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# Tameside & Glossop Care Together

## STRATEGIC COMMISSIONING BOARD

**Day:** Tuesday
**Date:** 17 April 2018
**Time:** 2.00 pm
**Place:** George Hatton Hall - Dukinfield Town Hall


| Item No. | AGENDA | Page No |
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| **1.** | **WELCOME AND APOLOGIES FOR ABSENCE** | |
| **2.** | **DECLARATIONS OF INTEREST** | |
| | To receive any declarations of interest from members of the Single Commissioning Board. | |
| **3.** | **MINUTES OF THE PREVIOUS MEETING** | 1 - 8 |
| | To receive the Minutes of the previous meeting held on 20 March 2018. | |
| **4.** | **FINANCIAL CONTEXT** | |
| **a)** | **FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** | 9 - 22 |
| | To consider the attached report of the Director of Finance. | |
| **5.** | **COMMISSIONING FOR REFORM** | |
| **a)** | **COMMISSIONING IMPROVEMENT SCHEME 2018/19** | 23 - 28 |
| | To consider the attached report of the Interim Director of Commissioning. | |
| **b)** | **PROVISION OF CALL HANDLING SYSTEM FOR COMMUNITY RESPONSE SERVICE** | 29 - 42 |
| | To consider the attached report of the Assistant Director (Adult Services). | |
| **c)** | **PROVISION OF E-ROSTERING AND ALLOCATION SYSTEM FOR REABLEMENT SERVICE, COMMUNITY RESPONSE SERVICE AND LONG TERM SUPPORT SERVICE** | 43 - 50 |
| | To consider the attached report of the Assistant Director (Adult Services). | |
| **d)** | **PROVISION OF A LEARNING DISABILITY RESPITE SERVICE** | 51 - 56 |
| | To consider the attached report of the Director of Adult Services. | |
| **6.** | **QUALITY AND PERFORMANCE CONTEXT** | |
| **a)** | **QUALITY REPORT** | 57 - 70 |
| | To consider the attached report of the Director of Safeguarding and Quality. | |
| **b)** | **PERFORMANCE REPORT** | 71 - 94 |
| | To consider the attached report of the Assistant Director (Policy, Performance and Communications). | |


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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.

**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).

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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 March 2018**

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

**Present:**
Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Bill Fairfoull – Tameside MBC
Councillor David Sweeton – Tameside MBC
Dr Christina Greenhough – NHS Tameside and Glossop CCG
Dr Alison Lea – 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
James Thomas – Director of Children's Services
Debbie Watson – Interim Assistant Director of Population Health
Sandra Whitehead – Assistant Director – Adults Services
Stephen Wilde – Finance Business Partner
Alison Lewin – Deputy Director of Transformation

**Apologies:**
Steven Pleasant – Tameside MBC Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Jim Fitzpatrick – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Councillor Leanne Feeley – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Jean Wharmby – Derbyshire CC
Dr Jamie Douglas – NHS Tameside and Glossop CCG
Gill Gibson – Director of Safeguarding and Quality

## 41. DECLARATIONS OF INTEREST

| Members | Subject Matter | Type of Interest | Nature of Interest |
|---|---|---|---|
| Dr Christina Greenough | Item 6(b) – Primary Care Access Service | Prejudicial | Director - Go-To-Doc |
| Dr Vinny Khunger | Item 6(b) – Primary Care Access Service | Prejudicial | Clinical Lead – Go-To-Doc |

## 42. CHAIR'S OPENING REMARKS

The Chair welcomed everyone to the meeting and updated Members in respect of recent CCG elections and announced that Dr Jamie Douglas and Dr Alison Lea had been reappointed along with a new GP member; Dr Ashwin Ramachandra. He further announced that there was one departure from the Governing Body, Christina Greenough. The Chair thanked Christina for all her hard work.

In addition, the Chair advised of a new position taken up by a newly qualified GP – Dr Chan and a new lay member; Maggie Murdoch.

## 43. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 20 February 2018 were approved as a correct record.

## 44. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND – MONTH 10 2017/18

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 10 financial position at 31 January 2018 and the projected outturn at 31 March 2018. The total Integrated Commissioning Fund was £487m in value. However, it was noted that this was subject to change as new inter authority transfers were actioned 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 1 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 £4.2m.
- 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 £23.7m 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 3 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 1 to the report. It was noted that there was a forecast £0.4m under achievement of this efficiency sum by the end of the financial year. It was noted that the gap of £3.6m reported last month had since been resolved through the risk share contribution that had been transacted non-recurrently in month 10. 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 10 financial position at 31 January 2018 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.**

## 45. COMMISSIONING FOR QUALITY FRAMEWORK

The Director of Safeguarding and Quality submitted a report explaining that, in Tameside and Glossop Pubic Health, Social a Care and the Clinical Commissioning Group (CCG) had come together as a Single Commissioning Function, combining commissioning teams and budgets. With this arrangement came a commitment and responsibility for securing continued high quality services for its local population.

It was reported that the Tameside and Glossop Strategic Commission Quality Framework (as appended to the report) set out a Commitment to Quality from the leaders of Tameside and Glossop Single Commissioning Function. The framework provided a mechanism for overseeing

quality across health and social care. The framework complied with the nationally agreed definition of quality and the Greater Manchester Health and Social Care Partnership Quality Improvement Framework. The framework ensured quality was embedded at all stages of the commissioning cycle, from strategic planning, to procurement assurance and supporting service improvement.

It was noted that the framework was appended to the Terms of Reference for the Quality and Assurance Group, which would be reviewed in 12 months' time.

**RESOLVED**
**That the Commissioning for Quality Framework and the Terms of Reference for the Quality Performance Assurance Group be endorsed.**

## 46. POPULATION HEALTH INVESTMENT FUND

A report of the Interim Assistant Director of Population Health and the Interim Director of Children's Services was submitted, seeking 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 was 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; and
- Preventing and Managing Long Term Conditions.

A summary of the proposals and strategic commission leads for each of the priority areas above, was detailed in the report.

Board members were informed that the proposed priority areas for investment would be resourced via the non-recurrent Population Health reserve of £3.004 million and a key consideration was the sustainability of the interventions recommended for approval. Rigorous evaluation of the outputs and outcomes from the prevention interventions would enable an assessment of the value to the health and social care community of different approaches. The proposals would be evaluated and monitored and reported back to the Strategic Commissioning Board.

It was explained that if the proposed programmes were supported, three more detailed business cases would be produced for discussion and agreement through the Strategic Commission Governance.

The first of the three business cases was then presented for agreement and details of 'Delivering our new approach to Early Help for Children and Families reducing demand on Children's Social Care' was appended to the report.

It was explained that the Early Help approach was a key driver within Tameside in terms of the Tameside Think Family approach and public service reform. The Early Help Business Case investments would 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.

Detailed discussion ensued in respect of the proposals and members sought further clarity with reference to the non-recurrent funding and sustainability for the future.

The Interim Assistant Director of Population Health explained that robust impact assessments and outcomes framework measures would be carried out and suggested that reports be submitted to the Board on a regular basis in respect of this.

**RESOLVED**

**(i) That the priority areas for investment, as outlined in the report, be agreed;**

**(ii) That the proposals set out in Early Help business case, as appended to the report, be agreed;**

**(iii) That the extension of the 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, be approved;**

**(iv) That a waiver to standing orders to allow the direct award of contract to Home-Start (Oldham, Stockport and Tameside) for a period of two years form 1 April 2018 to 31 March 2020, with an annual value of £250,000 to deliver the Community Parenting Service, be granted.**

## 47. INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP

Consideration was given to a report of the Interim Director of Commissioning, which explained that Tameside and Glossop Strategic Commission had led the development of a locality vision for an enhanced offer of urgent care, i.e. support for conditions that needed prompt medical help to avoid them deteriorating but were not life threatening. Officers were asked to bring back a fully developed proposed model to the Strategic Commissioning Board following public consultation.

It was explained that 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.

The two options had 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 had taken place through contacting specific groups across Tameside & Glossop.

The report detailed the consultation analysis and an Equality Impact Assessment which responded to issues arising during the consultation and explored mitigations.

Details of proposed actions, timelines and milestones for the implementation were also detailed.

The report concluded that the Strategic Commission were confident that the four key themes set out in the NHS England October 2015 guidance on major service change and reconfiguration had been met as follows:

**Preparation and Planning:** the development of the model for urgent care had been a key workstream for the Tameside and Glossop Accident and Emergency Care Board and was 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 and social care in Tameside and Glossop. The Strategic Commission had 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.

**Evidence**: the ‘case for change’ information included in the report indicated that proposals for urgent care had been developed based on clear clinical evidence and that they align with clinical guidelines, best practice and national expectations.

**Leadership and clinical involvement:** The case for change for the urgent care model had been driven by the Tameside and Glossop Accident and Emergency Care Board, the membership of which included all representatives for existing providers, commissioners and the voluntary sector along with Care Together programme, with the Integrated Care HNS Foundation Trust, the Local

Authority and the Clinical Commissioning Group as key partners in the programme. This had involved working with a wide range of health and social care providers and community organisations/3rd sector partners. The consultation and engagement work which had been undertaken between 1 November 2017 and 26 January 2018 had 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 the report.

**Involvement of Patients and the Public**: The consultation process, as outlined in the report, provided details of extensive public and patient engagement in the consultation. Public meetings had 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 had taken place as part of the consultation process. The Strategic Commissioning Board meetings, where decisions were taken in relation to commissioning proposals, were public meetings.

Discussion ensued with regard to a number of issues, in particular with regard to the relatively poor response to the consultation; the variations between Option 1 and Option 2 and how best to deliver the vision, and it was:

**RESOLVED**

**(i) That the Strategic Commissioning Board NOTE the following:**

- **(a) The content of the 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 improvement in clinical outcomes, patient experience and operational efficiency, to the proposed recommendations on the way forward;**
- **(b) The case for change;**
- **(c) The responses arising from the Urgent Care consultation and the Strategic Commission responses which have shaped the recommendations to the Board;**
- **(d) The detailed Equality Impact Assessment which outlined further mitigations; and**
- **(e) 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.**

**(ii) That the Strategic Commissioning Board RECOMMEND APPROVAL of Option 2, as outlined within the consultation, as the preferred model for future provision of Urgent Care and the relocation of walk-in access from Ashton Primary Care Centre to the hospital site. The Strategic Commissioning Board gave this recommendation following the consideration of appropriate mitigations, as detailed in the report, addressing any adverse impacts caused by the relocation of walk in access from Ashton Primary Care Centre to the Hospital site.**

***Dr Christina Greenough and Dr Vinny Khunger, having declared a prejudicial interest, left the room during consideration of the following item and paid no part in the discussion or decision thereon.***

## 48. PRIMARY CARE ACCESS SERVICE

The Interim Director of Commissioning submitted a report setting out the need to consider the future commissioning of the proposed Primary Care Access Service (the Urgent Care element). The Urgent Care element was the name of the new service which combined 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 outlined the rationale for a single contract for these three services to continue the drive for an integrated service model and financial efficiencies in line with the Urgent Care strategy. It identified the benefits and risks for commissioning the new model through a formal competitive tender process rather than via a direct award.

It was noted that the report was being considered following the decision made on the previous item on the agenda (Minute 47 refers - Integrated Urgent Care in Tameside and Glossop).

Board members sought further clarity in respect of governance going forward and how the service would be monitored. Managing conflicts of interest within the governing body GPs relating to connections with current providers, which would affect which members were able to provide clinical advice and support within the procurement process was also highlighted. Members were assured that all conflicts of interest would be managed in accordance with NHS regulations.

