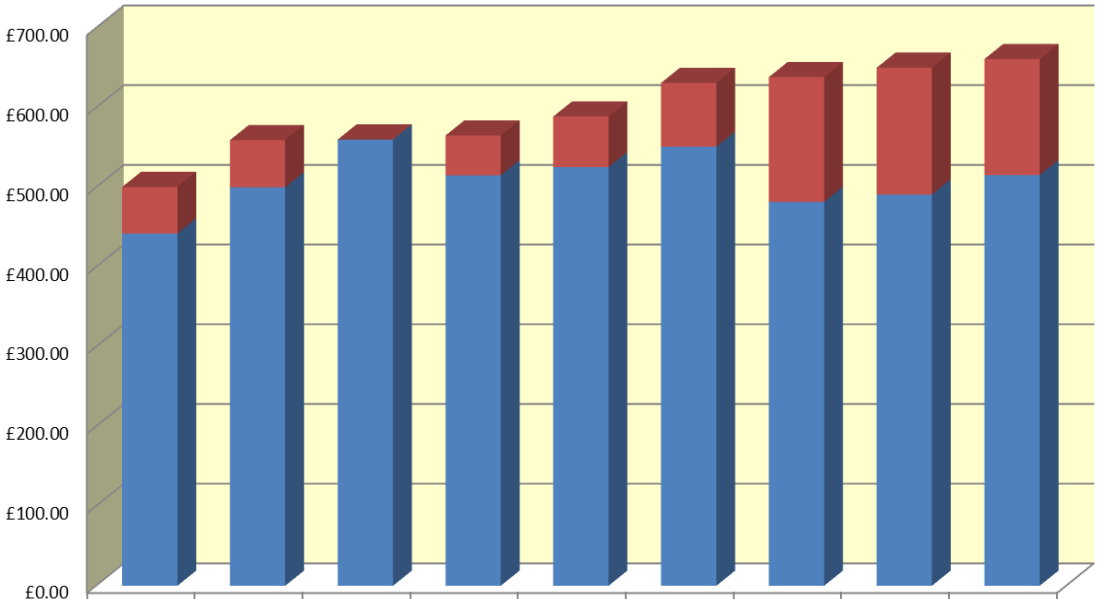
Appendix D

Benchmarking Data

	2017-18 Actual Fees paid (inclusive top-ups)			
	Residential	Residential with dementia	Nursing~	Nursing with dementia~
Tameside*	£516.00	£560.00	£520.10	£564.10
Trafford^	£616.68	£638.09	£633.99	£693.29
Salford	*£500.43*	*£500.43*	*£500.43*	*£500.43*
Lancashire	£553.24	£588.86	£558.98	£647.92
Bolton	*£508.36*	*£558.36*	*£508.36*	*£558.36*
Warrington	£565.00	£631.00	£642.00	£673.00
Cheshire East	£571.98	£660.93	£707.80	£671.63
Oldham	£520.00	£565.00	£520.00	£565.00
Stockport+	£615.00	£650.00	£663.00	£691.00

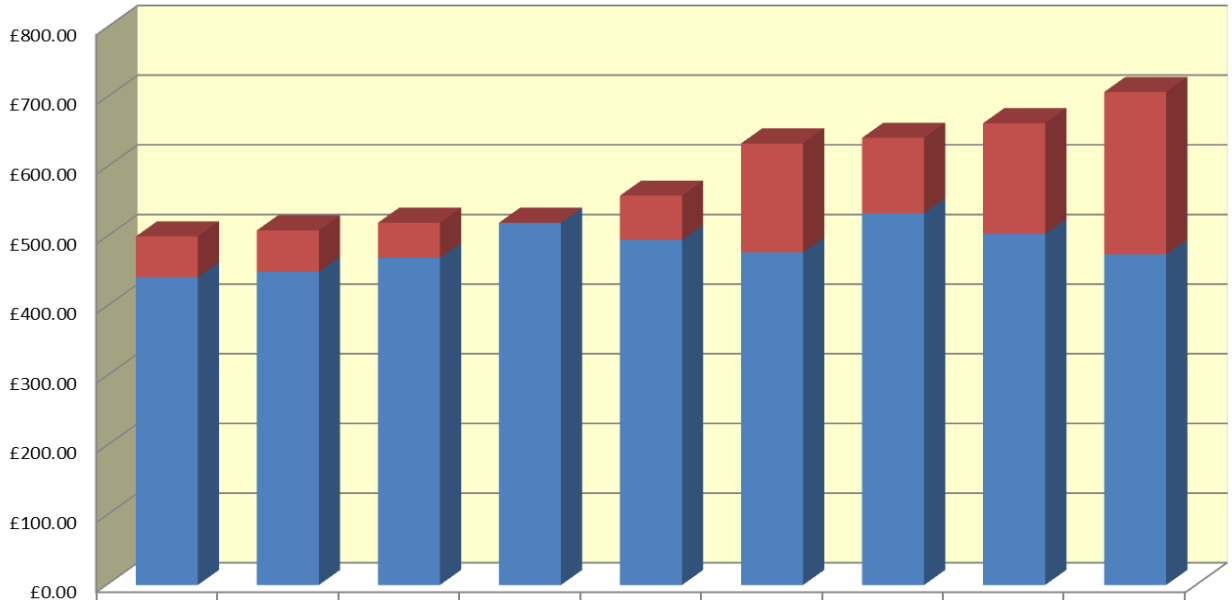


Weekly Residential w/Dementia Fees

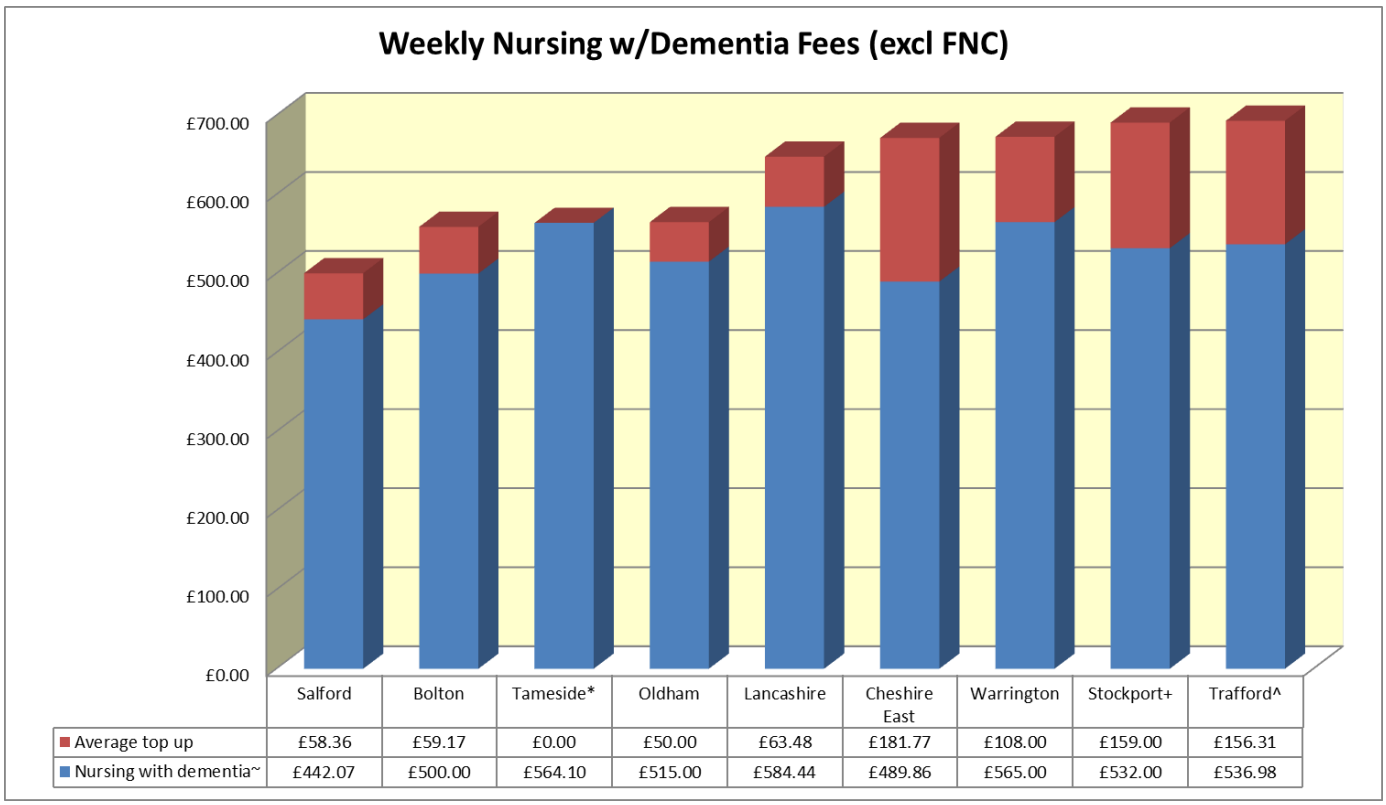


	Salford	Bolton	Tameside*	Oldham	Lancashire	Warrington	Trafford^	Stockport+	Cheshire East
Average top up	£58.36	£59.17	£0.00	£50.00	£63.48	£80.00	£156.51	£159.00	£145.59
Base Residential w/dementia Fee	£442.07	£500.00	£560.00	£515.00	£525.38	£551.00	£481.78	£491.00	£515.34

Weekly Nursing Fees (excl FNC)



	Salford	Bolton	Oldham	Tameside*	Lancashire	Trafford^	Warrington	Stockport+	Cheshire East
Average top up	£58.36	£59.17	£50.00	£0.00	£63.48	£156.31	£108.00	£159.00	£233.27
Nursing~	£442.07	£450.00	£470.00	£520.10	£495.50	£477.68	£534.00	£504.00	£474.53



	Salford	Bolton	Tameside*	Oldham	Lancashire	Cheshire East	Warrington	Stockport+	Trafford^
Average top up	£58.36	£59.17	£0.00	£50.00	£63.48	£181.77	£108.00	£159.00	£156.31
Nursing with dementia~	£442.07	£500.00	£564.10	£515.00	£584.44	£489.86	£565.00	£532.00	£536.98

Appendix E

DERBYSHIRE COUNTY COUNCIL

ADULT CARE FEE RATES FROM 1st October 2017 (REVISED)

NURSING CARE	Standard Rate	Quality Premium 21.70 p/w	Net of FNC	
			Standard	QP
Older People / Mental Health / Drug Alcohol	678.79	700.49	523.74	545.44
Physical Disability (<65)	707.98	729.68	552.93	574.63
Learning Disability	653.73	675.43	498.68	520.38

Nursing fees include FNC payment of £155.05 p/w

RESIDENTIAL	Standard Rate	Quality Premium 21.70p/w
Older People / Mental Health / Drug & Alcohol	490.49	512.19
Physical Disability (< 65)	560.00	581.70
Learning Disability	505.75	527.45

DEMENTIA PREMIUM PAYMENT	
Residential & Nursing	40.95

DAY CARE	
Residential & Nursing	36.56

Subject / Title	Care Home Policy Change

Team	Department	Directorate
Joint Commissioning & Performance Management Team	Adults	Adults

Start Date	Completion Date
18 October 2017	*2 February 2018*

Project Lead Officer	Tim Wilde
Contract / Commissioning Manager	Trevor Tench
Assistant Director/ Director	Sandra Whitehead

EIA Group (lead contact first)	**Job title**	**Service**
Sandra Whitehead	Assistant Executive Director	Adult Services
Trevor Tench	Service Unit Manager	JC&PMT
Stephen Wilde	Finance Business Partner	Finance
Michelle Walsh	Deputy Director of Nursing & Quality, NHS Tameside and Glossop	FNC Team, CCG
Tim Wilde	Team Manager	JC&PMT

PART 1 – INITIAL SCREENING

An Equality Impact Assessment (EIA) is required for all formal decisions that involve changes to service delivery and/or provision. Note: all other changes – whether a formal decision or not – require consideration for an EIA.

The Initial screening is a quick and easy process which aims to identify:

- *those projects, proposals and service or contract changes which require a full EIA by looking at the potential impact on any of the equality groups*
- *prioritise if and when a full EIA should be completed*
- *explain and record the reasons why it is deemed a full EIA is not required*

A full EIA should always be undertaken if the project, proposal and service / contract change is likely to have an impact upon people with a protected characteristic. This should be undertaken irrespective of whether the impact is major or minor, or on a large or small group of people. If the initial screening concludes a full EIA is not required, please fully explain the reasons for this at 1e and ensure this form is signed off by the relevant Contract / Commissioning Manager and the Assistant Director / Director.

1a.	**What is the project, proposal or service / contract change?**	To change the policy of On/Off Framework providers that was established in 2012 by removing the Off Framework category and to contract with all care homes on the same basis. Also consulting on the removal of restrictions for the current On Framework provider to charge top-ups, i.e. they can only charge top-up payments for environmental factors that a service user has chosen, e.g. larger room, en-suite. The removal of restrictions would be for new service users only (providers would not be able to arbitrarily charge existing residents an increased fee).

1b.	**What are the main aims of the project, proposal or service / contract change?**	There is a recognition that the current On/Off Framework arrangement established in 2012 is no longer suitable in the current market and that the Off Framework providers are struggling to meet the requirements of the Care Quality Commission. It is proposed that the Off Framework category is discarded and that the fees paid for service users is the same across all care home, with the potential that all care homes will be able to apply for the Quality Premium payment. The aim is that all providers are treated equally and it will allow the [former] Off Framework provider to invest in the service to improve standards.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?
Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	□			The majority of residents in care homes are over 65 years of age
Disability	□			Residents in care homes now tend to have a number of co-morbidities
Ethnicity			□	
Sex / Gender		□		Given the disparity in life expectancies between men & women the majority of residents in care homes are female.
Religion or Belief			□	
Sexual Orientation			□	
Gender Reassignment			□	
Pregnancy & Maternity			□	
Marriage & Civil Partnership			□	

Other protected groups determined locally by Tameside and Glossop Single Commissioning Function?

Group (*please state)*	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Mental Health		□		Residents may feel anxiety about the proposed change, albeit that this change will not directly affect them
Carers			□	
Military Veterans		□		There may be some military veterans within the Off Framework care homes who would be affected by the policy change
Breast Feeding			□	

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

Group (*please state)*	Direct Impact	Indirect Impact	Little / No Impact	Explanation

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	Does the project, proposal or service / contract change require a full EIA?	Yes	No
		☐	
1e.	What are your reasons for the decision made at 1d?	Due to the demographic of service users who may be impacted as a result of the proposed change in policy (age and disability) it is necessary to undertake a full EIA. Due to the change in policy there may be a small number of people who are financially disadvantaged, i.e. the Council contracts for 17 people who have been assessed as paying the full contribution towards their care (the usual cost of care for Off Framework residential care is £444/week and 17 people have been assessed as paying £444/week). There are (in total) 117 service users in Off Framework care homes but the majority of these only pay a contribution towards their care and therefore will not be affected by any increase in the gross cost of care.	

If a full EIA is required please progress to Part 2.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

The current five year arrangement the Council & NHS Tameside & Glossop (the Commissioners) has with Tameside care homes established the Off & On Framework arrangement which expires at the end of March 2018.

As with the current arrangement, the proposed new pre-placement contract will be a joint contract with the Council and NHS Tameside and Glossop (and the provider). This approach reduces the burden on providers to comply with two contracts, and reduces the contract monitoring burden on the Commissioners as this is undertaken jointly.

The existing arrangement has a detailed fee uplift structure which required the care homes to submit information noting what they actually spent delivering the care & support for the previous year. This is taken into consideration when calculating the fees for the forthcoming year, which latterly also took account of the implementation of the national living wage. The contract also included an Enhanced Payment scheme that rewards providers for achieving a range of criteria that are used as measures of quality – these include the attainment of Investor in People award, the percentage of staff who have NVQ qualifications, completion of Gold Standard Framework or Six Steps end of life care accreditation/training, completion of Life Stories and organising events that include the wider community.

The Commissioners current arrangement of Off & On Framework care homes has distinctly different fee levels, with Off framework provider receiving between £36-£39 less per person per week than On Framework. On Framework provider also have the opportunity to apply for the enhance payment which, if achieved, attracts an additional £36-39 per person per week.

Please note that the Enhanced Rate is not available for those providers who are Off Framework.

The fees paid to Tameside care homes, for single rooms, are currently in the upper quartile when compared to other North West authorities (for all categories of care).

The Council allows top-ups to be charged by Off Framework care homes (without any restrictions) and only for environmental factors chosen by the resident in On Framework care homes.

Where it is determined that a service user has the appropriate resources (and support) to contract for their own placement the Council will not necessarily be involved with the contract. This could be prior to the commencement of any service or following a financial assessment where the

resident has resources available above the upper financial threshold (currently £23,250).

The state of the care home market has significantly changed since the start of the current contractual arrangements, i.e. there are fewer care homes operating in the borough offering fewer beds, i.e.:

August 2012			**January 2018**		
Type of Home	**Number**	**No. of Beds**	**Type of Home**	**Number**	**No. of Beds**
Residential	29	1106	Residential	27	1091
Nursing	14	683	Nursing	11	548
Total	43	1789	Total	38	1639

The Commissioners are also purchasing fewer beds than prior to the establishment of the existing contractual arrangements, i.e. in August 2012 the Commissioners were purchasing approx. 940 beds but in August 2017 this had reduced to 747 beds. However, the overall vacancy levels in the market have reduced, i.e. in August 2012 there were significant vacancy levels in Tameside, i.e. 158 (14.3%) residential and 118 (17.3%) nursing vacancies. As of August 2017 these figures are 90 (8.2%) residential and 29 (5.3%) nursing vacancies. The fact that vacancy levels are decreasing yet the Commissioners are purchasing fewer beds is down to a number of factors, i.e. reduced capacity in the market (specifically nursing beds), increased level of privately paying clients and increased purchasing in the borough by other authorities (due to paucity of placements in those localities).

The current residents' average age is just over 84 years of age and they have been resident in the care homes for an average of 1 year and 9 months.

Following the implementation of the Off & On Framework arrangement and the changes to the methodology of the way the Care Quality Commission (CQC) inspects care providers, the overall quality of providers has reduced during the last 5 years (as determined by the outcomes of the CQC inspections). At the start of the process the majority of the providers were CQC compliant, however the ratings profile is now (February 2018):

Rating	**No. of Homes**	**% of Homes**	**No. of Beds**	**% of Beds**
Outstanding	0	0%	0	0%
Good	19	50%	748	46%
Requires improvement	18	47%	873	53%
Inadequate	1	3%	18	1%

The above can also be broken down into Off, On Framework & Enhanced Payment providers:

Rating	**Off Framework**		**On Framework**		**Enhanced Framework**	
Outstanding	0	0%	0	0%	0	0%
Good	5	42%	3	75%	11	50%
Requires Improvement	6	50%	1	25%	11	50%
Inadequate	1	8%				0%
Total:	12		4		22	

It can be seen from the above table that those providers Off Framework are not faring as well as the other providers.

It is proposed that from the 1 April 2018 onwards the Commissioners remove the Off Framework category and pays those twelve providers the same (standard) rate as the other providers in order for them to invest the resources to improve services and allow them to apply for the Quality premium payment.

The scope of this EIA will only focus on the fees paid to the current Off Framework care homes and any financial impact for those service users who are assessed as paying the full contribution for services contracted for by the Commissioners. Providers will have, and have always had, the option to charge privately funded clients a separate rate than the Commissioners rate and, as these are outside the scope of the Commissioners contractual arrangements, these fees are also outside the scope of this EIA. The Commissioners will continue to work with the providers to ensure that any future pricing model meets the needs of both parties (and remains Care Act 2014 compliant).

2b. Issues to Consider

The following are areas for consideration when assessing the potential impact of the proposed policy change:

- The number of care homes affected by the policy change
- The number of Commissioner contracted placements in those care home
- The number of people assessed as paying the full contribution towards the cost of their care (and contracted by the Commissioners)
- The views of the service users/relatives of those who are assessed as paying the full contribution toward the cost of their care
- The Commissioners are the only authority in the North West that tendered for care home services to create the On/Off Framework split. The proposed removal of this arrangement and to contract with all providers with the same contract is in line with other authorities practices

2c. Impact

The proposed removal of the Off Framework category will only impact on the twelve care homes currently assessed as Off Framework. At the beginning of October 2017 the Council funded 117 placements in the twelve Off Framework care homes. Where placements are funded under Continuing Healthcare (CHC) in Off Framework homes any increase in fees will not impact on service user's financial contributions, i.e. it is free for the service user irrespective of the actual cost of care.

Of the 117 service users funded in Off Framework care homes there are seventeen Service Users who are assessed as paying the full cost of the placement (up to the Commissioners usual cost of care (see the above fees)) in standard care home placements, and these service users reside in eight different care homes. The majority of Off Framework care homes do not charge a top-up where the Council commissions the service, however, two of these care homes do. There are three service users residing in these two care homes and any increase in the Commissioners usual cost of care will mean a reduction in the third party contribution (on the understanding that the care home doesn't increase its gross fee).

The service users in these twelve homes (as with all other care homes) are the frail elderly who will have a number of co-morbidities (average age is 84). The average age of the people who may be affected by the proposed policy change is also 84. At this juncture it is not possible to determine whether these people have any other protected characteristics but it is likely, given that the majority of residents in care homes have a number of co-morbidities, that they may have some physical disability. Similarly, without undertaking further individual assessments it is not known whether any people possibly affected are military veterans. However, the key issue is the levels of savings that these service users have means they are financially adversely affected by the proposed policy change rather than them being adversely affected as a result of a protected characteristic.