**RESOLVED**
**That the Strategic Commissioning Board:**
**(i) Note the benefits of bringing three current services (Enhanced Access Service, Out of Hours and Alternative to transfer) together into one single contract;**
**(ii) RECOMMEND APPROVAL of the procurement for the single contract for the Urgent Care aspects of the Primary Care Access Service; and**
**(iii) RECOMMEND APPROVAL of 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.**

## 49. APPROVAL OF ADULT SOCIAL CARE FEES (EXCLUDING CARE HOMES 2018-19)

The Director of Adult Services submitted a report, the focus of which was the setting of revised prices to meet the increasing cost of providing social care support to vulnerable adults.

It was explained that work had been progressing over the past three months in relation to the impact of an number of cost pressures imposed nationally on current providers that significantly challenged the financial viability of what the council and CCG had 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.

Discussions with providers, whilst recognising the expectation that National Living Wage (NLW) and sleep-in rates were met, had 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.

Much work had been done over the past few years to radically change the way that services were provided. For example, in the Council's Adult Services a total of £23.6 million had been taken out of the budget since 2010 (a net budget reduction of 34%) which had been achieved through radical service redesign, a reduction in management capacity and 20% reduction in contract costs.

It was further explained that these reductions had been happening at the same time as demand for service provision had been rising – the increasing number of older people and younger adults with complex and life limiting conditions and disabilities had added further pressure to the services provided. Although many people were encouraged to seek help from within their own families or communities many still require help and support. The people who were now receiving care and support were those with more complicated and complex care and support needs that often needed 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 had also meant that many more

people in the Borough were living longer; however they were living with one or more health issues that required help and support.

The report set out proposals for costs that would constitute the minimum requirements to meet the specific cost pressures imposed on providers following consultation with the provider sector.

It was summarised that the health and social care economy had seen unprecedented reductions in funding over the past five years. As a result of these reductions all services had been subject to review to establish where efficiencies could be achieved and/or where services could be provided differently. This included consideration of services where there were statutory and non-statutory duties and responsibilities.

The demand to meet savings targets had progressed at a time when providers had in the main been facing increased operating costs. The most significant increase in costs had been those recently experienced specifically in relation to the introduction of the National Living Wage to a sector that had for many years been operating on wage levels at or close to minimum wage levels, but also in relation to increased pension contributions.

Work had been progressing over the past three months to work with providers to reflect these additional costs in realistic prices that could continue the delivery of what were essential services for the vulnerable adults concerned. The methodology adopted had included revising cost of care framework that reflected local factors, whilst, in the case of the supported accommodation had adopted open book accounting methodology to establish the impact on costs of these additional requirements.

This work had resulted in the proposed uplifts that were presented in the report. The estimated net costs of which amounted to £0.157 million for Home Care, with a further increase for the supported accommodation contracts of £0.543 million.

**RESOLVED**
**That the content of the report be noted and the following approved:**

**(i) 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;**
**(ii) The proposed new rate for Extra Care of £13.68 per hour;**
**(iii) The proposed sleep-in rate of £103.26 per night, and £137.65 per night for waking nights, across all adult services contracts;**
**(iv) The revised supported accommodation contract prices highlighted in Section 4 of the report, summarised in Appendix 3;**
**(v) 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; and**
- **Day services day rate of £31.37.**

**(vi) The revised contract prices for the Day Services highlighted in Section 4 of the report;**
**(vii) The revised contract price for the Community Recovery Service (LD Respite) highlighted in Section 4 of the report;**
**(viii) The revised fees for Shared Lives in Section 4, Table 3 of the report; and**
**(ix) That all the above proposed new rates will be effective from 1 April 2018.**

## 50. NEW CARE HOME MODEL AND FEES FOR 2018/19

A report was submitted by the Director of Adult Services, seeking approval for the proposed fees for the 2018/19 financial year, both for if the On/Off Framework arrangement was removed, or if it remained the same (to be agreed at Executive Cabinet on the 21 March 2018). Subject to Executive Cabinet agreeing to remove the On/Off Framework arrangement there were a small number of service users who would be directly financially disadvantaged by the change of policy, for which it was proposed the Council would pick up the difference.

It was explained that, as this change in policy would 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 noted the need to use the NHS Shorter Form contract as the basis for the continuing contractual relationship with the care homes and sought approval for the proposed Enhanced Payment criteria.

The report also sought approval to the way the approved list operated, i.e. to change the mechanism to a Dynamic Purchasing System (DPS), whilst recognising service users' rights to choose any care home provider that was registered with the Care Quality Commission and met the conditions as laid out in the Care Act Guidance 2017.

**RESOLVED**

**(i) That the fee structure for 2018-19 as set out in Section 8 of the report, be agreed;**
**(ii) It be agreed that current service users would not be disadvantaged by the change in contractual policy arrangements and any financial difference would be met;**
**(iii) That the criteria for the Enhanced Payment be agreed;**
**(iv) That the transitional period of 12 months, for those providers currently receiving the enhanced payment be agreed, but due to the inclusion of the CQC rating of 'Good' or 'Outstanding' in the new criteria, cannot now meet this criteria;**
**(v) That the requirement to use the NHS Shorter Form contract as the basis for the contract with the care homes, be recognised; and**
**(vi) It be acknowledged that there will be service users financially disadvantaged by the proposal, and agreed that the Section 75 Pooled Budget would meet the difference between the Off & On Framework rates for those service users.**

## 51. 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

Consideration was given to a report of the Director of Adult Services, which outlined the rationale 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.

**RESOLVED**
**That the content of the report be noted and 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, be approved.**

## 52. URGENT ITEMS

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

## 53. DATE OF NEXT MEETING

It was noted that the next meeting of the Strategic Commissioning Board would take place on Tuesday 17 April 2018 commencing at 2.00 pm at Dukinfield Town Hall.

**CHAIR**

| | |
|---|---|
| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 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 28 FEBRUARY 2018 AND PROJECTED OUTTURN TO 31 MARCH 2018** |

**Report Summary:**

This is a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the consolidated financial position of the Economy.

The report provides a 2017/2018 financial year update on the month 11 financial position (at 28 February 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 the 2017/2018 financial year update on the month 11 financial position (at 28 February 2018) and the projected outturn (at 31 March 2018).
- Acknowledge the significant level of savings required during the period 2017/18 to 2020/21 to deliver a balanced recurrent economy budget.
- Acknowledge 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**<br><br>This report provides the consolidated financial position statement of the 2017/18 Care Together Economy for the period ending 28 February 2018 (Month 11 – 2017/18) together with a projection to 31 March 2018 for each of the three partner organisations.<br><br>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.<br><br>A risk share arrangement is in place between the Council and CCG 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.<br><br>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 CCG. | |

**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 : |

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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 A**.

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 and 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 provided in **Appendix A**. 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:-

- Following transaction of the ICF risk share the CCG is able to show a balanced financial position in 2017/18. However this ignores significant underlying pressures in individualised commissioning of approximately £6.4 million compared to the opening budget.

- Children's Services within the Council is managing unprecedented levels of service demand which is currently projected to result in additional expenditure of £8.2m 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) savings target which is conditional upon the CCG agreeing to a reciprocal arrangement in 2019/20 and 2020/21. For 2017/18 an increased Council contribution of £4.2m has been transacted in line with this agreement. 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 £ 7.43m 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**

| | Forecast Position | | | Forecast Position | |
|---|---|---|---|---|---|
| **Organisation** | **Budget** | **Forecast** | **Variance** | **Previous Month** | **Movement in Month** |
| | **£000's** | **£000's** | **£000's** | **£000's** | **£000's** |
| **Strategic Commission** | 487,381 | 494,810 | -7,429 | -7,116 | -313 |
| **ICFT** | -23,730 | -23,730 | 0 | 0 | 0 |
| **Total** | **463,651** | **471,080** | **-7,429** | **-7,116** | **-313** |

**Table 2 – Risk Share**

Risk share contributions transacted in 2017/18.

| 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 |

2.3 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 A.**

2.4 A summary of the financial position of the ICF, analysed by directorate is provided in **Table 3.**

**Table 3 – 2017/18 ICF Financial Position**

| | Budget | Forecast | Variance | Previous Month | Movement in Month |
|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 |
| Acute | 203,170 | 205,736 | - 2,566 | - 2,233 | - 333 |
| Mental Health | 29,754 | 29,995 | - 240 | - 196 | - 45 |
| Primary Care | 83,109 | 81,775 | 1,334 | 1,192 | 142 |
| Continuing Care | 13,623 | 14,340 | - 717 | - 712 | - 5 |
| Community | 27,473 | 27,501 | - 28 | - 108 | 80 |
| Other | 28,970 | 26,760 | 2,210 | 2,053 | 157 |
| QIPP | - | - | - | - | - |
| CCG Running Costs | 5,197 | 5,189 | 8 | 4 | 3 |
| Adult Services | 44,185 | 43,660 | 525 | 526 | - 1 |
| Children's Social Care | 35,192 | 43,400 | - 8,208 | - 7,812 | - 396 |
| Population Health | 16,708 | 16,454 | 254 | 170 | 84 |
| **Integrated Commissioning Fund** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |
| | | | | | |
| CCG Expenditure | 391,296 | 391,296 | - 0 | - 0 | 0 |
| TMBC Net Expenditure | 96,085 | 103,514 | - 7,429 | - 7,116 | - 313 |
| **Integrated Commissioning Fund** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |
| | | | | | |
| A: Section 75 Services | 266,791 | 266,929 | - 138 | - 128 | - 10 |
| B: Aligned Services | 187,296 | 195,161 | - 7,865 | - 7,502 | - 363 |
| C: In Collaboration Services | 33,294 | 32,720 | 574 | 513 | 60 |
| **Integrated Commissioning Fund** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |

2.5. **Acute** - Against a full year budget of £203.1m, expenditure is forecast to be £205.7m. This represents an overspend of £2.6m. The acute position has deteriorated by £0.3m since month 10, mainly driven by high cost critical care patients, non contracted activity and acute oncology costs. Emergency admissions and critical care continue as the chief contributors to the overall pressure. As year-end approaches settlement positions on associate provider contracts are being agreed. The position outlined above includes settlements on the Manchester Foundation Trust, Pennine Acute and Wrightington, Wigan & Leigh contracts. While the position is fixed in terms of income & expenditure for the 2017/18 accounts, post reconciliation adjustments will be made based on actual activity when final data is available in June. In total the projected overspend on associate contracts is £2.5m analysed in table 4:

**Table 4 – Associate Contracts**

| | £ m |
|---|---|
| **A&E** | (0.2) |
| **Planned Care** | 0.3 |
| **Outpatients** | (0.5) |
| **Urgent Care** | (1.2) |
| **Excess Bed days** | (0.1) |
| **Critical Care** | (0.9) |
| **Other** | 0.03 |

2.6 **Mental Health** - Against Core budgets a £0.2m overspend is forecast. This is a £0.05m adverse movement on the position reported last month due to individualised commissioning placements. The CCG received an additional allocation of £0.3m to fund services for children and young people. Liaison is ongoing with Pennine Care regarding settlement of the 2017/18 position. The CCG remains on track to meet the Mental Health Investment Standard (MHIS), at Month 11 mental health spend is 2.85% higher than last year, against a target of 2.00%

2.7 **Primary Care –** Currently forecast at £1.3m underspend. This is an overall improvement of £0.1m since last month. This relates to an additional allocation to fund winter pressures in primary care, which the CCG had already committed to fund from baseline allocation.

2.8 **Continuing Care** – Against Core budgets there will be a £0.7m overspend. This is a minimal deterioration on the position reported last month. This cost centre includes a £3.5m contribution through the ICF risk share which offsets some of the reported overspend versus the original budget.

Growth in individualised packages of care remains the CCGs biggest financial risk. Across Continuing Healthcare and individually commissioned packages in mental health and neuro rehab there is a total pressure of £6.4m, £4.2m of which is mitigated by the increased Council contribution to the risk share.

2.9 **Community** - The majority of spend within this directorate is within the block contract for the ICFT. There is an £0.1m favorable movement in the position at month 11 following successful resolution of query raised with HM Revenue and Customs.