There is therefore a potential that seventeen service users may be financially adversely affected by the Commissioners decision to remove the Off Framework arrangement and to pay these care homes the current On Framework rate. Please note that the family for one service user is seeking Power of Attorney to take responsibility for the finances and, given the level of savings for this service user, and following the process agreed in August 2012, the Council will likely terminate its contract and the family will contract privately for their relative, reducing the number of people affected to eleven.

Despite numerous attempts by the neighbourhood teams only 4 relatives of service users could be contacted (the service users themselves did not have capacity). The relatives contacted expressed views that they did not wish to see the fees increase as they felt they paid enough already. This will not be an issue If the Council meets the difference.

The impact of proposed new contract/fees for at least another 4 service users would be reduced as their assets would have reduced below the upper financial limit by the time the consultation period ended.

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
The financial impact on the seventeen service users	*Negated if the Council meets the difference.*
Consultation with the service users' affected by the policy change	*The Commissioners have undertaken targeted consultation with the service users (and/or representatives) to determine their views about the proposed policy change for the period after the 31 March 2018. The views of the respondents have been considered.*

2e. Evidence Sources
CQC rating for the care providers in Tameside Responses to Freedom of Information Requests re: the number of placements that the Council purchases Responses to the consultation from The Big Conversation, questionnaires received via the post or from providers Notes made by Tim Wilde during residents/relatives meetings at care homes

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**

Signature of Contract / Commissioning Manager	**Date**
Signature of Assistant Director / Director	**Date**

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 March 2018

Officer of Strategic Commissioning Board Debbie Watson, Interim Assistant Director of Population Health

James Thomas, Interim Director of Children's Services

Subject: **TAMESIDE POPULATION HEALTH INVESTMENT FUND AND BUSINESS CASE (1 OF 3) - DELIVERING OUR NEW APPROACH TO EARLY HELP FOR CHILDREN AND FAMILIES, REDUCING DEMAND ON CHILDREN'S SOCIAL CARE**

Report Summary: The purpose of the report is to seek approval for a programme of investment in prevention interventions in 2018-19, 2019-20 and 2020-21, using public health reserve to support the priorities within the new Tameside Corporate Plan, Locality Plan and refreshed Health and Wellbeing Strategy. The investment is focused on three cross cutting priority areas:

- Delivering our new approach to Early Help for children and families
- Improving Mental Health and Wellbeing in our neighbourhoods
- Preventing and managing Long Term Conditions

The Early Help approach is a key driver within Tameside in terms of the Tameside Think Family approach and public service reform. The report presents the first of three business cases for agreement at Strategic Commissioning Board. The Early Help Business Case investments will provide more family/child centred personalised innovative interventions based on strong collaborative working across all partners and agencies and building capacity in the community and voluntary sector.

Recommendations: The Strategic Commissioning Board is recommended:

- To agree the priority areas for investment outlined in section 5 of the report
- To agree the proposals set out in the Early Help business case in **Appendix 1**
- That approval is given to extend current grant funding for the core activity of Home-start (Oldham, Stockport and Tameside) from 1 October 2018 to 31 March 2020 to align with the Community Parenting Service.
- That a waiver to standing orders is granted to allow the direct award of contract to Home-start (Oldham, Stockport and Tameside) for a period of two years from 1 April 2018 to 31 March 2020, with an annual value of £250,000 to deliver the Community Parenting Service.

Financial Implications:

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

ICF Budget	**£'000**
Tameside Council – Population Health	3,004

Section 75 **Strategic Commissioning Board**	

Additional Comments

The proposed priority areas for investment as outlined in Section 5 of the report will be resourced via the non-recurrent Population Health reserve of £ 3.004 million.

It is essential to ensure that services are procured in accordance with procurement standing orders where appropriate.

In addition it is also essential that robust performance monitoring arrangements are implemented to ensure the service demand preventative aims of the investment are realised and the proposed impact is incorporated within the Medium Term Financial Plan of the Strategic Commission.

Legal Implications:

(Authorised by the Borough Solicitor)

F4 of the Council's Procurement Standing Orders say that where the Procurement Rules apply (which they do in this case) a direct award of a contract i.e. without any competition can only be made if:

- No suitable tender is received capable of meeting our requirements.
- Our requirements can only be met by a single bidder because:
  - (i) the aim of the procurement is the creation or acquisition of a unique work of art or artistic performance, or
  - (ii) competition is absent for technical reasons;
  - (iii) we have to protect exclusive rights such as intellectual property rights and no reasonable alternative or substitute exists.
- There is extreme urgency due to events which we could not foresee and are not our fault. This usually means Act of God situations such as fire or flood.

The decision –maker will therefore need to be satisfied that the report demonstrates the above criteria to agree a direct award.

How do proposals align with Health & Wellbeing Strategy?

The proposals and strategic direction are consistent and aligned.

How do proposals align with Locality Plan?

The proposals are aligned to the locality plan.

The proposals are consistent with the following priority transformation programmes:

- Healthy Lives (early intervention and prevention)
- Locality-based services

How do proposals align with the Commissioning Strategy?

The proposals are aligned to the Commissioning strategy.

The service contributes to the Commissioning Strategy by:

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

Recommendations / views of the Health and Care Advisory Group:	The recommendations were supported by the Health and Care Advisory Group, with the request to ensure any commissioning proposals and delivery programmes considered the impact for Glossop residents.
Public and Patient Implications:	Public and patient implications have been considered for each of the proposals included in the document.
Quality Implications:	A quality impact assessment has been completed
How do the proposals help to reduce health inequalities?	The proposals will have a positive impact on health inequalities. The proposal seeks to reduce health inequalities, target the resources to where most needed and ensure services are accessible to all.
What are the Equality and Diversity implications?	An Equality Impact Assessment has been completed on this proposal. It is not anticipated that the proposal will have a negative effect on any of the protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	There are no anticipated safeguarding implications. Where safeguarding concerns arise as a result of the actions or inactions any providers and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. Any procured service will include minimum requirements for training and qualification of interpreters which includes standards and requirements for information governance, privacy and respect.
Risk Management:	A detailed risk log will be managed as part of the implementation following approval of the proposal.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Interim Assistant Director of Population Health Telephone: 0161 342 3358 e-mail: : debbie.watson@tameside.gov.uk

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to seek approval for a programme of investment in prevention interventions in 2018-19, 2019-20 and 2020-21 using public health reserve to support the priorities within the Tameside Corporate Plan, Locality Plan and refreshed Health and Wellbeing Strategy

2.0 BACKGROUND

2.1 Prevention is better than cure. By failing to invest in prevention, it can be argued that we are allowing avoidable death and poor health to continue and inequities in health to remain.

2.2 Key messages include:

- Benefits can be derived from preventative approaches both in terms of improved outcomes for people and communities and reduced demands on public services.
- A high proportion of premature death, illness and health care demand is preventable.
- This burden falls more on the poorest, where prevention should be focussed and should start younger.
- The system together can make a significant contribution to prevention efforts.

2.3 The public health grant is provided to enable local authorities to discharge their duty to improve the public's health. Statutory guidance states public health funding will be invested towards:

- Improving the health and wellbeing of local populations;
- Delivering and assuring health protection and health improvement responsibilities delegated from the Secretary of State;
- Reducing health inequalities across the life course, including within hard to reach groups;
- Improving healthy life expectancy; and,
- Ensuring the provision of population healthcare advice.

3.0 PUBLIC HEALTH RESERVE

3.1 An estimated £3m is available within the Tameside Council public health reserve non-recurrently over 2-3 years, accumulated since 2013 via the ring fenced public health grant. The overall aim is to align this resource to support the priorities and ambitions within the Tameside Corporate Plan, Locality Plan and Health and Wellbeing Strategy, improving health and reducing inequalities through prevention interventions.

3.2 It is proposed that a Tameside Population Health Investment Fund is created. Given the financial challenge the Strategic Commission currently faces, projects delivered through the Investment Fund would need to have an 'invest to save' focus and reduce demand on more costly services. The projects will help generate some new and creative ideas to deliver services differently. The investment would be applied in accordance with Department of Health rules on the use of the Public Health ring fence grant.

4.0 PRIORITIES FOR INVESTMENT

4.1 'Thrive and Prosper' the Strategic Commission's One Corporate Plan 2018 – 2025, sets out five themes in our local vision to enable residents to lead healthy, long and fulfilling lives.

- **Excellent Health & Care** – we want all our residents to have access to high quality joined up health and care services that help our residents to live longer and healthier lives.
- **Successful Lives** – we want our young people to live in a safe and supportive environment where they have the opportunity to reach their full potential.
- **Vibrant Economy** – we want to provide greater access to jobs and opportunities, attract more businesses to the area and improve connectivity.
- **Stronger Communities** – we want to build stronger communities that look out for one another, take a pride in the area they live in and have access to quality homes.
- **Digital Future** – we want to provide everyone with the opportunity to get on-line to access services, learning and information.

4.2 The delivery of Tameside & Glossop Locality Plan 'A Place-Based Approach to Better Prosperity, Health and Wellbeing' is through our Care Together programme, enabled through six priority transformation programme areas across the Starting, Living and Ageing Well lifecourse.

- **Healthy Lives (early intervention and prevention):** a focus on education, skills and support for people to avoid ill-health, including lifestyle factors but also employment, housing, education and income inequalities.
- **Community development:** this will strengthen and sustain community groups and voluntary sector organisations' work to provide the necessary support in the community.
- **Enabling self-care:** improving skills, knowledge and confidence of people with long-term conditions or with on-going support needs to self-care and self-manage.
- **Locality based services;** for people who need regular access to health and social services, these will be fully integrated in localities, offering services close to, or in, people's homes. They will be supported by multi-disciplinary teams (MDT) with a named care co-ordinator, based on a personalised care plan which focuses on the individual's life goals and aspirations, not just health and care needs. This will involve identifying upfront those people most in need of this care co-ordination.
- **Urgent integrated care services:** for people in crisis or who need urgent medical attention, other health or care support, and a single urgent care hub will align a range of urgent and out of hours care services around A&E to make it easier for people to access the most appropriate service.
- **Planned care services:** to ensure the provision of planned (elective) care in line with the Devolution and Healthier Together programmes.

4.3 A recent review of premature mortality by the Health and Wellbeing Board aligned priorities outlined in the Joint Health and Wellbeing Strategy, agreed that the Board should consider an Action Plan for 2018/19 to strengthen the local drive towards a place-based approach to reducing early deaths, improving healthy life expectancy and delivering sustainable reductions in health inequalities, in order to realise our ambition to bring health experience in Tameside line with regional and national averages.

The focus is on the continuing importance of early identification of circulatory and respiratory disease and cancers, our 'big killer' to enable effective self-care and treatment to reduce further illness and mortality. The proposed approach endorses the current Locality Plan and RightCare priorities.

4.4 Therefore, it is proposed that the Population Health Investment Fund is focused on three cross cutting priority areas:

- **Delivering our new approach to Early Help for children and families;**
- **Improving Mental Health and Wellbeing in our neighbourhoods;**
- **Preventing and managing Long Term Conditions.**

4.5 The delivery of investment programmes against these priority areas should be aligned to build, maximise effectiveness and scale up existing investment. They should work across the population health system to provide access to a wide range of preventative services and coordinate effectively with partners. Delivered in close partnership or commissioned via the VCFSE sector the propositions should look to build stronger communities to support and enable individuals to manage their own health more effectively.