2.10 **Other** – This area includes the Better Care Fund, estates, transformation funding and reserves. Better Care Fund 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 NHS Property Services.

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

2.11 **Quality, Innovation, Productivity and Prevention (QIPP)** – Against an annual savings target of £23.9m, all £23.9m has been fully achieved. Following transaction of the risk share the CCG is reporting a post mitigation risk for 2017/18 of zero to NHS England

2.12 **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.

2.13 **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.

The increase in the number of Homecare hours delivered throughout January was reflected in the previous months report and the current forecast reflects a stabilisation in the number of hours throughout February 2018.

Whilst Nursing bed capacity in Care Homes has improved slightly since the previous reporting period, vacancy levels remain low at 6.2% (33 beds) across the borough.

2.14 **Children's Services** – Pressure of £8.2m 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 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. There has been an increase of £0.1m to the projected employee related expenditure reported at month 11 when compared to month 10, primarily relating to agency social workers.

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.

The number of Looked After Children has increased from 519 at April 2017 to 613 in March 2018 (590 in January 2018). The projected placements related expenditure for month 11 has subsequently increased by £0.3m when compared to the month 10 projected outturn value.

The current placements budget allocation will finance approximately 450 placements, assuming average weekly unit costs for placements.

2.15 **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 A** provides supporting analysis of the delivery against this requirement for the whole economy. It is worth noting that there is a forecast £0.3m under achievement of this efficiency sum by the end of the financial year.

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

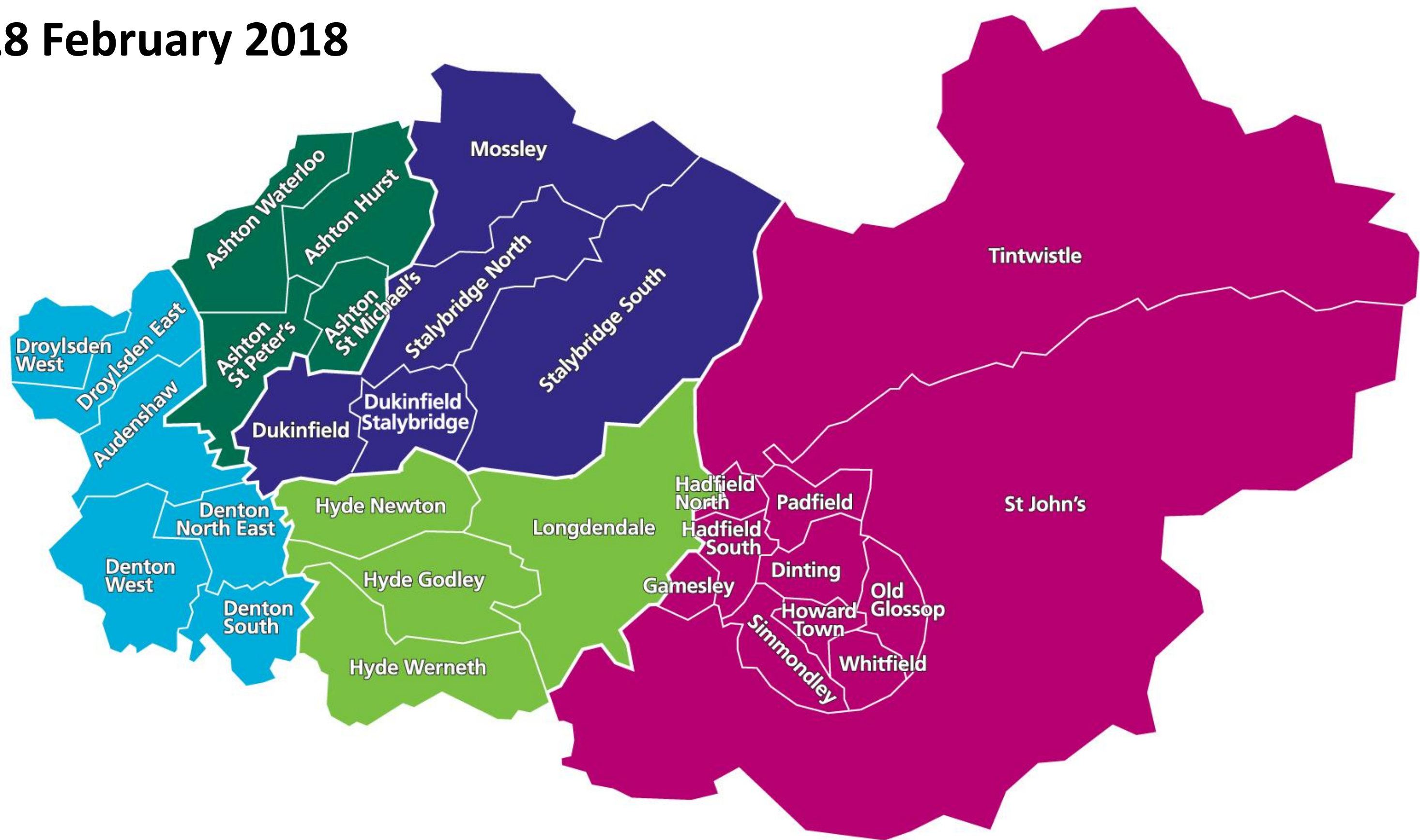
## 4 RECOMMENDATIONS

4.1 As stated on the report cover.

TAMESIDE AND GLOSSOP
Care together

# Tameside and Glossop Integrated Financial Position
*financial monitoring statements*

**Period Ending 28 February 2018**
**Month 11**






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 £7,429k financial gap

## How do we close this gap?

| | YTD Position | | | Forecast Position | | | Forecast Position | |
|---|---|---|---|---|---|---|---|---|
| Organisation | 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** | 444,335 | 451,150 | -6,815 | 487,381 | 494,810 | -7,429 | -7,116 | -313 |
| **ICFT** | -22,088 | -22,054 | 34 | -23,730 | -23,730 | 0 | 0 | 0 |
| **Total** | **422,247** | **429,096** | **-6,781** | **463,651** | **471,080** | **-7,429** | **-7,116** | **-313** |



- Following transaction of the Integrated Commissioning Fund risk share, the Strategic Commission funding position shows a gap of £7,429k. 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. Both CCG and council continue to report that we will meet financial control totals.
- The ICFT are working to a planned deficit of £23,730k for 2017/18, which is consistent with the reported position last month. Trust efficiencies of £10,397k are required in order to meet this control total.
- 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 equals 1.6% of the total budget:

**Economy Wide Highlights**

- The full £23,900k QIPP target has been achieved in year (£12,252k delivered recurrently). As such the CCGs post mitigation risk for 2017/18 is reported as 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 £2,193k. This includes the increased contribution from the risk share highlighted above. This doesn't change the underlying position that there is a £6,393k cost pressure in this area.
- £8,208k projected overspend on Children's Services predominantly driven by out of area placements. £500k from the risk share contribution was transacted in this area as outlined above.
- £2,566k 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 11 | | | Year to Date | | | Forecast Outturn | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Variance | Plan | Actual | Variance | Plan | Actual | Variance |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Normalised Surplus/(Deficit) | (1,767) | (1,040) | 727 | (22,088) | (22,054) | 34 | (23,730) | (23,730) | 0 |
| Capital Expenditure | 1,131 | 489 | (642) | 4,825 | 2,451 | (2,374) | 4,664 | 4,664 | 0 |
| Cash and Equivalents | 1,190 | 1,510 | 320 | | | | | | |
| Trust Efficiency Savings | 1,230 | 904 | (326) | 9,134 | 8,612 | (522) | 10,397 | 10,096 | (301) |
| Use of Resources Metric | 3 | 3 | 0 | 3 | 3 | 0 | 3 | 3 | 0 |

YTD Net position is £22m deficit, which is broadly in line with plan

Internal management forecast at Month 11 is c£23.7m deficit, which is line with plan

Trust Efficiency Programme is c. £0.5m behind the year to date (YTD) target

Cash is £0.3m 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 £54.8m. It is anticipated that this will increase to £78.1m 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 February month end cash balance was £0.3m above the expected the £1.2m plan.
- **Winter Tranche 1 & 2** – The forecast assumes the receipt of Tranche 1 monies of £618k which will reduce the Trusts Planned deficit to £23.7m. 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 £1.2m. Currently the Trust is forecasting to achieve the Agency cap by c. £0.3m, Total Forecast spend at Month 11 is £10.9m

**Overall Risk Rating - Medium**

Pressure/High Risk  Improvement/Low risk

# Tameside and Glossop Strategic Commissioner Financial Position

- Forecast overspend of £7,429k is driven by significant pressures in children's services, which has seen further deterioration of £396kin M11. This deterioration relates primarily to an increase in the number of looked after children.

- The ICF risk share has been transacted as follows:
  - 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 | 185,918 | 188,847 | - 2,929 | 203,170 | 205,736 | - 2,566 | - 2,233 | - 333 |
| Mental Health | 27,050 | 27,239 | - 189 | 29,754 | 29,995 | - 240 | - 196 | - 45 |
| Primary Care | 76,089 | 74,765 | 1,324 | 83,109 | 81,775 | 1,334 | 1,192 | 142 |
| Continuing Care | 12,485 | 12,278 | 207 | 13,623 | 14,340 | - 717 | - 712 | - 5 |
| Community | 25,239 | 25,360 | - 121 | 27,473 | 27,501 | - 28 | - 108 | 80 |
| Other | 24,297 | 24,184 | 113 | 28,970 | 26,760 | 2,210 | 2,053 | 157 |
| QIPP | - | - | - | - | - | - | - | - |
| CCG Running Costs | 4,867 | 3,277 | 1,590 | 5,197 | 5,189 | 8 | 4 | 3 |
| Adult Social Care | 42,328 | 41,847 | 481 | 44,185 | 43,660 | 525 | 526 | - 1 |
| Children's services | 30,040 | 37,564 | - 7,524 | 35,192 | 43,400 | - 8,208 | - 7,812 | - 396 |
| Public Health | 16,022 | 15,789 | 233 | 16,708 | 16,454 | 254 | 170 | 84 |
| **Integrated Commissioning Fund** | **444,335** | **451,150** | **- 6,815** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |
| | | | | | | | | |
| CCG Expenditure | 355,945 | 355,950 | - 5 | 391,296 | 391,296 | - 0 | - 0 | 0 |
| TMBC Expenditure | 88,390 | 95,200 | - 6,810 | 96,085 | 103,514 | - 7,429 | - 7,116 | - 313 |
| **Integrated Commissioning Fund** | **444,335** | **451,150** | **- 6,815** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |
| | | | | | | | | |
| A: Section 75 Services | 245,701 | 244,736 | 965 | 266,791 | 266,929 | - 138 | - 128 | - 10 |
| B: Aligned Services | 168,211 | 176,503 | - 8,291 | 187,296 | 195,161 | - 7,865 | - 7,502 | - 363 |
| C: In Collaboration Services | 30,423 | 29,911 | 512 | 33,294 | 32,720 | 574 | 513 | 60 |
| **Integrated Commissioning Fund** | **444,335** | **451,150** | **- 6,815** | **487,381** | **494,810** | **- 7,429** | **- 7,116** | **- 313** |

# Integrated Commissioning Fund Risks

## Individualised Commissioning (A)

- Growth in individualised packages of care remains the CCGs biggest financial risk. While overspend in the ledger is £2,193, this includes mitigation through increased council contribution to the ICF risk share. The underlying pressure against opening budgets is £6,393k.
- A financial recovery plan is in place and work is underway to implement the schemes and a paper looking at procurement of care home beds for patients with dementia went through the governance process in February.
- 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 £8,208k 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 was 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 615 in February 2018.
- The current budget allocation will finance approximately 450 placements

## QIPP (G)

- The CCG had an annual savings target of £23,900k in 17/18, which has been reported as fully achieved in year.
- However less than half of this was achieved on a recurrent basis, meaning we will start 2018/19 with a target of £19,800k. Further work is required to identify new schemes to close this gap recurrently.