4.6 The funding available for the proposals set out in section 5 is public health ring fenced grant received from Public Health England to Tameside Council, to improve health outcomes for Tameside residents. Where the programmes would be delivered across Tameside & Glossop, an impact assessment will be carried out to ensure any negative impacts identified are mitigated and that similar services commissioned by Derbyshire CC Public Health are aligned. Derbyshire CC do have a similar investment fund to deliver on specific priority programmes.[1]

5.0 TAMESIDE POPULATION HEALTH INVESTMENT FUND - PROPOSITIONS

5.1 In consultation with Strategic Commission leads and partners possible early approaches for the application of the investment fund, identified a number of 'invest to save' propositions that would deliver on Strategic Commission priorities, show return on investment and social value, and contribute to a reduction in demand on complex services whilst improving outcomes for residents. A summary of the proposals and strategic commission leads can be seen in the table below:

TAMESIDE POPULATION HEALTH INVESTMENT FUND		
Title of intervention and proposed allocation	**Brief summary of intervention**	**Impact/ Invest to Save/ ROI**
PRIORITY 1: **DELIVERING OUR NEW APPROACH TO EARLY HELP FOR CHILDREN AND FAMILIES, REDUCING DEMAND ON CHILDREN'S SOCIAL CARE** **Strategic Lead: James Thomas** **Population Health Lead: Debbie Watson** Intervening as early as possible and working with the whole family to support positive changes and outcomes for all is at the heart of our Early Help Offer. The primary focus will be upon families that currently receive a Social Work response from Children's Social Care, as we currently over-intervene in family lives in Tameside approximately 20% more frequently than statistical neighbours. The delivery of the four proposals outlined below with match funding from the Troubled Families Programme to create a single investment plan is an integral part of our new ambitious Early Help service offer and is one of several programmes and interventions that are embedded in our holistic Think Family centred approach to service delivery. The Early Help approach is a key driver within Tameside in terms of the Tameside Think Family approach and public service reform. The overarching vision underpinning our approach is to ensure that we move from reactive service provision, based around responding to accumulated acute needs, towards earlier intervention via		

[1] https://www.derbyshire.gov.uk/images/7%20i%20200916%20PH%20Prevention%20Fund%20Investment_tcm44-284047.pdf

targeted interventions, where problems can be addressed before they escalate taking a holistic whole family approach based on early intervention and prevention. The proposed investments outlined below will provide more family/child centred personalised innovative interventions based on strong collaborative working across all partners and agencies and building capacity in the community and voluntary sector. It also provides the opportunity to develop and implement a Children's Integrated Neighbourhood model for Tameside, complementing the neighbourhood/place based approaches already in place in the borough. Early consultation with relevant partners about this approach has been extremely positive and the aim will be to launch our neighbourhood model in September 2018.		
Building capacity to meet additional need 0-10 yrs **Tameside Community Families Programme** Building on the current home visiting programme provided by Home-start (Oldham, Stockport and Tameside) £150,000 per year for two years (with a matched £100,000 per year for two years proposed from Troubled Families Funding)	**Purpose:** To develop and deliver a service and a range of interventions with an emphasis on trusting peer relationships that will include two sets of beneficiaries: community family volunteers /parent champions and the parents, children and young people they support they support. To recruit and train community volunteers/parent champions to work as peer supporters, providing them with the necessary skills and knowledge to deliver the service and improving their personal confidence, building social capital and enhancing opportunities for further training and employment To develop and delivery support packages individually tailored to each family based on the active participation and involvement of families **Target Group:** Children (0-10yr) and Families at Level 2 continuum of need with a strong emphasis upon the high end of Level 2 **Outcomes:** • Reduced demand for Children's Social Care via new pathway from the Hub • Increased step down from Children's Social Care Children In Need • Improved health related lifestyle behaviours for both adult(s) and child(ren) • Improved mental health and emotional wellbeing for both adult(s) and child(ren) • Improved child/ adult relationship and attachment • Improved 'family/household' skills including budget managing • Improved access to wider services available	Home-Start's volunteer led model of early intervention and prevention is a very cost-effective form of family support: • On average, it costs a local Home-Start £10.69 per week to support a child. • On average it costs a local Home-Start £22.93 to support a family for a week. SROI by New Economy in development.
Building Capacity to meet additional need 11-16yrs **Targeted Young People's Casework Team**	**Purpose:** This project will provide a service for young people 11-16yrs and their families The aim of the service is to engage young people (aged 11-16) whose emotional and behavioural needs, and family circumstances, indicate a risk of entry to care as they become older. There will be a need to work particularly closely with secondary	It is estimated that a young person in the criminal justice system costs the taxpayer over £200,000 by the time they are 16. But one who is given support to stay out of trouble

£198,462k per year for two years Grade F Neighbourhood Family Intervention Workers £33,077 x 6 - £198,462	schools and with Healthy Young Minds in developing an effective response, and supporting parents/families to meet the needs of their adolescent children. **Target Group:** Young People 11-16 yr with risk factors that indicate potential entry to care at later stage **Outcomes:** • Reduced demand for Children's Social Care via new pathway from the Hub • Increased step down from Children's Social Care Children In Need • A reduction in incidents of ASB involving 14-19 year olds • The diversion of 14-19 year olds from involvement in the criminal justice system • Improved engagement in education, employment and training	costs less than £50,000. Tameside's LAC profile shows higher than expected numbers in care aged 11 to 15.
Domestic Violence Children's Advisors (CHIDVA) x2 2018/19 - £20,000 (6 months) 2019/20 - £40,000 (12 months) 2020/21 - £20,000 (6 months) (with match funding from Tameside Troubled Families Funding)	**Purpose:** This proposal requests funding to enable the continued provision of 2 Children's Independent Domestic Violence Advisors (CHIDVA). The IDVAs role is to address the safety of victims who are at high risk of harm of domestic abuse. This project is unique in Greater Manchester. The prevalence of Domestic Abuse in families referred to Children's Social Care is extremely high. **Target Group:** The CHIDVAs core work is with children aged 6-18 through the provision of 1:1 support and group work. Children aged under 5 can be supported as part of a whole package of support with the family. **Outcomes:** The programme supports our approach to tackling Domestic Violence. Delivery against the work of the existing CHIDVAs is assessed by: • Number of children supported 1: 1 • Number of programme sessions provided • Number of children commencing attendance on programmes • Number of children completing programmes Qualitative data is collected through case studies and testaments provided by parents and children. This is analysed against key outcomes from the GMCA Victims Services Outcomes Framework.	In the UK 140,000 children live in homes where there is high-risk domestic abuse and 64% of high and medium risk victims have children, on average 2 each. • A quarter (25%) of children in high-risk domestic abuse households are under 3 years old. On average, high-risk abuse has been going on for 2.6 years, meaning these children are living with abuse for most of their life • 1 in 4 children witness domestic abuse, their physical and mental well-being and chances of doing well at school suffer from an abusive upbringing. • 62% of children

		living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others.

Delivering a full Children's Integrated Neighbourhood Model for Tameside
 	
4x H grade Neighbourhood Early Help Coordinators
 	
1x C grade Business Support
 	
£392,029 over two years
 	
WORKFORCE DEVELOPMENT:
 	
£30K 18/19
£30K 19/20
	Capacity to developed a stepped approach to a full Integrated Neighbourhood model for Children and Families, joining up services at the three key tiers of need – universal, targeted and specialist
	• Development of four neighbourhoods in line with adult model, Children's Centres, Tameside Families Together and Safeguarding Teams/ INS
	• Core wrap around approach for core universal services where children receive core support– the Team Around Approach:
	  • Early Years Providers
	  • Primary Schools
	  • Secondary Schools
	  • Primary Care
	  • Youth Services
	• Systematic delivery of targeted early help services – getting the right service to the right family
	• Join up with Children's Social Care for effective step up and step down, and enabling family's needs to be met at the lowest level of intervention possible
	• Common workforce development programme for a defined set of services – shared vision, shared outcomes framework, shared language, shared ways of working with families – approach in development to complement 'Signs of Safety'.
	• Agreed pathways with specific pathways for specific needs
		An integrated Model for children and families is associated with a number of positive outcomes, including improved system performance, better outcomes for children and enhanced quality and resident satisfaction. Improving coordination, continuity and timeliness of support is central to this approach and key to reducing demand upon Children's Social Care

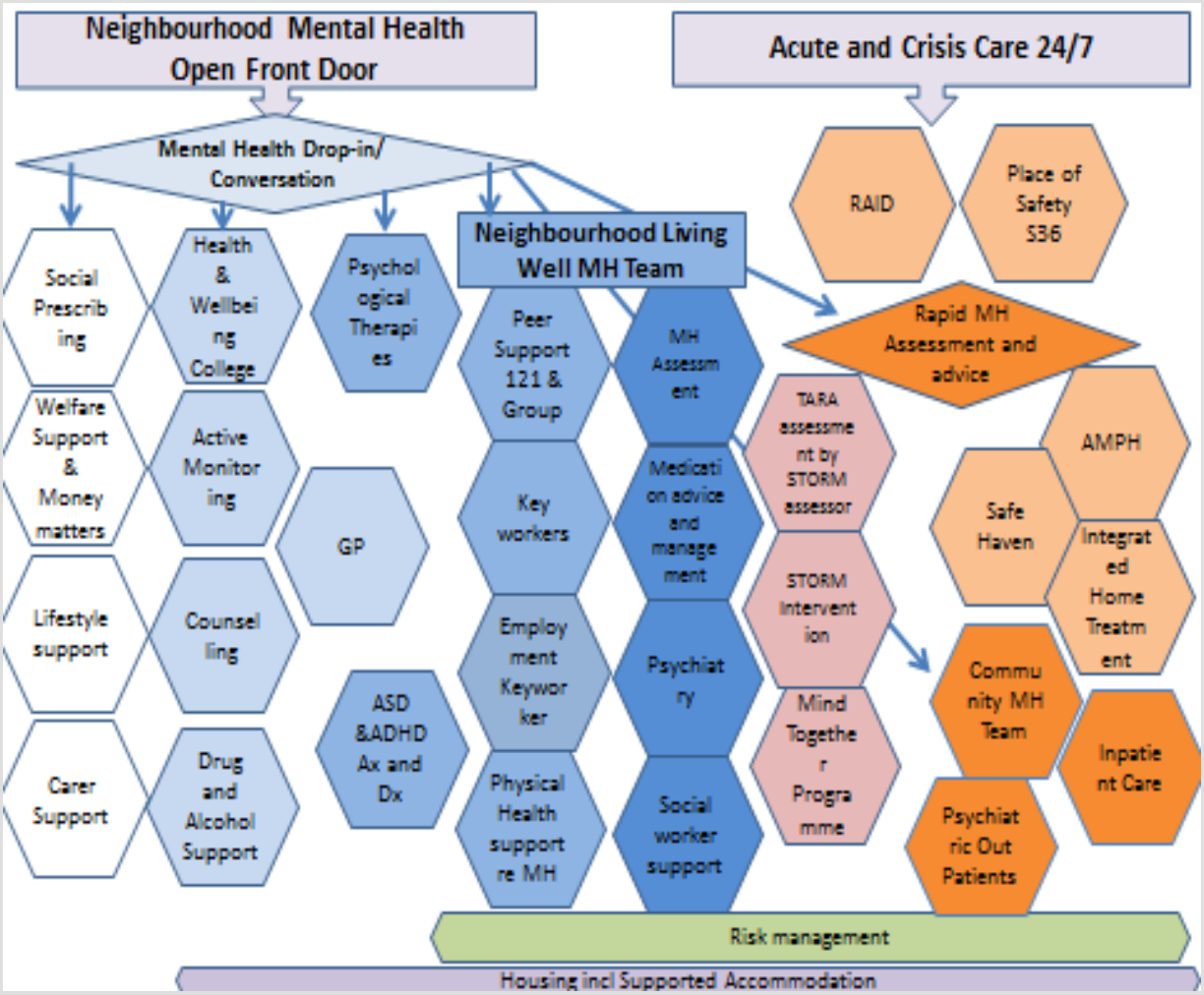
PRIORITY 2:

IMPROVING MENTAL HEALTH AND WELLBEING IN OUR NEIGHBOURHOODS

Strategic Lead: Jessica Williams
Population Health Lead: Anna Moloney

The proposal looks to build the local Neighbourhood Mental Health Offer to complement our current approach to social prescribing. There will be no eligibility criteria or clinical threshold with easy access via community drop in's or online self-referral. Asset based brief conversations about needs and solutions via drop-in or telephone will take place within Neighbourhoods with support into locality initiatives eg Social Prescribing, welfare and debt support, lifestyle, housing, skills and employment.

There will be direct access to a broad offer of mental health specific social, therapy, employment, physical and mental health with access to the Health and Wellbeing College programmes. The model below describes the proposed programme with the population health investment funding current gaps in provision – Health and wellbeing College and Neighbourhood Keyworkers.



Mental Health – Health and Wellbeing College £80,000 per annum for two years	**Purpose:** The Health and Wellbeing college aims to provide something very different for local people. It moves away from the clinical focus offered by many traditional mental health support services; instead we offer an educational approach designed to empower you to take control of your own health and wellbeing, while learning new skills, making friends and connecting with others. Our recovery-focused courses can support you to recognise your potential and make the most of your talents and resources, through self-management. In turn, this can help you to deal with any health challenges you may experience and achieve the things you want in life. **Outcomes:** Core Values: • **Educational** – Recovery focused syllabus of courses, which will aim to increase knowledge, understanding, coping strategies	The College has a number of case studies illustrating positive outcomes and reduced dependency on complex services.

	and skills for self-management of health and wellbeing. Learning opportunities will be facilitated through the Recovery based curriculum, facilitated by experts by experience and experts by expertise • **Collaborative** – Lived experience and professional expertise are brought together in co-production, co-delivery, co-facilitation, and co- learning • **Recovery Focused** – For all students and staff, achievements, strengths, skills, and qualities will be identified, built upon and rewarded. Where there are challenges to learning, adjustments and support will be offered to individuals to assist to overcome them • **Choice & Agency** – While students may be signposted to the college by health professionals, they will be encouraged to enrol independently wherever possible. Students will not need a health professional to signpost them. Students will develop an individual learning plan (ILP) to identify their self-directed personal goals, ambitions and aspirations. Students will choose the courses they wish to study, and identify supports they find helpful • **Progressive** – Students will work towards learning goals and/or to overcome personal challenges whilst gaining knowledge of their health and wellbeing. Progress through the academic year will culminate in graduation • **Community Focused** - The College aims to be community facing and will seek active engagement with community organizations and Further Education colleges to co-produce relevant courses and aim to facilitate valued roles and relationships and pathways to future education, learning, employment and daily occupations • **Inclusive** – The College will aim to offer self-management and learning to students of all abilities, over the age of 18, from all cultures, ages and experience	
To support the 'honeycomb' model illustrated above Four neighbourhood mental health and wellbeing Key Workers: £100,000 per annum for three	**Purpose:** Support offered from the mental health key workers will include: • Medications advice • Mindfulness techniques • Education and self-help techniques to support people to self-manage • Accessing personal health budgets • Urgent housing support and advocacy to prevent housing evictions, manage tenancy and arrears, or other housing related issues • Benefits advice and support to attend appeals	A similar programme in Lambeth Offered over 4000 people support • Reduced referrals into the previous secondary care entry point by 43% • Reduced referrals into all community secondary care teams by 29% • Supported the

years Three neighbourhood skills and employment workers: £75,000 per annum for three years	or complete forms • Advice around accessing specialist services and treatment Employment key workers would be dedicated to identifying and engaging working age adults with mental health barriers to move into work. As part of the Neighbourhood Mental Health Team the clients would be engaged through that route but also through the social prescribing model. The Employment Key Workers would provide personalised and tailored assessment and action planned activity to move the patient towards employment including increased skills. The team would work primarily with those with lower level mental health conditions to provide an early intervention and prevention response and deliver a base level of outcomes.	Adult Mental Health redesign to reduce caseloads by 25% in the past three years • Contributed to a broader system wide change of the 'flow' of people accessing and receiving support • Made significant progress in changing the culture of the workforce • Demonstrated that –people are satisfied with support offered, –that this support meets some of their needs and –helps them deal with their problems more efficiently
PRIORITY 3: **PREVENTING AND MANAGING LONG TERM CONDITIONS** **Strategic Lead: Jessica Williams** **Population Health Lead: Gideon Smith** Tackling premature mortality and health inequalities is vital to rebalancing our local health economy and achieving sustained reductions in health inequalities and improvement in local life expectancy. • recent mortality trends highlight the importance of tackling premature cardiovascular, respiratory disease and cancer • the Tameside and Glossop RightCare programme highlights the importance of tackling circulatory and respiratory disease		
Tobacco – Making Smoking History in Tameside Funding requested per year: £190,000 over three years	**Purpose:** **Smokefree Nurse led Specialist team for Tameside Hospital** A new nurse specialist-led smokefree team would contribute to the local ambition to reducing smoking prevalence by supporting smokers who are accessing hospital services to quit. The team will establish referral systems from each department of	Smoking cessation interventions are considered among the most cost-effective available in the health care sector [2] and are a key component of tobacco control

[2] http://www.ncsct.co.uk/usr/pub/B7_Cost-effectiveness_pharmacotherapy.pdf

	the hospital and provide 1-2-1 quit support for all patients except pregnant women. **Scaling up the Midwife-led stop smoking service** This project aims to expand the successful midwife-led service to further reduce smoking in pregnancy rates by supporting more pregnant women to quit smoking. The project will also prepare for and support the additional workload that will be required from the local delivery of the GM tobacco strategy's Baby Clear and incentive scheme. **Scaling up activity to tackle illicit and illegal tobacco** Proposal: Build on the programme with Environmental protection to ensure more illicit and illegal tobacco is seized in Tameside communities. Tobacco detection dog visit to Tameside 4 times per year over 3 years to ensure more effective enforcement activity. **Target Group:** Smokers and their families **Outcomes:** The New Ambition for a Smokefree Tameside is an initiative to make faster progress towards becoming a smokefree borough and to meet Greater Manchester ambitions to achieve a smoking prevalence of 13% for adults and 5% for 15 year olds by 2020/21. To achieve these ambitions we need to considerably scale up investment and commitment to tobacco control in Tameside across all partners.	strategies because they offer smokers their best chance of quitting[3].
Lung Screening Total cost is £250k for a cohort of 5000 eligible people.	**Purpose:** The Liverpool Healthy Lung Programme (http://www.liverpoolccg.nhs.uk/health-and-services/healthy-lungs/) has recently reported on a successful project to screen for lung cancer which has clear potential for local adoption to make inroads into local lung cancer mortality, smoking rates and impact of COPD (http://www.liverpoolccg.nhs.uk/media/2665/liverpool-healthy-lung-project-report_final.pdf). We can adapt the Liverpool model for Tameside and Glossop by: • establishing a capacity for suitable assessment clinics • establishing a capacity for CT scanning • selecting and inviting a population of ever smokers and patients with COPD identified	Cost effectiveness of the Liverpool Healthy Lung Programme was comparable to breast and bowel screening: the majority of the quality adjusted life years gained were derived from early diagnosis and treatment of COPD (67%), with 17% from early detection of lung cancer and 16% from smoking cessation.

[3] http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf

	from GP records • confirming capacity for referrals for suspected lung cancer or COPD **Target Group:** At risk residents **Outcomes:** • reduced smoking in adults, young people and pregnant women • increased one year survival • reduced the number of preventable deaths from cancer • improved patient experience	
Macmillan GP £23,401 18/19 £43,251 19/20	**Purpose:** Tameside and Glossop CCG were awarded a grant from Macmillan in 2014-15 towards funding a Macmillan GP post for two years. The agreement with Macmillan was that the CCG would evaluate the role with a view to funding the post from June 2018. The role has been evaluated successfully and the proposal is to continue this work with added focus on early detection and prevention as well as: • facilitating training, education and development within primary care and ensure knowledge exchange sessions between wider stakeholders • enhancing the knowledge and skills of primary health care teams in providing care to cancer patients with regard to early diagnosis, pathways of care, symptom control and supportive and end-of-life care to ensure the delivery of optimal care as well as early recognition of needs at all stages of the cancer pathway • enhancing knowledge and provision of information on the availability of services to cancer and palliative care patients and routes of access to services within the locality • enable cancer patients to have a greater understanding of their condition, treatment and navigation of the services and support available to them (including self-management) • support the use of and roll-out of National, Greater Manchester and Macmillan programmes • represent patient views and opinions and ensure equity of service.	In addition to ongoing membership of the locality's Cancer Board and Cancer Strategy group(s) the work plan for 2017/18 (to June 2018), includes: • Improving Early Diagnosis of Cancer in Tameside & Glossop (e.g. GP endorsed letters for all Bowel screening invites from the central hub, teaching around NICE guidelines). • Review cancer risk prediction tools and implement e.g. Q Cancer Prediction tool. • Be aware of recurrent themes in delayed diagnosis and consequently emergency presentations; barriers to diagnosis and early diagnosis. • Targeted communications to practices around awareness campaigns to include promotional material and link in

		with Be Well campaigns. • Set up a cancer champion in each surgery (clinical and clinical administrative role) to link with Macmillan information points and Greater Manchester cancer champions. • Support development of practices level data packs to improve quality • Support Practices to ensure they complete the modules on Gateway C and other e learning events (Cancer Research UK to support). • Explore the role and implications of the Genetics service provision (breast/bowel initially). • Provide two way feedback between Primary and Secondary Care (for example on Cancer Care Reviews) to share good practice and improvements made • Support Implementation of the Recovery Package as recommended both nationally and as part of the GM cancer plan.
Social Marketing Programme Love your Lungs Hypertension –	**Purpose:** Sustain and develop social marketing programmes which allow us to identify the 'missing thousands' from current disease registers in primary care, using risk stratification and insight. All programmes will seek to ensure Tameside	

Check it campaign Physical activity Cancer Early Detection Don't Be the One Smoking Campaign £196,000 over two years	residents: • are engaged with their own health and wellbeing • understand how their lifestyle choices impact on their current and future health outcomes (and, in the case of parents, their children's health outcomes) • can obtain sound advice about what constitutes a healthy lifestyle, and • have access to appropriate services, products and tools to support and help them change their behaviour.	