## Acute services (A)

- Demand Management for emergency services at the associate providers remains a key risk for the CCG. There has been a further deterioration in the position at M11, driven by critical care and acute oncology. In total overspend against signed contracts is £2,489k, broken down as follows:.

| | |
|---|---|
| A&E | (£186k) |
| Planned Care | £284k |
| Outpatients | (£483k) |
| Urgent Care | (£1,201k) |
| Excess Bed days | (£72k) |
| Critical Care | (£859k) |
| Other | £27k |

## 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 safer staffing requirements are also a risk.

## Adult Social Care (A)

- While an in year underspend of £525k 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 £34,769k are expected, which is an improvement of £94k from M10, but still leaves a shortfall of £301k within the ICFT (although the provider planned deficit will still be met).
- The ICFT still have £1,147k savings to deliver in final month 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.

**Key Headlines:**

- £33,923k of actual savings delivered in first 11 months of year.
- This represents an over-achievement against plan of £5,299k due to the profiling.
- Final projected economy savings are £301k lower than target. More work is required to bring forward new schemes addressing the short fall.
- £19,592k (56%) of expected savings are due to be delivered on a recurrent basis.

| £000's | YTD Position Target | YTD Position Delivered | YTD Position Variance | Annual Target | Risk Rated Forecast Position Posted | Low | Medium | High | Expected Savings | Variance |
|---|---|---|---|---|---|---|---|---|---|---|
| **ICFT** | **9,134** | **8,612** | **- 522** | **10,397** | **9,250** | **846** | **-** | **592** | **10,096** | **- 301** |
| Technical Target | 1,139 | 1,680 | 541 | 1,243 | 1,705 | 62 | - | - | 1,767 | 524 |
| Divisional Target - Corporate | 923 | 1,386 | 464 | 1,020 | 1,442 | - | - | 13 | 1,442 | 422 |
| Pharmacy | 329 | 428 | 99 | 392 | 448 | 77 | - | 8 | 525 | 133 |
| Divisional Target - Surgery | 585 | 662 | 77 | 640 | 727 | - | - | - | 727 | 87 |
| Transformation Schemes | 111 | 151 | 40 | 121 | 151 | 20 | - | - | 171 | 50 |
| Workforce Efficiency | 800 | 404 | - 396 | 1,000 | 453 | 547 | - | 145 | 1,000 | 0 |
| Estates | 450 | 491 | 41 | 557 | 508 | - | - | 7 | 508 | - 49 |
| Paperlite | 115 | 6 | - 109 | 125 | 8 | - | - | 3 | 8 | - 117 |
| Divisional Target - Medicine | 734 | 667 | - 68 | 803 | 725 | 7 | - | 17 | 732 | - 72 |
| Medical Staffing | 626 | 458 | - 168 | 716 | 518 | - | - | 35 | 518 | - 198 |
| Nursing | 890 | 623 | - 267 | 975 | 633 | 70 | - | - | 703 | - 272 |
| Demand Management | 1,557 | 1,259 | - 298 | 1,732 | 1,453 | 4 | - | 337 | 1,457 | - 274 |
| Procurement | 875 | 398 | - 478 | 1,073 | 479 | 59 | - | 27 | 538 | - 535 |
| **Strategic Commissioner** | **18,852** | **24,673** | **5,821** | **24,673** | **24,673** | **-** | **-** | **-** | **24,673** | **- 0** |
| Technical Target | 1,635 | 10,611 | 8,976 | 1,875 | 10,611 | - | - | - | 10,611 | 8,736 |
| Primary Care | 1,700 | 2,279 | 579 | 1,748 | 2,279 | - | - | - | 2,279 | 532 |
| Single Commissioning | 1,034 | 1,221 | 187 | 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 | 1,375 | 815 | - 560 | 1,500 | 815 | - | - | - | 815 | - 685 |
| Mental Health | 294 | 296 | 2 | 994 | 296 | - | - | - | 296 | - 698 |
| GP Prescribing | 2,265 | 1,185 | - 1,079 | 2,516 | 1,185 | - | - | - | 1,185 | - 1,331 |
| Back Office Functions | 480 | 562 | 81 | 2,024 | 562 | - | - | - | 562 | - 1,463 |
| Demand Management | 7,205 | 4,840 | - 2,365 | 8,885 | 4,840 | - | - | - | 4,840 | - 4,045 |
| Adult Social Care | 308 | 308 | - | 336 | 308 | 5 | 23 | - | 336 | - |
| Public Health | 400 | 400 | - | 437 | 400 | 30 | 6 | - | 437 | - |
| **Total Economy Position** | **27,986** | **33,285** | **5,299** | **35,070** | **33,923** | **846** | **-** | **592** | **34,769** | **- 301** |

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| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Officer of Strategic Commissioning Board** | Jessica Williams, Interim Director of Commissioning |
| **Subject:** | **COMMISSIONING IMPROVEMENT SCHEME 2018/19** |
| **Report Summary:** | A two element Commissioning Improvement Scheme (CIS) scheme is being proposed to support Tameside and Glossop General Practice in 2018/19. This report outlines the two elements of the proposal for consideration by Strategic Commissioning Board. The aim of the proposal is to support continued transformation of the economy, improving Healthy Life Expectancy, reducing health inequalities, improving outcomes and delivering financial sustainability of services across the economy. We are therefore proposing to move CIS to a neighbourhood focus and alongside this want to make available up front via investment in neighbourhoods to test or continue schemes which will address pressures, quality and financial. |
| **Recommendations:** | The Strategic Commissioning Board is asked to consider and support:<br>1. The proposal for 2018/19 and approve communication of this proposal to practices.<br>2. The calculation of budgets at neighbourhood level, in line with 2017/18 budget setting methodology, and with the continuation of high cost patient risk pool in line with 2017/18.<br>3. The cap on CIS achievement payments per neighbourhood of £100k and the proposed continuation of a panel process for approval of spend proposals and to indicate any recommendations for criteria for how this investment could be spent.<br>4. The proposal of a panel approval process for the Invest to Save element of the scheme and to indicate any recommendations for criteria for how this investment could be spent. |

**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** | 1,125 | - | - | 1,125 |
| **Total** | **1,125** | **-** | **-** | **1,125** |
| **Section 75 - £'000 Strategic Commissioning Board** | | Neighbourhood CIS element (capped at £100k per neighbourhood): | | |

| | |
|---|---|
| | 5 X £100k = £500k<br>Invest to save element:<br>5 X £125k = £625k |
| **Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparison**<br>Provision has been made through the 2018/19 budget setting process to fund both elements of the Commissioning Improvement Scheme as set out in this report.<br>It is believed that engagement of neighbourhoods in a scheme such as the one set out in this report is key to controlling spend in secondary care and other high cost areas. | |

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| **Legal Implications:**<br><br>**(Authorised by the Borough Solicitor)** | The Commissioning Improvement Scheme should support and provide outcomes in line with the Strategies outlined below and within this report. |
| **How do proposals align with Health & Wellbeing Strategy?** | The proposal supports implementation of innovative proposals which will allow neighbourhoods to test services which will address pressures, quality and financial, or maintain elements of the 2017/18 CIS projects and expand these to a neighbourhood footprint. |
| **How do proposals align with Locality Plan?** | The aim of the proposal is to support continued transformation of the economy, improving Healthy Life Expectancy, reducing health inequalities, improving outcomes and delivering financial sustainability of services across the economy. |
| **How do proposals align with the Commissioning Strategy?** | The proposal aligns to the Commissioning Strategy and Integrated Neighbourhoods, putting services into neighbourhoods, where appropriate, to improve patient experience and address pressures in the health and care system. |
| **Recommendations / views of the Health and Care Advisory Group:** | The discussion paper taken to HCAG in March set out a proposal to either replicate in 2018/19 the 2017/18 practice level CIS or to move to a neighbourhood proposal, therefore reflecting future direction. A hybrid proposal as an interim, one year, step was the outcome of that discussion. |
| **Public and Patient Implications:** | Both elements of proposal support neighbourhoods to put in place services which support how and where patients access care with a view to making services more accessible. Services approved will be required to demonstrate the patient experience impact and benefit. |
| **Quality Implications:** | Schemes implemented under both elements of the CIS proposal will be agreed to provide patients with the appropriate care, treatment, advice and redirection that they require in order to access the most appropriate service for them. Services approved will be required to demonstrate the quality impact and benefit. |
| **How do the proposals help to reduce health inequalities?** | The neighbourhood approach in the scheme is designed to address health inequalities and variation within neighbourhoods. |
| **What are the Equality and Diversity implications?** | Proposals agreed under the scheme will be required to demonstrate any equality and diversity implications. |

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| **What are the safeguarding implications?** | There are no additional safeguarding implications, services and proposals will be designed in line with safeguarding responsibilities through core GMS. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | There are no additional IG implications, services and proposals will be designed in line with IG responsibilities through core GMS. |
| **Risk Management:** | Risk will be managed through scheme proposals in line with risk management of core GMS. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Tori O'Hare <br> Telephone: 07920 086397 <br> e-mail: tori.ohare@nhs.net |

## 1. PROPOSAL

1.1 A two element Commissioning Improvement Scheme (CIS) scheme is being proposed to support Tameside and Glossop General Practice in 2018/19. We are aiming to support Practices as far as possible both with CIS and also with funds associated with improving access under the GM Health and Social Care Partnership via the Primary Care Investment Agreement (PCIA). This will be subject to a separate communication as soon as the next steps have been established.

1.2 The aim of the Tameside and Glossop Strategic Commission is to continue to transform our economy and deliver our vision of improving Healthy Life Expectancy, reducing health inequalities, improving outcomes and delivering financial sustainability of services across the economy. We are therefore proposing to move CIS to a neighbourhood focus and alongside this want to make available up front via investment in neighbourhoods to test services which will address pressures, quality and financial, or maintain elements of the 2017/18 CIS model so that those previously successful practices can work in their neighbourhoods to create stability and expand current CIS schemes.

1.3 The two approaches are presented below.

**Neighbourhood CIS**

1.4 This is the current CIS format in place in 2017/18 however with outcomes (underspend and/or improvement) measured at neighbourhood level. This should enable some practices to achieve CIS when this has previously proved too challenging.

| | Budget Outcome | Achievement Proposal |
|---|---|---|
| **A** | Neighbourhood achieves an underspend against their 2018/19 budget and achieved an underspend against their 2017/18 budget | Neighbourhood receives an underspend payment of 50% of the value of the 2018/19 underspend. |
| **B** | Neighbourhood achieves an underspend against their 2018/19 budget and this is an improvement from an overspent year-end variance in 2017/18 | Neighbourhood receives an underspend payment of 50% of the value of the underspend. Neighbourhood receives 20% of the improvement made, the value of the overspend to breakeven position. |
| **C** | Neighbourhood overspends against their 2018/19 budget however that this is an improvement in comparison to the year-end variance in 2017/18. | Neighbourhood receives 20% of the improvement value. |
| **D** | Neighbourhood overspends against their 2018/19 budget and this is not an improvement in comparison to the year-end variance in 2017/18. | Neighbourhood does not qualify for an achievement payment. |

1.5 To note:

- Achievement payments to be calculated in line with the principles of the 2017/18 achievement grid updated to reflect neighbourhood approach for 2018/19.
- The maximum payment to each neighbourhood is to be capped at £100k.
- The budget setting methodology and the high cost patient risk pool arrangement in place in 2017/18 are to be used in 2018/19.
- The forecasting of achievement payments will be calculated at month 9 data and repeated each month thereafter until a final position is calculated once receipt of month 12 data.
- A panel process, relative to achievement value, will be applied as in 2017/18.
- The criteria by which achievement payments can be utilised to be made stricter but to be for the neighbourhood to determine within that scope.

- The achievement payments will be made to neighbourhoods in 2019/20. It will be for each neighbourhood to determine the receiving organisation within the neighbourhood.

**2018/19 Invest to Save Project**

1.5 In addition to the Neighbourhood CIS the Strategic Commission would like to make £125k available to each neighbourhood in 2018/19 for delivery of an invest to save project to benefit the neighbourhood population and deliver efficiencies; both financial and quality, across the locality.

1.6 It is for each neighbourhood to determine:
- how their funding is to be invested;
- how the funding is to be transacted to the neighbourhood;
- how the plan will be achieved; and
- how the impact and success of the plan will be measured and any reviews and adjustments made as required in year.

1.6 Scheme proposals should align to the Tameside and Glossop vision. A light touch panel process will be put in place to assess and approve proposals. This will include criteria around the maintenance of best referral and prescribing management practice which have previously been embedded through prior year CIS and therefore support the continued reduction in value of acute contracts.

1.8 The Primary Care Team, Commissioning Business Managers and Finance Business Partners will be available to support any practice or neighbourhood discussions.

## 2. RECOMMENDATIONS

2.1 As set out on the front of the report.

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| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Reporting Member / Officer of Single Commissioning Board** | Cllr Brenda Warrington - Executive Leader<br>Sandra Whitehead - Assistant Director Adults |
| **Subject:** | **PROVISION OF COMMUNITY RESPONSE SERVICE CALL HANDLING SYSTEM** |
| **Report Summary:** | The report is seeking permission to spend for the provision of a community response call handling system and authorisation to use a direct call off agreement with a supplier from the ESPO framework 203_15. |
| **Recommendations:** | That the Board notes the content of the report and:<br>1. Approves the direct award of a contract from ESPO framework 203_15, Tunstall, the existing provider of the existing call handling system.<br>2. Approves that the service leases an upgraded call handling system to support the Community Response Service (CRS) no later than 13 August 2018 when the current lease expires. |

**Financial Implications:**

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

| ICF Budget | £'000 |
|---|---|
| **Tameside Council – Adult Services**<br>**Section 75**<br>**Strategic Commissioning Board** | 32 – Recurrent<br><br>4 – Non Recurrent |

**Additional Comments**.

The Community Response Service (CRS) budget forms part of the Section 75 pooled budget of the Integrated Commissioning Fund. Recurrent funding is included within this budget of £ 0.032 million in 2018/19 to meet the ongoing maintenance costs of the call handling system. Annual cost details are provided within section 5.2 of the report and demonstrate that these are affordable within the existing annual budget allocation.

The non recurrent cost of the IT tablets as referenced within section 5.2 of the report will be financed from the 2018/19 Adult Services improved Better Care Fund allocation of £ 3.299 million

It is essential that funding for replacement tablets at the end of their useful life is identified in future years to ensure that remote working can continue to be supported.

It should be noted that the terms of the proposed lease agreement for the upgraded system upgrade will be reviewed prior to acceptance to ensure there are no additional liabilities to those detailed within section 5.2 of the report for the duration of the five year agreement.

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| **Legal Implications:**<br><br>**(Authorised by the Borough Solicitor)** | There is always a risk of challenge from other competitors where a direct award is made to one provider as opposed to running a tendering exercise. The success of this would depend on whether they could demonstrate they should have been considered for the tender, which is not quantifiable at this stage. The Board need to be satisfied in any event that this is the most appropriate provider for this service, and provides value for money and stability going forward and there is clear and satisfactory performance. |
| **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:<br>• Enabling self-care<br>• Locality-based services<br>• Planned care services |
| **How do proposals align with the Commissioning Strategy?** | The service contributes to the Commissioning Strategy by:<br>• Empowering citizens and communities<br>• Commission for the 'whole person'<br>• Create a proactive and holistic population health system |
| **Recommendations / views of the Health and Care Advisory Group** | Not applicable. |
| **Public and Patient Implications:** | None |
| **Quality Implications:** | The Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness. |
| **How do the proposals help to reduce health inequalities?** | Via Healthy Tameside, Supportive Tameside and Safe Tameside. |
| **What are the Equality and Diversity implications?** | The proposal will not affect protected characteristic group(s) within the Equality Act.<br><br>The service will be available to adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership. |
| **What are the safeguarding implications?** | None |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. |

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| **Risk Management:** | There are no anticipated financial risks, however, there may be other risk considerations should the tenants not receive the support – including access to 24-hour support – they require to live safely. Please refer to Section 7 of the report. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting:<br>Trevor Tench – Head of Commissioning<br>Telephone: 0161 342 3649<br>e-mail: trevor.tench@tameside.gov.uk<br><br>Mark Whitehead – Head of Operations<br>Telephone: 0161 342 3791<br>e-mail: mark.whitehead@tameside.gov.uk |

## 1 INTRODUCTION

1.1 This report seeks permission to re-commission a new call handling system to support the Community Response Service (CRS). The lease on the current call handling system that supports the service is due to expire on 13 August 2018.

1.2 The current contract is with Tunstall (PNC7 system) and the commissioners are seeking to enter into a call off agreement with this provider who is an identified supplier on the ESPO framework 203_15.

1.3 The rationale to enter into a call off agreement with Tunstall for the continued delivery of this service offers the council a number of benefits:

- The supplier is known to deliver the software and outcomes required to support the needs of the services; any new system would be an unknown.
- The supplier's goods and services are compatible and operate with the Council's IT hardware and software system versions. A new supplier may require different operating platforms on which their software will run, potentially increasing costs, increasing time scales for implementation and resources in terms of staffing to implement any changes.
- Reduces the uncertainty in terms of data exchange from one system to another should a supplier change. There are a number of risks as the capability of the transfer between suppliers would be unknown, potential loss of data, establishing costs and timeframes for completion, as well as developing a manual backup system through the transition.
- The Council has a number of highly trained staff who understand the current system and have the skills and knowledge to train other team members. Transferring to a new system will require more intensive staff training, and take longer for staff to be familiar with, which is an added resource not only in terms of costs but also releasing staff.
- Continuity of service and maximising business administration efficiencies can be realised for a vulnerable group of service users. Moving to a new supplier could result in a diminished service whilst a transition takes place.
- The supplier has a proven track record in service delivery in terms of responsive customer service, flexible approach to the Council's needs in making changes to the system, ensuring updates and training are available as required and a well-established working relationship.
- There could be some savings in proceeding with this supplier because the new system (PNC 8) would be a free upgrade, with an additional module provided for free (Service Manager) that would have extra reporting capabilities (which is a key business requirement), rather than the cost of buying a completely new system. Extra modules that the service needs, 'Proactive Call Software' for anticipating customer issues before they occur, would be provided free of charge (saving an additional £8,500).
- PNC8 will also be fully General Data Protection Regulation (GDPR) compliant.

1.4 Disaster Recovery for this service is currently shared with Stockport MBC. This is primarily because the system needs to be shared with another provider who uses the same system PNC. This arrangement will continue with this provider until it is reviewed as part of the wider integration of social care and health.

1.4 To inform this decision a wider benchmarking exercise has been undertaken to establish what CRS needs are going forward to support this service function, what other call handling systems are being used elsewhere and their effectiveness, and where the upgraded PNC8 is being used, what the user's experience is of the system's functionality.

## 2 COMMUNITY RESPONSE SERVICE BACKGROUND

2.1 Tameside Adult Services operates an in-house telecare service. Staff are employed to provide an emergency response service 24 hours a day, 365 days a year to people of

Tameside who may be vulnerable or at risk. In December 2017 there were 3,547 customers connected to the service. CRS Control Centre receives approximately 18,000 calls (alerts) every month.

2.2 CRS customers range in age from 18 years, with no upper age limit. 1,272 people aged 85 years and over are living independently within the community with the help of telecare systems.

2.3 The key aims of the service are:

- To support individuals to remain at home for longer with safety and security
- To reduce inappropriate admissions to residential and nursing care
- To encourage earlier/safer discharge from hospital to home
- To allow more personal freedom and reassurance for carers
- To support people outside of the formal social care system
- To enhance/complement the offer to local people.

2.4 The service provides a range of sensors and devices, dependent upon the needs and health of individuals. Some devices are activated by the user by pressing their pendant alarm; others are automatically triggered by sensors installed in the home. When the button is pressed by the customer or activated by a telecare sensor, an alert is raised at the Control Centre. Appropriate action is taken by staff at the Control Centre; this may be to contact relatives, friends, to call emergency services or for a Community Response Worker to respond by attending the customers' home.

2.5 The service is connected to Sheltered Housing schemes and Extra Care Housing schemes across the borough, providing a response 24 hours a day, whether this be door entry, building alarm alerts, pull cord activations or a person summoning help in an emergency. There are four Social Housing providers who are connected to the service to deliver telecare in their accommodation across the borough.

2.6 For people with a diagnosis of dementia an additional service, 'Just Checking', is also available. This is a simple on-line activity monitoring system that provides a chart of daily living activity via the web. Small wireless sensors are placed in the home and generate activity information based on the person's movements etc. The information can then be used as an assessment tool in planning individual care and support as it gives a clearer picture of a person's capabilities and actions when they are alone. This service forms part of the statutory assessment process and can only be accessed via the person's Social Worker and with agreement from the individual and/or family representative where appropriate.

2.7 The service vehicles carry lifting equipment which can be used to raise someone from the floor, when it is safe to do so. Community Response workers are increasingly called out to help people up from the floor after a fall, which is known as assisted lifting. From 1 April 2017 to 31 December 2017 the service attended 1,775 times to customers that had a fall, of which only 230 required an ambulance. This service can help prevent visits to A&E, which is a good example of how the service can contribute to system savings across the health economy. It also allows the ambulances to respond to more urgent calls and therefore further supporting improved outcomes for people as we are able to assist in deploying the right service for the right needs.

2.8 The service aims to respond physically to calls that require a warden within 20 minutes of activation.

2.9 CRS is available to the general public, with 78% of customers choosing to access and self-fund the service who currently do not receive any other services.

2.10 Whilst the current service works well and is highly valued by users, families/carers and professionals, the service and systems available have been reviewed and a preferred service model has been produced.

2.11 The new model of service delivery will lead to an improved interface with partner agencies; and, ultimately, improved outcomes for service users through the provisions of better integrated services across the health and social care spectrum.

2.12 There is scope to extend the provision of telecare, telehealth and telemedicine into the wider community, promoting and supporting the ethos of 'helping people live at home'. This ethos is grounded in early intervention and prevention, and in providing better outcomes for people in the community.

2.13 There is also scope to extend the offer into residential and nursing care settings, potentially reducing the need for GP intervention, ambulance attendance and possible transfer to hospital.

2.14 In line with the Care Together Programme, work has been undertaken with the key stakeholders within neighbourhoods including GPs, health colleagues, Registered Social Landlords and Community Organisations when reviewing CRS and its future role in supporting residents of the borough to have more choice and control.

2.15 The call handling system is a fundamental facet in the provision of this service without which the service would be unable to operate as activations are reliant on an efficient and effective system that supports service operations.

**3 BENCHMARKING**

3.1 The process commenced with the development of call handling systems' functionality which was mapped against CRS business requirements. Managers and staff who are familiar with the current Tunstall PNC7 system were asked to identify / rate functions and requirements from an operational user perspective, while considering the future vision / direction for the service, and provide any suggestions. This was supplemented by managers of the service in terms of information requirements that would enhance operational performance. This criterion was then used to compare the different systems on the framework.

3.2 A review of providers on the framework identified three organisations who provide a call handling system. To establish which organisations could meet the requirements a number of telephone contacts were made with other organisations and two visits were made to Bradford (Jontek) and Wakefield (Tunstall PNC8) to look at systems in use. While all provider systems had similar functionality except one which currently does not support digital technology, some of the extra functions needed would have required increased costs as 'add-on' functions, or bespoke tailoring, increasing the actual overall cost of the service. Tunstall who provide the system currently used offered most of these extras as part of the upgrade at no extra cost.