Table 1: Population Health Investment Fund Proposals

	Yr1 18/19	Yr2 19/20	Yr3 20/21
Priority 1: **Delivering our new approach to early help for children and families, reducing demand on children's social care.**			
Tameside Community Families	£150,000	£150,000	
11-16 Programme	£198,462	£198,462	
Domestic Abuse – CHIDVA role	£20,000	£40,000	£20,000
Children and Families Neighbourhood Model	£196,014	£196,014	
Workforce Development	£30,000	£30,000	
Total	**£594,476**	**£614,476**	**£20,000**
Priority 2: **Improving mental health and wellbeing in our neighbourhoods.**			
Health and Wellbeing College	£80,000	£80,000	
Key Workers – Mental Health	£100,000	£100,000	£100,000
Key Workers – Employment and Skills	£75,000	£75,000	£75,000
Total Living Well	**£255,000**	**£255,000**	**£175,000**
Priority 3:			

Preventing and managing long term conditions.			
Making Smoking History	£190,000	£190,000	£190,000
Lung Cancer Screening	£125,000	£125,000	
MacMillan GP	£23,401	£43,251	
Social Marketing/ Comms programme	£100,000	£96,500	
Total Ageing Well	**£438,401**	**£454,751**	**£190,000**
Total	**£1,287,877**	**£1,324,227**	**£385,000**

6.0 NEXT STEPS

6.1 The Population Health Investment funding is non-recurrent, and a key consideration is the sustainability of the interventions recommended for approval.

6.2 Rigorous evaluation of the outputs and outcomes from the prevention interventions will enable an assessment of the value to the health and social care community of different approaches. The proposals will be evaluated and monitored and reported back to the Strategic Commissioning Board.

6.3 The Strategic Commission can confirm its commitment to being a population health practicing partnership by recognising the need for and systematically making marginal shifts in its future spend towards cost effective preventive interventions that can be delivered in our Tameside neighbourhoods. Therefore every programme will have an outcomes framework to monitor performance and impact.

6.4 If the proposed programmes are supported, three more detailed business cases will be produced for discussion and agreement through Strategic Commission governance.

6.5 Business Case 1 - delivering our new approach to Early Help for Children and Families, reducing demand on Children's Social Care is attached at **Appendix 1** for discussion and agreement.

7.0 RECOMMENDATION

7.1 As stated on the report cover.

APPENDIX 1

DELIVERING OUR NEW APPROACH TO EARLY HELP FOR CHILDREN AND FAMILIES - REDUCING DEMAND ON CHILDREN'S SOCIAL CARE

1. Background

1.1. Tameside's Early Help strategy, "Smarter, Stronger, Sooner, Safer; An Integrated Approach to supporting Children, Young People and their Families through Early Help in Tameside" is a statement outlining Tameside's integrated approach to improving outcomes for children, young people and their families through early help and provides a guide to the workforce on the vision, principles, model, priorities and enablers of early help that will impact on children and families lives.

1.2. Priority one of the Tameside Population Health Investment Fund (Delivering our new approach to Early Help for children and families, reducing demand on children's social care) is a response to the needs analysis conducted for the Early Help strategy and a need to reduce demand on Children's Social Care. It commits resources to intervening as early as possible and working with the whole family to support positive changes and outcomes for all is at the heart of our Early Help offer

1.3. During September and October 2016, Tameside's children's services were inspected by Ofsted and the report published in December of 2016 found that they were Inadequate. In response the Council were required by Ofsted to produce a plan setting out the steps that would be taken to improve services. The original plan was submitted on 20 March 2017. This plan was adopted throughout the year and led the service through the first phase of improvement. During this leg of the journey, the plan oversaw improving practice in the Children's Hub, stronger safeguarding processes and lower caseloads for staff. Crucially the plan needed to go further to drive improvements at a strong pace. It was therefore felt that, alongside new leadership, a new improvement plan would be necessary to drive the momentum of change to improve for families in Tameside. The proposals in this business case supports the delivery of the Implementation Plan and will look to ensure children will have their needs clearly identified and those needs met with effective interventions rooted in relationship based practice which is effectively structured and managed.

1.4. The primary focus is upon families that currently receive a Social Work response from Children's Social Care, as we currently over-intervene in family lives in Tameside - approximately 20% more frequently than statistical neighbours. The delivery of the four proposals outlined below with match funding from the Troubled Families Programme to create a single investment plan is an integral part of our new ambitious Early Help service offer and is one of several programmes and interventions that are embedded in our holistic Think Family centred approach to service delivery. The Early Help approach is a key driver within Tameside in terms of the Tameside Think Family approach and public service reform.

1.5. The overarching vision underpinning our approach is to ensure that we move from reactive service provision, based around responding to accumulated acute needs, towards earlier intervention via targeted interventions, where problems can be addressed before they escalate taking a holistic whole family approach based on early intervention and prevention.

1.6. The delivery of investment programmes against priority areas aims to be aligned to build, maximise effectiveness and scale up existing investment. They should work across the population health system to provide access to a wide range of preventative services and coordinate effectively with partners. Delivered in close partnership or commissioned via the VCFSE sector the propositions should look to build stronger communities to support and enable individuals to manage their own health more effectively.

1.7. The proposed investments outlined below will provide more family/child centred personalised innovative interventions based on strong collaborative working across all partners and agencies and building capacity in the community and voluntary sector.

1.8. They also provides the opportunity to develop and implement a Children's Integrated Neighbourhood model for Tameside, complementing the neighbourhood/place based approaches already in place in the borough. Early consultation with relevant partners about this approach has been extremely positive and the aim will be to launch our neighbourhood model in September 2018.

2. LOCAL NEED

2.1 Local data and intelligence that highlight some stark statistics that we would hope to have an impact on over time. This data and intelligence can be found in the recently completed Early Help Needs Assessment (available on request).

2.2 In summary:

- 23.4% of children in Tameside are in low income families, compared to the 19.9% nationally;
- 15.3% of pregnant mothers smoke in Tameside, compared to the 11.4% nationally;
- 237 children and young people aged 10-24 were admitted to hospital because of self-harm;
- 535 children living with parents in treatment for drug or alcohol addiction;
- 538 Looked After Children;
- 404 Children on Child Protection Plan;
- 2489 Child in Need;
- 2347 Incidents of domestic violence;
- 95% of eligible two years olds access free nursery provision;
- 94% of children in Tameside go to a Good or Outstanding school;
- 1167 VCSE organisations in Tameside focus on support for children and families;
- 66% of children are assessed as school ready – this is below the NW and England average;
- The rate of permanent exclusions from Tameside schools is roughly three times the national average.

(2016 data source)

3. INVESTMENTS

Investment One - Building capacity to meet additional need in the 0-10 years Tameside Community Families Programme

3.1 The proposal is to build upon the current home visiting programme provided by Home-start (Oldham, Stockport and Tameside) with additional funding of £250,000 per year for two years. Funding of £150,000 from Population Health with a matched £100,000 per year for two years proposed from Troubled Families Funding. This would see an additional 80-100 families supported each year.

3.2 The purpose of the increased investment is to develop and deliver a service and a range of interventions giving family support with an emphasis on trusting peer relationships that will include two sets of beneficiaries: community family volunteers /parent champions and the parents, children and young people they support they support.

3.3 The service will support a caseload of families and recruit and train community volunteers/parent champions to work as peer supporters, providing them with the necessary skills and knowledge to deliver the service and improving their personal

confidence, building social capital and enhancing opportunities for further training and employment.

3.4 It will develop and delivery support packages individually tailored to each family based on the active participation and involvement of families.

3.5 The target group will be children (0-10yr) and families at Level 2 continuum of need with a strong emphasis upon the high end of Level 2.

3.6 Outcomes expected include**:**

- Reduced demand for Children's Social Care via new pathway from the Hub;
- Increased step down from Children's Social Care, Children In Need;
- Improved health related lifestyle behaviours for both adult(s) and child(ren);
- Improved mental health and emotional wellbeing for both adult(s) and child(ren);
- Improved child/ adult relationship and attachment;
- Improved 'family/household' skills including budget managing;
- Improved access to wider services available.

3.7 Home-Start's volunteer led model of early intervention and prevention is a very cost-effective form of family support: SROI by New Economy in development has shown:

- On average, it costs Home-Start £10.69 per week to support a child.
- On average it costs Home-Start £22.93 to support a family for a week.

Investment Two - Building Capacity to meet additional need 11-16yrs

3.8 The proposal is to invest £198,462 per year for two years in the Targeted Young People's Casework team. The team would be based in Tameside Neighbourhoods as part of the Tameside Families Together service, consisting of six Youth Intervention Workers.

3.9 The purpose of this investment is to provide a service for young people 11-16years and their families.

3.10 The aim of the service is to engage young people (aged 11-16) whose emotional and behavioural needs, and family circumstances, indicate a risk of entry to care as they become older. There will be a need to work particularly closely with secondary schools and with Healthy Young Minds in developing an effective response, and supporting parents/families to meet the needs of their adolescent children.

3.11 The target Group will be young people 11-16 years with risk factors that indicate potential entry to care at later stage.

3.12 Outcomes expected include**:**

- Reduced demand for Children's Social Care via new pathway from the Hub
- Increased step down from CSC CIN
- A reduction in incidents of ASB involving 14-19 year olds
- The diversion of 14-19 year olds from involvement in the criminal justice system
- Improved engagement in education, employment and training

3.13 It is estimated that a young person in the criminal justice system costs the taxpayer over £200,000 by the time they are 16. But a young person who is given support to stay out of trouble costs less than £50,000.

3.14 Tameside's Looked After Children profile shows higher than expected numbers in care aged 11 to 15yrs.

Investment Three - Domestic Violence Children's Advisors (CHIDVA)

3.15 The proposal is to invest £80,000 (£40,000 per annum) with additional match funding from Troubled families fund.

3.16 The purpose of this investment is to enable the continued provision of 2 Children's Independent Domestic Violence Advisors (CHIDVA). The IDVAs role is to address the safety of victims (children) who are at high risk of harm of domestic abuse. This project is unique in Greater Manchester. The prevalence of Domestic Abuse in families referred to Children's Social Care is extremely high.

3.17 Target Group: The CHIDVAs core work is with children aged 6-18 through the provision of 1:1 support and group work. Children aged under 5 can be supported as part of a whole package of support with the family.