3.3 One of the providers (Chubb) was not 'digital ready' which is a requirement going forward for our equipment, and could not provide a timescale when this would be ready for, so this supplier could not deliver what the service needed. This left two viable providers upon which to explore functionality and cost.

3.4 The actual cost of the system was a key determinant in making the recommendation contained within this report. This relates to actual cost of the system and cost in terms of service continuity. In terms of financial costs the Tunstall PNC7 system is currently being used by the service so an upgrade to PNC8 would not generate any increased cost as this would be a free upgrade and would maintain a monthly lease charge which is contained in

section 5 below. In terms of continuity, moving to an alternative provider could impact on the disaster recovery arrangements within the transition period placing the service and service users at risk.

3.5 The PNC8 system would not require the system information to be migrated onto a new system, which would be extra cost and potentially timely process to undertake. This would negate the need and potential risk of system shut down for a transition period which would place customers at risk. Staff are familiar with the current system although further training on enhanced functions would be necessary.

3.6 The lease would include system support and maintenance. A 'Service Manager' system on PNC8 would allow the ability to generate automatic management reports which will support managing service performance and activity including the ability to match data with health partners (when appropriate information governance arrangements are in place). This is a function that causes significant labour intensive work at the moment as the current system does not fully support this function which is currently a labour intensive exercise.

3.7 Disaster recovery could be maintained at the Stockport site as Stockport still have the PNC system in operation which can support this function. This is being reviewed in terms of the wider proposed IT and integration changes in the future, but is an essential requirement when looking at a new system to ensure business continuity.

3.8 Business continuity and confidence in the systems' ability is a significant consideration when looking at the systems on offer, and PNC8 offers this as an upgrade on an existing system in use with enhanced features at the same cost as we currently pay, even when including the 'Service Manager' function (in effect getting this for free).

3.9 After 5 years, an option to buy the system equipment is available, that would just require an annual maintenance arrangement at a reduced cost but this would be a decision that would have to be taken in the future as we are unable to project future developments in technology and service requirements, and if the equipment was bought, it would be an additional cost to the Council to replace it if needed in the future. Equipment includes items such as server hardware and workstations etc.

3.10 Summary table:

| | **Tunstall (PNC8)** | **Jontek** | **Chubb** |
|---|---|---|---|
| Indicative cost of call handling only (annual) | £25,471 | £21,836 | |
| Digital Ready | ✓ | ✓ | ✗ |
| Data migration needed | ✗ | ✓ | |
| Full staff training needed | ✗ | ✓ | |
| Interim disaster recovery move needed quickly | ✗ | ✓ | |

| Others | • Includes free Service Manager reporting module.<br>• Includes free upgrade to PNC 8.<br>• Includes extra module the service needs – Proactive Call Software for free, saving an extra £8,500.<br>• Includes continuity of service through current DR system until wider review.<br>• Includes upgrade of all call handling operator workstations, and administrator workstations, and DR workstation if needed.<br>• Negates the need and cost for staff training | • Equipment would need to be replaced periodically and not included in cost.<br>• May be additional cost for training, and if an interim disaster recovery solution is required before a wider IT review is complete. | |
|---|---|---|---|

## 4. CONTRACTING/PROCUREMENT PROPOSAL

4.1. Based on information available it is requested that consideration is given to award the lease directly to Tunstall for a five year contract commencing 14 August 2018.

4.2 The procurement approach proposed is a direct award from ESPO framework 203_15 (see **Appendix A**).

4.3 A call off without competition can be utilised and a single supplier approached where it can be identified that they are able to meet the customer's needs in terms of the goods, services and pricing schedule detailed on the framework.

## 5. FINANCE

5.1 The current contract value is £32,000 per annum. The resource for this contract is included within the CRS budget of Adult Services for 2018/19. The non-recurrent cost of £ 3,865 in 2018/19 for the IT tablets as stated in section 5.2 will be financed from the Adult Services improved Better Care Fund allocation of £ 3.299 million.

5.2 Anticipated costs (inclusive of estimated inflationary uplifts in future years)

| NON-RECURRENT INVESTMENT | Comment | 2018/19 £ | 2019/20 £ | 2020/21 £ | 2021/22 £ | 2022/23 £ | Total 5 year investment £ |
|---|---|---|---|---|---|---|---|
| IT tablets for remote working | Windows tablets £644.15 each. 6 needed. | 3,865 | 0 | 0 | 0 | 0 | 3,865 |

| RECURRENT INVESTMENT | Comment | | | | | | |
|---|---|---|---|---|---|---|---|
| Lease for equipment and PNC8 system maintenance | Includes new equipment, Proactive Call and Service Manager for free. | 25,471 | 26,108 | 26,760 | 27,429 | 28,115 | 133,884 |
| Field Force Management App (geo location) | £25 per device per month.<br>£270 per month for management portal.<br>(6 devices x £25 x 12 months) + (£270 x 12 months) = £5040 | 5,040 | 5,166 | 5,295 | 5,428 | 5,563 | 26,492 |
| IT 4G call plans | Sim card £12 for 4GB data per month<br>(6 devices x £12) x 12 months) | 864 | 886 | 908 | 930 | 954 | 4,541 |
| | **Subtotal - Recurrent Investment** | **31,375** | **32,159** | **32,963** | **33,787** | **34,632** | **164,917** |
| | **TOTAL COST** | **35,240** | **32,159** | **32,963** | **33,787** | **34,632** | **168,782** |

5.3 This funding will enable the service to develop remote working options through use of digital technology and the purchase and supply of tablets to enhance service efficiency and effectiveness moving away from paper based systems. This therefore allows the service to dedicate more time to supporting vulnerable people and delivering the service, rather than administration of completing paperwork out on the field and then coming back to base and having to input onto computers, which also increases the risk of human error.

## 6. OPTIONS

6.1 Not to commission a Community Response Service Call Handling System - This option has not been considered viable due to the value of the service in terms of outcomes for service users, and the preventative nature of the service. Based on data from the Social Care Institute for Excellence (SCIE) the cost benefits of services such as this are significant in terms of cost avoidance across the social care and health system.

6.2 Carry out a competitive procurement exercise - research of other systems and providers has been undertaken but it has been concluded that the system offered by Tunstall meets the Council's requirements in the most comprehensive way, and due to the rationale identified in 1.3 and Section 3 above it has been identified as the best option available.

## 7. RISK

7.1 There is low risk in terms of cost – The actual costs of the new system will be within existing budget parameters. The contract will ensure that adequate safeguards are in place to protect against any unexpected increases in cost.

7.2 There is a minimum risk in terms of product reliability – The contract includes support and maintenance arrangements and the existing provider has always been excellent at offering urgent support and maintenance when there have been issues with the systems functioning.

7.3 System failure within this service / major incident impacting on infrastructure could lead to serious harm or death should systems fail to function and alert control in the event of an incident. Disaster Recovery (DR) is an important element of this service in terms of business continuity. Because Tunstall (PNC) operate in Stockport we have reciprocal DR arrangements in place which have had to be activated twice in the past six months due to IT works and power supply work. It is essential DR is robust and we have confidence in this system.

7.4 there is a potential for other providers on the Framework to challenge the direct award of the contract. The council is confident that the risk of this low as it is clear from the benchmarking undertaken that the Tunstall system can offer value for money and reduces the internal costs of staff training and the risks of information transfer.

## 8. EQUALITIES

8.1 The proposal will not affect protected characteristic group(s) within the Equality Act. The service will be available to adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage / civil and partnership.

## 9. SUMMARY

9.1 We are required to re-commission the call handling system for CRS to ensure compliance with Procurement Standing Orders. The current system PNC7 is supplied by Tunstall. The service and support provided has been very satisfactory however, based on current and future service and system needs functionality does need updating to provide a wider range of information to inform performance management.

9.2 This report centres on market testing and procuring a new call handling system through a review of providers contained within the framework 203-15. The process commenced with the development of call handling systems' functionality which was mapped against CRS business requirements. Managers and staff who are familiar with the current Tunstall PNC7 system were asked to identify / rate functions and requirements from an operational user perspective, while considering the future needs and requirements of a new system.

9.3 The review of the framework identified three providers who potentially could provide this system, however on further review one of these providers could not currently support digital technology which is a future requirement for this system. This left two providers. One provider was Tunstall who offer an upgraded system to our current system and Jontec.

9.4 While the indicative costs indicate that Jontec is £3,635 per annum cheaper than Tunstall's PNC8 system there were other variables considered including:

- Tunstall's PNC system is a system staff and managers are familiar with so there would be minimal training required on the upgrade to PNC 8. Costs would be incurred by changing to a brand new system in terms of staff training.

- Current Disaster Recovery arrangements are with Stockport who operate using the PNC system provided by Tunstall. A move to a new system would require alternative disaster recovery arrangements being required which will be at a cost to the service, and potentially impact on business continuity arrangements.
- Extras provided by Tunstall are a free upgrade to PNC 8, free 'Service Manager' reporting module, free proactive call Software, upgrade to workstations including disaster recovery.
- Minimum disruption to service and less risk of service being unavailable as part of transfer.

9.5 Fundamentally there is sufficient funding within the budget to fund either option as indicative costs are slightly lower than current costs of the system. Further funding (iBCF) has been identified for further technology to support future working using smart phones and other technology to improve service efficiency and effectiveness.

9.6 Based on cost, additional extras that will enhance the service offer and to reduce risk in terms of disaster recovery arrangements the recommendation is to maintain the current supplier Tunstall.

## 10. RECOMMENDATION

10.1 As stated on the report cover.

# APPENDIX A

**Framework 203_15 – Telecare and Telehealth** Issue 11

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Page **3** of **60**

**1. Overview of the Framework Suppliers**

**LOT 1**

Catalogue supply of telecare and telehealth products and services (including relevant software)

· **BROOMWELL HEALTHWATCH**
· **CHUBB COMMUNITY CARE**
· **DOCOBO LTD**
· **DORO CARE AB (formerly CARETECH AB)**
· **JONTEK LTD**
· **NRS HEALTHCARE**
· **OYSTA TECHNOLOGY**
· **SAFE PATIENT SYSTEMS LTD**
· **TUNSTALL HEALTHCARE (UK) LIMITED**
· **TYNETEC A BUSINESS UNIT OF LEGRAND ELECTRIC LTD**
· **WEALDEN AND EASTBOURNE LIFELINE**

**LOT 2**

Provision of telecare and telehealth services. This lot is mainly accessed by secondary competition and is mainly for the provision of managed services (including complete service outsourcing).

· **BAYWATER HEALTHCARE UK LIMITED**
· **BOC LTD**
· **CHUBB COMMUNITY CARE**
· **ELDERCARE**
· **INVICTA TELECARE LTD**
· **JOHNNIE JOHNSON HOUSING TRUST (ASTRALINE)**
· **MEDVIVO CARELINE LIMITED**
· **MSD**
· **PA CONSULTING**
· **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**
· **TUNSTALL HEALTHCARE (UK) LIMITED**
· **WEALDEN AND EASTBOURNE LIFELINE**

This framework provides the user with a large number of suppliers to choose from and a full list with contact details can be found in Section 5 of the full User Guide.

**How to use this Framework**

**Step 1** - Complete the Customer Access Agreement (Appendix 3 of the User Guide) and return it to ESPO.

**Step 2 -**
Review the User Guide to establish whether your needs can be met by a single supplier or whether you need to conduct a further competition. Section 3 contains more information on how to place an

order. Typically smaller, more straightforward requirements can be met by one supplier, larger, more complex requirements will require a further competition to achieve the best supply solution.