3.18 The programme supports our approach to tackling Domestic Violence. Delivery against the work of the existing CHIDVA's is assessed by:

- Number of children supported 1:1;
- Number of programme sessions provided;
- Number of children commencing attendance on programmes;
- Number of children completing programmes with outcomes met.

3.19 Qualitative data is collected through case studies and testaments provided by parents and children. This is analysed against key outcomes from the GMCA Victims Services Outcomes Framework.

- In the UK 140,000 children live in homes where there is high-risk domestic abuse and 64% of high and medium risk victims have children, on average 2 each.
- A quarter (25%) of children in high-risk domestic abuse households are under 3 years old. On average, high-risk abuse has been going on for 2.6 years, meaning these children are living with abuse for most of their life.
- 1 in 4 children witness domestic abuse, their physical and mental well-being and chances of doing well at school suffer from an abusive upbringing.
- 62% of children living with domestic abuse are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others.

Investment Four - Delivering a full Children's Integrated Neighbourhood Model for Tameside

3.20 The proposal is to invest £392,029 over two years to fund 4x H grade Neighbourhood Early Help Coordinators and 1x C grade Business Support plus £60k (£30k per annum) for workforce development.

3.21 Capacity to develop a stepped approach to a full Integrated Neighbourhood model for Children and Families, joining up services at the three key tiers of need – universal, targeted and specialist including:

- Development of four neighbourhoods in line with adult model, Children's Centres, Tameside Families Together and Safeguarding Teams/ INS.
- Core wrap around approach for core universal services where children receive core support – the Team Around Approach:
    - Early Years Providers;
    - Primary Schools;
    - Secondary Schools;
    - Primary Care;
    - Youth Services.
- Systematic delivery of targeted early help services – getting the right service to the right family.

- Join up with Children's Social Care for effective step up and step down, and enabling families needs to be met at the lowest level of intervention possible.
- Common workforce development programme for a defined set of services – shared vision, shared outcomes framework, shared language, shared ways of working with families – approach in development to complement 'Signs of Safety'.
- Agreed pathways with specific pathways for specific needs.

3.22 An integrated Model for children and families is associated with a number of positive outcomes, including improved system performance, better outcomes for children and enhanced quality and resident satisfaction. Improving coordination, continuity and timeliness of support is central to this approach.

3.23 Underpinning the model would be a joint workforce development plan – providing the foundations of effective partnership working, both by bringing partners together to foster good working relationships and by introducing a shared framework of how we work with families to either a Restorative Practice[4] or a Signs of Safety[5] model.

4. FINANCIAL CASE

4.1 We know that the economic and social effects of not supporting vulnerable children and families are substantial. For example the fiscal benefits of supporting vulnerable families through the Troubled Families model have already been demonstrated.[6]

4.2 The proposals listed must ensure value for money but have also drawn attention to the costs of doing nothing. For example the economic and social costs of domestic abuse are significant. The Tameside Domestic Abuse Strategy 2016-19 estimates the annual cost to Greater Manchester and Tameside using the updated 2009 Walby Formula (pro-rata by population) an example table:

	Greater Manchester	**Tameside**
Physical and mental health care	£84.4m	£7.5m
Criminal justice	£61.5m	£5.5m
Social services	£13.8m	£1.2m
Housing and refuges	£9.6m	£0.9m
Civil legal services	£18.9m	£1.7m
Local economic output loss	£93.7m	£8.4m
Total costs	£281.8m	£25.2m
The Walby formula estimates further human and emotional costs	£485.6m	£43.4m

[4] Restorative approaches are value-based and needs-led. They can be seen as part of a broader ethos or culture that identifies strong, mutually respectful relationships and a cohesive community and the foundations on which good teaching and learning can flourish. In such a community, young people are given a lot of responsibility for decision-making on issues that affect their lives, their learning and their experiences.

[5] https://www.signsofsafety.net/signs-of-safety/

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/79377/20130208_The_Fiscal_Case_for_Working_with_Troubled_Families.pdf

4.3 Illustration of return on investment will be key and positive outcomes will be shared through the Single Commissions governance. Tameside & Glossop Strategic Commission have a strategic priority to 'embed social value at the heart of our commissioning approach'. The list below illustrates some of the ways we intend to gain social benefits from the investment:

- Creating skills and training opportunities (e.g. volunteers, apprenticeships or on the job training);
- Providing additional opportunities for individuals or groups facing greater social or economic barriers;
- Creating additional investment and supply chain opportunities for local VCFSE organisations;
- Improving market diversity;
- Encouraging community engagement.

4.4 An Early Help scorecard is in development which will allow The Strategic Commission to contribute to research on a Cost Benefit Analysis to measure impact and to help inform future commissioning decisions. New Economy have offered support with this.

4.5 The sustainability of our investment into the Integrated Place based Tameside model and into the services which most effectively support families rests on two main strategies.

4.6 **Reducing Demand** is a key focus of our approach, given that Tameside is currently experiencing an extraordinary rise in demand for specialist statutory services – most notably for Children's Social Care where Tameside is now an outlier within GM and is showing pressures throughout the social care system at a level approximately 20% over our statistical neighbours. It is a primary focus both of Tameside's Improvement Plan for Children's Social Care and of our Early Help Strategy, and therefore of our investment, to drive a reduction in these levels of demand over the next two years. As this demand reduces, and in particular the extraordinary pressure on Looked After Children placement costs comes down, then this will enable further investment in the Early Help services that Troubled Families investment will be supporting over the next two years.

4.7 **Integrated Working and Integrated Investment.** As we build our Integrated Neighbourhood Model we are already in discussions with partners about the principles of joint funding of services, where they can demonstrate that they reduce levels of need – with a particular focus upon the Council, CCG, health providers and schools.

5. DELIVERY / PROCUREMENT APPROACH

5.1 Investments two and four are both within in-house teams and as such there are no procurement issues to address.

5.2 Investments one and three are proposed for external organisations, currently Home-start (Oldham, Stockport and Tameside) and New Charter, in order to extend current provision.

5.3 The Council is obliged to follow its own procurement standing orders which include provision to make a direct award where there are exceptional circumstances to justify such a course of action and it will not contravene any legal obligation.

5.4 The services concerned are subject to Public Contract Regulations 2015 which permits: under the Light Touch regime (LTR) an award of contract without exposure to cross-border competition. This expenditure complies with the criteria of LTR as one of the specified Common Vocabulary Codes (CPV) and the proposed value of expenditure is below the LTR threshold of £589,148 Therefore this procurement route is complaint.

5.5 Procurement Standing Order F1.4 permits a direct award where our requirements can only be met by a single bidder because competition is absent for technical reasons. In this case

this is the specialist localised experience of the service providers combined with the integration with other fundamental services offered to members of the public.

6. HOME-START (OLDHAM, STOCKPORT AND TAMESIDE)[7]

6.1 Investment One, Building capacity to meet additional need in the 0-10 years Tameside Community Families Programme, proposes additional funding of £250,000 per year for two years for Home-start (Oldham, Stockport and Tameside). Funding comprises of £150,000 from Population Health and £100,000 per year for two years from Troubled Families Funding. This funding will deliver the new Tameside Community Families Service via a two year contract.

6.2 In addition it is proposed that the existing core grant for Home start of £75,000 per annum is extended beyond its current end date of 30 September 2018 until 31 March 2020 to align with the new contract for the Tameside Community Families Service.

6.4 Home start supports parents with young families as they learn to cope, improve their confidence and build better lives for their children. The benefits of their support include improved health and wellbeing and better family relationships.

6.5 Home start provides one-to-one support for parents via a team of dedicated and supervised volunteers. Home start volunteers can visit the family's home for a couple of hours every week. Support is tailored to meet the particular needs of parents and children with a commitment to keep visiting until the youngest child turns five or starts school, or until the parents feel they can manage independently. Parents and volunteers often develop a trusting relationship which can lead to powerful change within the family. Home start also run family groups and social events for families.

6.6 The grant funding to Home start increases the quality, quantity, impact and accessibility of volunteering throughout Tameside. The Council celebrates the contribution and value of volunteering in all of its diversity to individuals, communities, causes and the wider society. Home start has one hundred and fifty (150) active volunteers on its database at any one time.

6.7 Home start has been operating in Tameside since 1998, and the Council was instrumental in supporting the local organisation to set up at that time. The Council has had a productive partnership with Home start since around 2008 delivering a home visiting and befriending service. Home start was established for the benefit and well-being of vulnerable families in Tameside, and its uniqueness is defined in their service model of using trained and supervised volunteers to deliver agreed support interventions to families.

6.8 The service has always worked closely with the Council to proactively review its service model and make adaptations to service options in order to meet the changing needs of families locally, and the challenges faced by the locality.

6.9 Parents, carers and the wider family accessing the service offered by Home start are typically vulnerable because they may:

- have poor physical or emotional health, or feel isolated or depressed;
- have problems with substance misuse;
- have learning difficulties;
- have disengaged from statutory services;
- be living in poor environments with very limited financial resources, poor housing or temporary accommodation and limited means of transport;
- be bringing up children on their own;

[7] https://home-starthost.org.uk/

- be teenage parents;
- be experiencing domestic abuse;
- feel discriminated against because they are from black and minority ethnic communities, or because they are refugees or asylum seekers;
- have been poorly parented themselves and so have few models of good parenting;
- be experiencing particular difficulties with a child with behavioural problems;
- be caring for a child with disabilities;
- be a parent of twins or multiples;
- be looking after a child who is looked after.

6.10 Home-start has worked with the Council to redesign its service offer over the years, responding to the changing profile of family's needs being presented along with the tightening of financial resources available.

6.11 Nationally there continues to be strong government emphasis on early intervention. Early intervention and prevention in Children's Services represents an intelligent approach to spending. It requires small investments to deal with root causes, rather than the much greater costs of dealing with the after-effects. It allows us to act in a less intrusive, more cost-effective for example a preventative community parenting programme, can save money on high cost interventions (youth crime and prison, unemployment, mental health problems and going into care) further down the line.

6.12 Evidence suggests that effective preventative intervention help to break recurring cycles of poor social outcomes, and prevent extensive and expensive responses from public services at a later stage. The aim is to shift priorities and resources from damage limitation to prevention and early intervention. It is fully accepted that this is a long-term endeavour.

6.13 The Home Visiting and Befriending Service delivered by Home start over the last six years is a key strand in the borough's parenting provision and support for parent infant attachment. Service evaluation has shown that parents accessing the service become less isolated, more confident and able to cope better as parents. The fundamental purpose of the service is to improve child outcomes through effective prevention, early intervention and quality family support.

6.14 The existing service has successfully used volunteers and members of the local community in establishing contact with those families where there is often a mistrust of professionals and a reluctance to use statutory services. Working in partnership with health visitors and early years services has enabled early intervention with vulnerable families. Trained and supported volunteers, who themselves are parents, have offered support in the families' own homes and in children's centres. The volunteers have offered practical help, support and friendship in order to help prevent family breakdown and crisis. Families have received specific and targeted support and have been signposted to other services to support them making healthy life choices.

6.15 Home-Start's volunteer led model of early intervention and prevention is a very cost effective form of family support:

- On average, it costs a local Home-start £10.69 per week to support a child.
- On average it costs a local Home-start £22.93 to support a family for a week.

6.16 **Procurement Approach:** The services concerned are subject to Public Contract Regulations (PCR) 2015 which permits: under the Light Touch regime (LTR) an award of contract without exposure to cross-border competition. This expenditure complies with the criteria of LTR as one of the specified Common Vocabulary Codes (CPV) and the proposed value of expenditure is below the LTR threshold of £589,148 Therefore this procurement route is complaint.

6.17 Regulation 77 PCR 2015 allows contracting authorities to reserve certain contracts for certain types of 'qualifying' organisations. As a Charitable organisation Home-start is covered by Regulation 77 for Reserved Contracts.

6.18 Procurement Standing Order F1.4 permits a direct award where our requirements can only be met by a single bidder because competition is absent for technical reasons. In this case this is the specialist localised experience of the service providers combined with the integration with other fundamental services offered to members of the public.

6.19 Authorisation for the direct award of contract is therefore seen as low risk and sought on the following grounds:

- The funding is to extend an existing high performing local Charity, with charitable objectives and any profits reinvested into the Charity.
- The Home start service model is bespoke and uniquely tailored to the requirements of Tameside communities and the Community Families Model. Oldham and Stockport give a direct award to the Home-start due to the unique nature of their delivery model. No alternative providers have been identified who can deliver the same peer family support model.
- The service has an established pathway from the Children and Families Hub and so is able to support families directly contacting Children's Social Care and reduce the considerable demand.
- Recruitment of peer support volunteers is central to the cost effectiveness of the delivery model and Home start have an impressive track record in delivering this in Tameside. Alternative models implemented with paid workers would be much more costly and arguably less effective due to the unique relationships that peer support can offer.
- Due to the urgent need to deliver improvements at pace, reduce demand and improve outcomes and support for families at risk, and the delivery of the Ofsted Improvement Plan, there is an urgency to delivering this community service. Home start are able to commence delivery immediately utilising their current peer support volunteers whilst working to recruit and increase capacity.

6.20 Authorisation is sought to award a waiver to standing orders and a direct contract award to Home start for the provision of the extended peer support service for a period of two years and increase capacity of the service to support a further 80-100 families per year at a value of £250,000 per annum from 1 April 2018 to 31 March 2020.

6.21 Authorisation is also sought to extend the current core grant (£75,000 per annum) to Home-start which supports the organisations core activities until 31 March 2020 to align with the above service.

7. EXTENSION OF DOMESTIC ABUSE CONTRACT

7.1 Investment Three, Domestic Violence Children's Advisors (CHIDVA), proposes to invest £80,000 (£40,000 per annum) to match funding from the Troubled Families Fund to fund the provision of 2 Children's Independent Domestic Violence Advisors (CHIDVA).

7.2 IDVAs are currently embedded and integrated within the provision of domestic abuse services. This includes the provision of one Children's IDVA funded via GM Police and Crime Commissioners Office. The funding for this post will be picked up by the Troubled Families Fund. Funding from the Population health investment fund will fund the additional capacity.

7.3 The contract for Domestic abuse provision (the Bridges service) is currently held by New Charter. The contract expires on 30 September 2018 and a procurement process is underway to procure a new contract from 1 September 2018.

7.4 Due to the uncertainty and short term nature of several of the funding streams for the domestic abuse service the tender value was of a range that will accommodate this additional funding. The specification included the provision of a children's IDVA. There should therefore be no procurement or contractual barriers to including this additional funding in the new service once procured.

7.5 The Children's IDVAs role is to address the safety of victims who are at high risk of harm of domestic abuse. This project is unique in Greater Manchester. The prevalence of Domestic Abuse in families referred to Children's Social Care is extremely high.

7.6 Authorisation is sought to vary the current Domestic Abuse contract with New Charter from 1 April 2018 to continue the current Children's IDVA provision and to increase provision by an additional Children's IDVA until the expiry of the contract on 30 September 2018 at a value of £40,000.

7.7 Authorisation is also sought to increase the value of the new domestic abuse contract when awarded to include the provision of the two Children's IDVAs at a cost of £80,000 per annum until 31 March 2020.

8. VALUE OF THE PROPOSAL

8.1 The total value of the proposal is £714,476 in 2018/19, £754,476 in 2019/20 and £40,000 in 20-21. Details for the four investment programmes are as follows:

Delivering our new approach to early help for children and families, reducing demand on children's social care					
Title of intervention	**Proposed Allocation**	**Proposed Funding**			
		18/19	**19/20**	**20/21**	
Building capacity to meet additional need 0-10 yrs	Tameside Community Families Programme - Building on the current home visiting programme provided by Homestart	150,000	150,000		
		100,000	100,000		*proposed from Troubled Families Funding
Building Capacity to meet additional need 11-16yrs	Targeted Youth team	198,462	198,462		
Domestic Violence Children's Advisors (CHIDVA) x2		20,000	40,000	20,000	
		20,000	40,000	20,000	*proposed from Troubled Families Funding
Delivering a full Integrated Neighbourhood Model for Tameside	4x H grade Neighbourhood Early Help Coordinators / Admin/ Workforce development	196,014	196,014		
		30,000	30,000		
		714,476	**754,476**	**40,000**	
	Proposed funding over 3 years	1,508,952			
	Troubled Families Grant	280,000			
	Popualtion Health	1,228,952			

This page is intentionally left blank

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 March 2018

Officer of Strategic Commissioning Board Sandra Whitehead - Assistant Director — Adults

Subject: **PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF STRAIGHT AND CURVED STAIR LIFTS, VERTICAL LIFTS, STEP LIFTS AND OVERHEAD TRACK HOISTS INSTALLED IN DOMESTIC PROPERTIES IN TAMESIDE AND OLDHAM**

Report Summary: The report describes the rationale for and purpose of an extension of the above contract for a period up to 6 months in order to re-tender the service following the abandonment of the previous tender process as a result of issues identified in the tender process.

Recommendations: That the Strategic Commissioning Board note the report and approve an extension of the contract with the current provider of the service, City Lift Services (NW) Ltd for a period of up to 6 months to enable a further procurement exercise to be undertaken.

Financial Implications:

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

ICF Budget	S 75 £'000	Aligned £'000	In Collab £'000	Total £'000
TMBC Adult Services	120	-	-	120
Section 75 - £'000 Strategic Commissioning Board			120	

Additional Comments

The service provided via this contract supports the Care Together vision of enabling residents to live independently within their own homes.

There are no major concerns on the existing performance of the contract provider. The proposed six month extension is affordable within the existing budget allocation within the Adult Services directorate; 2.5 months within 2017/18 and a further 3.5 months within 2018/19.

It is essential that the re-tender of the service remains affordable within the budget allocation. Clearly a reduced annual cost will be preferable to ensure savings are realised which will contribute towards the care together locality funding gap.

Legal Implications:

(Authorised by the Borough Solicitor)

Whilst an extension of existing arrangements is not ideal, it is not unlawful to extend the arrangements to enable an open, transparent and fair procurement exercise to take place. There is materially lower risk of challenge from this approach than proceeding with the award of the previously tendered contract.

How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Developing Well and Living Well programmes for action
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Health Care Advisory Group:	Not Applicable.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	People are supported to continue living in their own homes.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to this service
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information will be maintained at all times by both purchaser and provider. The purchasers Terms and Conditions for services contains relevant clauses regarding Data Management
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan
Access to Information :	The background papers relating to this report can be inspected by contacting Linsey Bell, Contracts & Commissioning Officer, Strategic Commissioning Unit Telephone: 07773233740 e-mail: Linsey.bell@tameside.gov.uk

1. BACKGROUND

1.1. This report concerns a contract for the provision of the inspection, servicing, maintenance and repair of straight and curved stair-lifts, vertical through-floor lifts, step lifts and overhead track hoists installed in domestic properties in Tameside and Oldham.

1.2. The contract was jointly commissioned with Oldham MBC, with Tameside as the lead commissioner - City Lift Services (NW) Ltd is the current provider. The current contract was extended in early 2017 for an additional 12 months allowed for in the contract. The contract expired on 18 January 2018.

2. CURRENT SITUATION

2.1 A notice was placed in the Official Journal of the European Union on 7 September 2017 seeking expressions of interest from bidders interested to tender for the above contract. The notice stated that bids would be evaluated on a Cost/Quality basis of 40%/60%.

2.2 The tender return date was Monday 9 October 2017. Eleven (11) tenders were received and were evaluated resulting in the intention to award the contract to City Lift Services (NW) Ltd, the incumbent provider.

2.3 Letters were issued to all bidders advising them of the Council's intention to award the contract and providing them with the information required under Regulation 86 of the Public Contracts Regulations. This is known as a standstill letter which triggers a standstill period during which the Council cannot enter into a contract to allow participants to scrutinise the award decision. Following the issue of the correspondence, a number of requests were received for clarification about the evaluation methodology and how this applied to the tenderers submission.

2.4 In responding to those requests for clarification, officers became aware of an inconsistency within the tender documentation which has resulted in the Council being unable to award the contract in an open, transparent and fair way. To do so would have resulted in a significant risk to the Council and the procurement would be susceptible to challenge. A decision was taken by the Head of Strategic Operations, Adult Services to abandon the procurement and reprocure. All bidders were advised of the outcome on 17 January 2018.

3. PROCUREMENT STANDING ORDER SEEKING TO WAIVER/AUTHORISATION TO PROCEED

3.1 Authorisation is sought pursuant to Procurement Standing Order F1.2 to extend the existing contract as only the existing contractor can meet the tender requirements and no reasonable alternative or substitute exists.

4. VALUE OF THE CONTRACT

4.1 Costing on this contract is per job and varies depending on the type of job: maintenance of straight and curved stair-lifts, through-floor lifts, step and platform lifts, ceiling track hoists and removal, disposal and reconditioning.

4.2 In order to provide an estimation of the costs for the duration of the proposed extension, spend for the same duration last year was calculated as £28,518 on callout/ repairs and servicing (£24,978 on call out and £3,540 on servicing) plus an extra £3,500 on removals totalling £32,018 for a 3 month duration. The annual contract value is a maximum of £200,000 (£120,000 Tameside MBC/£60,000 - £80,000 Oldham MBC).

5. GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

5.1 Authorisation is sought pursuant to Procurement Standing Order F1.2 to extend the existing contract for a period of up to 6 months to enable a procurement exercise to be undertaken.

5.2 City Lifts have delivered this service since January 2014 and overall have performed very well for both boroughs with nothing except occasional and minor complaints about the time it sometimes can take to get an engineer to site and the length of time it can take to acquire non-stock parts demonstrated a consistent level of quality provision.

5.3 To ensure that people are supported to continue to live in their own homes, the Council needs to extend the existing arrangements to ensure a more robust procurement exercise is undertaken.

6. RECOMMENDATION

6.1 As stated on the report cover.