**Lot 1**

A line list is provided for lot 1, however your will need to contact the appropriate suppliers for prices. Please quote ESPO framework 203_15 when you do this to ensure you get the framework prices. If you decide that a supplier can meet your requirements based on the pricing and/or other information provided in the User Guide, simply place an order with that supplier. Suppliers are required to provide monthly invoice information to ESPO so that checks can be made to ensure compliance with the framework and their tendered prices.

**Lot 2**

Lot 2 is accessed by further competition. Customers should select ALL service providers that have indicated that they can meet the requirements from the ‘Scope of Services’ table set out in Section 2 of the User Guide and invite them to bid in a further competition. More specific details on how to conduct a further competition can be found in Section 3 of the User Guide.

**Please quote ESPO framework reference 203_15 on all correspondence.**

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| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Reporting Member / Officer of Single Commissioning Board** | Cllr Brenda Warrington – Executive Leader<br>Sandra Whitehead – Assistant Director Adults |
| **Subject:** | **INTRODUCTION OF AN ELECTRONIC ROSTERING AND ALLOCATION SYSTEM FOR THE REABLEMENT SERVICE, COMMUNITY RESPONSE SERVICE AND LONG TERM SUPPORT SERVICE** |
| **Report Summary:** | The report is seeking permission to spend for the provision of an e-rostering and allocation system and authorisation to carry out a mini tender exercise with suppliers on the existing ESPO Framework 394_15 – Elec. Homecare Monitoring & Scheduling. |
| **Recommendations:** | That the Board notes the content of the report and:<br>• Approval to spend on an e-rostering system is given.<br>• Approval to carry out a procurement exercise using existing ESPO framework is given. |

**Financial Implications:**

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

| ICF Budget | £'000 |
|---|---|
| **TMBC - Adult Services** | |
| **Section 75** | 36 – Recurrent |
| **Strategic Commissioning Board** | 51 – Non Recurrent |

The budget for the Reablement Service forms part of the Section 75 Pooled Budget arrangement.

The initial one off system set up cost of £50,713 will be funded by the non-recurrent Improved Better Care Fund allocation of £ 3.299 million in 2018/19.

The ongoing licence and maintenance costs of £36,442 per year will be met from the net staffing cost savings of £80,000 as stated in section 2.2 of the report.

There will therefore be a residual recurrent revenue saving of £43,558 in future years (reduced for annual RPI increases of the system).

**Legal Implications:**

**(Authorised by the Borough Solicitor)**

At high level the report makes out the desirability and benefits of transitioning to a better and more economic way of delivering the present services and there are no legal issues.

On the question of implementation it is clear that the proposals rely on changes in the staffing structure and resultant savings and it is reasonably clear from the report that there is agreement as to how these can be achieved. The financial commentary is based on this.

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| | It is clear that there is an IT solution with functionality which will achieve the implementation required.<br><br>In relation to the procurement, care must be taken to ensure that the proper procedures are carried out; and that the contract reflects the risks identified and the requirements of the project. It would be worthwhile to check again that the procurement proposals match the needs. |
| **How do proposals align with Health & Wellbeing Strategy?** | The proposals align with the Developing Well, Living Well and Working Well programmes for action. |
| **How do proposals align with Locality Plan?** | The proposals and strategic direction are consistent and aligned.<br><br>The service is consistent with the following priority transformation programmes:<br>• Healthy Lives (early intervention and prevention)<br>• Enabling self-care<br>• Locality-based services<br>• Urgent Integrated Care Services<br>• Planned care services |
| **How do proposals align with the Commissioning Strategy?** | The service contributes to the Commissioning Strategy by:<br>• Empowering citizens and communities<br>• Commission for the 'whole person'<br>• Target commissioning resources effectively |
| **Recommendations / views of the Health and Care Advisory Group** | Not Applicable |
| **Public and Patient Implications:** | Whilst there will be no impact on the quality of the service for service users, the new system will enable more hours of reablement to become available due to a more efficient rostering and allocation of the work coming into the service. This will enable more users to benefit from the service. |
| **Quality Implications:** | The 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?** | 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. |

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| **What are the Equality and Diversity implications?** | It is not anticipated that there are any equality and diversity issues with this proposal.<br><br>The proposal will not affect protected characteristic group(s) within the Equality Act.<br><br>The service will be available to adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage / civil and partnership. |
| **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 include standards and requirements for information governance, privacy and respect. |
| **Risk Management:** | Risks to Domiciliary Care Officer posts, but have engaged ECG in December and been through a consultation period.<br><br>Data Protection risks will be mitigated with appropriate contractual and IT safeguards and continued monitoring throughout the life of the contract. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting;<br><br>Paul Dulson – Head of Adult Assessment and Care Management<br><br>Telephone: 0161 342 4077<br><br>e-mail: paul.dulson@tameside.gov.uk |

## 1. INTRODUCTION

1.1 The aim of the Reablement Service is to provide an intensive short term period of intensive rehabilitation (up to 6 weeks) when someone has had a period of ill health or trauma. It is expected that during this period the person will be able to get back to their optimum level of independence.

1.2 The service has delivered good outcomes for people allowing them to continue to live at home with an ongoing reduced package of home care or in many cases with no ongoing support provision at all.

1.3 Reablement is recognised as one of the fundamental services within an integrated health and social care system and the value of the service is widely accepted across the country.

1.4 Although the service in Tameside is successful, there is potential to realise greater efficiency. The current system for the deployment of staff and the matching of demand and supply within the Reablement Service is carried out manually and without the help of an electronic solution.

1.5 This, not surprisingly, is both laborious and time consuming. Programmes of work are developed by the operational support staff as well as the Domiciliary Care Organisers (DCO) and the physical management of this process takes up considerable time. These administrative functions include scheduling staff rotas, managing annual leave and sickness, calculating payroll payments such as overtime/bank holidays/leave, recording training records and other personnel files.

1.6 To operate more effectively and efficiently, the service needs to be able to accept new pieces of work, deploy staff according to the needs of the users and deal with changes which are happening at multiple times during the day, and it needs to do so accurately and in a timely manner. As a manual system, this requires intense management with other senior managers within the service often becoming drawn into this process, including Assistant Team Managers (ATM) and the Team Manager.

1.7 Whilst considering options for an electronic solution to the staff rostering and allocation system within Reablement it has also become apparent that other areas of Adult Services could benefit with a similar solution, particularly the Long Term Support Service which already has a an electronic system staff rostering system in place that would benefit from an upgrade. The Community Response Service has also identified some potential benefits from having access to an electronic solution.

## 2. KEY BENEFITS

2.1 A report to the Employee Consultation Group in December 2017 outlined that the introduction of an electronic-rostering (e-rostering) system could impact on the three Domiciliary Care Officer (DCO) posts, and suggested that savings could be realised through reducing staffing levels. However, it is proposed that the DCOs would be replaced with an Assistant Team Manager instead that would enable other key management tasks to be maintained.

2.2 The annual cost saving realised from the reduction of three DCOs is £128,000, inclusive of on costs. The cost of the proposed Assistant Team Manager is £48,000 inclusive of on-costs; therefore the net staffing cost reduction would be £80,000 per year on a recurrent basis.

2.3 The service would run in tandem in the early stages of a new electronic system being in place to allow the system to bed in and to iron out any technical difficulties that may arise. This will also minimise any risk to service users during the transition period.

2.4 A more efficiently run service will result in more support hours being made available. Currently the manual system cannot make the necessary placements in terms of geography and time that an electronic system is able to, leading to some downtime and time being unnecessarily wasted in travel due to inefficient allocations of work.

2.5 The Community Response Service (CRS) could also benefit from this service, as one of their priorities is also to be a paperless and more efficient service, and would only require an additional license to be procured to allow this to happen.

2.6 The Long Term Support Service currently operates an e-rostering solution called 'Staff Plan' from a supplier called 'Advanced Health and Care Ltd'. A system upgrade would be timely to ensure that the most up to date technology and programmes are being used.

2.7 There are a number of electronic solutions available and some work has been carried out over the past few months to test out the market and to try and ascertain which is most suitable.

2.8 There is a Framework of suppliers available under procurement rules which would enable the Council to enter into a mini tender exercise with those providers that have already demonstrated that they can meet the necessary specifications of the system that the Council is requiring.

2.9 It is therefore proposed to carry out a mini tender under the existing procurement rules using the ESPO Framework 394_15 – Elec. Homecare Monitoring & Scheduling **(Appendix A).**

## 3. CONTRACTING/PROCUREMENT PROPOSAL

3.1 As highlighted earlier in the report there is an existing framework on the ESPO system for Homecare Monitoring and Scheduling. There are a number of providers who have already demonstrated that they meet a required standard to be included on the framework.

3.2 Currently there are 8 providers who can provide the type of system that Reablement, CRS and Long Term Support Service are seeking. All offer a slightly different approach and whilst some are perhaps more basic than others, officers have taken the opportunity to either speak with some of the providers directly, visit some of the local authorities that already have systems in place or take part in email communication and determined that there are perhaps a number of the 8 who would be able to offer a reasonable solution. Some of the systems would not be compatible with the Adult Service's Care Management IT system which would mean that data would have to be duplicated rather than smoothly transferred between the two systems. Some of the systems require the use of the providers own mobile telephone handsets whereas it is felt that it would be more beneficial if staff could use TMBC mobile telephones. There are some providers on the framework who appear to be able to meet all the requirements of the service specification required.

3.3 The current suppliers on the framework are:

- Advanced Health and Care Ltd;
- Assistive Partner Ltd;
- CACI Ltd;
- HAS Technology Ltd t/a Care Monitoring 2000;
- Malinko Care;
- TotalMobile Ltd;

- UDMS Ltd;
- Webroster Ltd.

3.4 Given that there is a framework in place for this type of system it is proposed that a mini tender is followed which will allow those providers who are interested to tender for the contract and be considered against an agreed service specification and criteria.

## 4. FINANCE

4.1 Improved Better Care Fund (iBCF funding has been identified to introduce the e-rostering system to the Reablement Service with the Community Response Service and Long Term Support Service benefiting from the contract award. This is an allocation of £3.299 million in 2018/19.

4.2 The current revenue budget for Reablement would remain in place, to allow for the staffing to be in place to run the manual and electronic systems in parallel until there is confidence to run the electronic system alone, at which point the savings realisation would be made.

4.3 Estimated costs to be financed from the iBCF are predicated upon indicative costs provided by suppliers in the conversations with officers over the past few months.

4.4 The cost in year one takes account of initial set up costs as well as the recurrent costs that will be incurred on an annual basis thereafter

The indicative amount required from the iBCF funding for year one is:

£50,713 (non-recurrent – funded from improved Better Care Fund as stated in section 4.1)
£36,442 (recurrent – via the £ 80,000 revenue saving as stated in section 2.2)
**£87,155**

4.5 Year Two onwards
**£36,442** plus RPI (recurrent – via the £ 80,000 revenue saving as stated in section 2.2)

4.6 Therefore, if the system proves efficiency, the ongoing net saving from staffing levels of £80,000 (stated in section 2.2) would offset the annual recurrent maintenance of £36,442 providing a recurrent saving of £43,558 in future years (reduced for annual RPI increases of the system).

4.7 There will be additional efficiency including the more efficient use of staff time enabling more hours of hands on Reablement to become available.

## 5. EQUALITIES

5.1 The Reablement Service works with people recovering after a period of ill health or trauma that has resulted in the loss of some of the skills and abilities of independent and everyday living. The Service is available to anyone over the age of 18 and although it does work successfully with younger adults between 18 and 64 it is predominantly utilised by older people.

5.2 The introduction of an electronic rostering and allocation system will not affect the groups who currently use Reablement. It will result in more care hours becoming available due to the more efficient allocation of work reducing travel and downtime. This will result in more people being able to access the Service or for more hours to be available to improve outcomes for people even further.

## 6. RISK MANAGEMENT

6.1 The introduction of an electronic rostering and allocation system will improve the efficiency of the Reablement Service, as well as Community Response and Long Terms Support Services. It has already been recognised that in looking for an electronic solution that certain roles within the Reablement Team will no longer be needed, most notable the role of Domiciliary Care Officer. A report has already been submitted to the Employee Consultation Group and consultation has been undertaken with the three members of staff who would be affected and their union representatives. Assurances have been given that any reduction in staffing will not take place until the new electronic system is in place and has been fully tested.

6.2 Any risks of poor service delivery will be mitigated by close monitoring of the new system as it is introduced and becomes embedded. The ceasing of the current manual system will not happen until there is absolute confidence in the new system.

6.3 With the introduction of any new electronic system there are potential risks around the use of data and the need to ensure as much protection as possible. Officers have worked closely with colleagues in the Council's IT Service to ensure that all necessary data management is in place and meets the necessary regulations and specifications.

6.4 The risk of not introducing an electronic system would leave the current services being dependent upon manual systems which in themselves offer a higher degree of risk due to human error. Most local authorities have either introduced or are in the process of introducing an electronic staff rostering system in much the same way as is being suggested for Tameside. The system will aid greater integration with other services most notably the Integrated Care Foundation Trust as the Council moves closer to that organisation.

## 7. CONCLUSION

7.1 The importance of the Reablement Service in the ongoing work of the health and social care economy in Tameside is well established and has been in operation for nearly 10 years. Equally so is the service provided by the Community Response Service and the Long Term Support Service. The services are constantly reviewing their ongoing effectiveness and regularly have regard for new developments in the social care system.

7.2 The introduction of a number of electronic staff rostering and work allocation systems over the past few years has led to greater efficiencies in this area of the market. After reviewing many of the systems that are on the market it is felt by officers working closely with these services that purchasing and procuring an effective system would enhance the current services and result in better outcomes for users of the services as well as opportunities to realise possible budget savings.

## 8. RECOMMENDATONS

8.1 As stated on the report cover.

# APPENDIX A

**Framework 394_15 – Elec. Homecare Monitoring & Scheduling** Issue 7

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**Suppliers**
· **Advanced Health and Care Ltd**
· **Assistive Partner Ltd**
· **CACI Ltd**
· **HAS Technology Ltd t/a Care Monitoring 2000**
· **Malinko Care**
· **TotalMobile Ltd**
· **UDMS Ltd**
· **Webroster Ltd**

A full list with contact details can be found in Section 3 of the full User Guide.

**How to use this Framework**

**Step 1** - Complete the Customer Access Agreement (Appendix 1 of the User Guide) and return it to ESPO.
**Step 2 -** Review the User Guide to establish whether your needs can be met by a single supplier or whether you need to conduct a Further Competition. Section 5 contains more information on how to place an order. Typically smaller, more straightforward requirements can be met by one supplier, larger, more complex requirements will require a Further Competition to achieve the best supply solution.
If you decide that a single supplier can meet your requirements based on the pricing and/or other information provided in the User Guide simply place an order with that supplier. A template order form is available for you to use at Appendix 3 of the User Guide.
If you decide you need to conduct a Further Competition you may do so by seeking quotations from **all** of the suppliers that are able to meet your requirements. More specific details on how to conduct a further competition can be found in Section 5 of the User Guide.

**Please quote ESPO framework reference 394_15 on all correspondence.**

| | |
|---|---|
| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Officer of Single Commissioning Board** | Stephanie Butterworth Director Adult Services |
| **Subject:** | **TENDER FOR THE PROVISION OF A LEARNING DISABILITY RESPITE SERVICE** |
| **Report Summary:** | The report is seeking authorisation to re-tender the service for a contract commencement date of 1 October 2018. |
| **Recommendations:** | That approval is given to tender for the Learning Disability Respite Service for a five year period. |

**Financial Implications:**

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

| **ICF**<br>**Budget** | **£'000** |
|---|---|
| **Tameside Council – Adult Services**<br>**Section 75**<br>**Strategic Commissioning Board** | 250.32 |

**Additional Comments**.

The service provided via this contract supports the Care Together vision of enabling residents to live independently within their own homes in the community whilst also ensuring their carers receive appropriate breaks to enable them to continue with their caring duties.

The existing contract is currently affordable within the revenue budget allocation of the Adult Services directorate for the period to 30 September 2018 and on a recurrent basis thereafter.

It is essential that the re-tender of the service remains affordable within the budget allocation. Clearly a reduced annual cost will be desirable to ensure recurrent savings are subsequently realised which will contribute towards the care together locality funding gap.

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| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | Retendering in accordance with the Council's procurement and contract standing orders, and taking into account the Care Quality Commission's requirements will ensure lawfulness and value for money, thus reducing the risk of successful judicial challenge, and should be commenced without delay if the deadline for contract award is to be achieved. |
| **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:<br>• Enabling self-care<br>• Locality-based services |

- Planned care services

| | |
|---|---|
| **How do proposals align with the Commissioning Strategy?** | The service contributes to the Commissioning Strategy by:<br>• Empowering citizens and communities<br>• Commission for the 'whole person'<br>• Create a proactive and holistic population health system |
| **Recommendations / views of the Health and 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?** | Via Healthy Tameside, Supportive Tameside and Safe Tameside. |
| **What are the Equality and Diversity implications?** | The proposal will not affect protected characteristic group(s) within the Equality Act.<br>The service will be available to Adults with a learning disability regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership. |
| **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?** | The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.<br>A privacy impact assessment has not been carried out |
| **Risk Management:** | Risk of Carer fatigue and break-down leading to costly permanent care should a respite service not be re tendered.<br>That the Council does not fulfill its statutory duty to meet eligible needs. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Denise Buckley<br> Telephone: 0161 342 3145<br> e-mail: denise.buckley@tameside.gov.uk |

## 1. INTRODUCTION

1.1 The report is seeking authorisation to retender the provision of a learning disability respite service for a contract commencing 1 October 2018.

## 2. BACKGROUND

2.1 Adult Services has provided a specialist respite/short stay service for people with a learning disability for more than three decades. The overall aim of the service has been to enable people to live as independent and fulfilling a life as possible in the community whilst ensuring their carers receive breaks to enable them to continue with their caring duties.

2.2 Following extensive consultation, a Key Decision in March 2013 approved a redesigned respite / short stay service comprising five beds (four respite beds and one emergency bed), at one building base: Cumberland Street, Stalybridge. This decision saw provision reduce from nine beds to five and a maximum allocation of twenty one nights per year per family. As a result, costs for the service were reduced by £74K per annum.

2.3 A procurement exercise was undertaken for the service at Cumberland St and awarded to Community Integrated Care (CIC). The contract commenced on 1 December 2013 and will expire on 30 September 2018 following a two year extension (there was a 2 month delay in the commencement date due health and safety adaptations to the building).

2.4 The current contract was tendered on the basis of the delivery of a respite service using a domiciliary model of provision.

## 3. CONTRACTING PROPOSAL

3.1. Consideration is given to tender the service at Cumberland St as the building facility with the continued delivery of a domiciliary care model for a period of 5 years commencing 1 October 2018.

3.2 The tendered service at Cumberland St will deliver 4 beds with access to a 5th emergency bed and will be available 365 days per year.

## 4. VALUE FOR MONEY

4.1 The current annual value for this service, 2017/18 is £220,320 for care and support. In addition, the Council incurs annual costs for rent, utilities and equipment at approx. £30k per annum.

4.2 To ensure a competitive tender in terms of delivering best value, evaluation criteria against the most economically advantageous tender will be implemented as part of the procurement re tender exercise. This will include a quality and cost weighting with the latter evaluated against an indicative budget guide with the lowest price receiving the highest weighting.

## 5. OTHER ALTERNATIVES CONSIDERED

5.1 This is an established service which meets the needs of those who receive support therefore it is felt appropriate to re-tender this service. Consideration has been given to ending the service, however the decision to move forward with a tender exercise has been driven by the vulnerable group supported through this contract and implications for more expensive packages of care should this service not continue. This service offers respite to families and

carers and a ceasing of the service could result in families not being able to sustain their full time caring roles as they do not have the opportunity for a break.

5.2 Evidence from assessment information shows that there is a high demand for this service, there are currently 56 people accessing respite. Detailed consultation was carried out in 2012 with service users and carers and further consultation carried out in 2015; both indicated that people felt there was a great deal of importance in the need for the continuation of a building based respite services with the main concerns raised including the risk of Carer fatigue and break-down leading to costly permanent care.

## 6. IMPLICATION IF THE SERVICE IS NOT RE-COMMISSIONED

6.1 All service users have been assessed as having eligible needs as defined in the Care Act 2014. Failure to provide the service would therfore put service users at risk and may increase the numbers who enter more costly services due to family breakdown.

6.2 The current cost of the service is £847 per person per week. This compares to supported accommodation contracts in the borough at an average of £1044 per week and approx £2200 for residential placements for younger adults with a learning disability in the Greater Manchester region.

## 7. EQUALITIES

7.1 It is not anticipated that there are any equality and diversity issues with this proposal.

7.2 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.

7.3 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

## 8. RISK MANAGEMENT

8.1 Any risks of poor service delivery will be mitigated by close monitoring of the service to ensure that needs are being met of both service users and their carers. This will include existing oversight from care management alongside quarterly contract monitoring.

8.2 The risk of not recommissioning the service would lead to carer fatigue and potential breakdown - this would in most cases mean a move to costly permanent care for individuals. Continuing the provision of this service will minimise/delay the need for costly permanent care and maintain service users safely in their family home.

8.3 There is a significant risk that ceasing the provision of this service will mean that the Council does not fulfill its statutory duty to meet eligible needs. Continuing this popular service will mean that the Council continues to fulfil its statutory duties at a very economic cost.

## 9. CONCLUSION

9.1 The Care Act requires the Council to provide services that meet assessed eligible needs. Respite care is a service that allows users and their families to have a break from each other in order to allow users to remain at home being cared for by their families for as long as possible.

9.2 The current model of respite care provision has been in place for many years and is a valued service currently accessed by 55 families.

## 10. RECOMMENDATONS

10.1 As stated on the front of the report.

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| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Officer of Single Commissioning Board** | Gill Gibson, Director of Safeguarding and Quality<br>Slawomir Pawlik, Quality and Patient Safety Lead |
| **Subject:** | **BIMONTHLY QUALITY ASSURANCE REPORT** |
| **Report Summary:** | The purpose of the report is to provide the Single Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned; to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns. |
| **Recommendations:** | The Strategic Commissioning Board is asked to NOTE the content of the report. |
| **Financial Implications:**<br>**(Authorised by the statutory Section 151 Officer & Chief Finance Officer)** | The quality assurance information in this report is presented for information and as such does not have any direct and immediate financial implications. |
| **Legal Implications:**<br>**(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. A framework needs to be developed to achieve this. It must include complaints and other indicators of quality. |
| **How do proposals align with Health & Wellbeing Strategy?** | Strengthened joint working in respect of quality assurance aim to support identification or quality issues in respect of health and social care services. |
| **How do proposals align with Locality Plan?** | Quality assurance is part of the locality plan. |
| **How do proposals align with the Commissioning Strategy?** | The service contributes to the Commissioning Strategy by providing quality assurance for services commissioned. |
| **Recommendations / views of the Health and Care Advisory Group:** | This section is not applicable as the report is not received by the Health and Care Advisory Group. |
| **Public and Patient Implications:** | The services are responsive and person-centred. Services respond to people's needs and choices and enable them to be equal partners in their care. |
| **Quality Implications:** | The purpose of the report is to provide the Single Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned and promote joint working. |
| **How do the proposals help to reduce health inequalities?** | As above. |

| | |
|---|---|
| **What are the Equality and Diversity implications?** | None currently. |
| **What are the safeguarding implications?** | Safeguarding is part of the report. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | There are no information governance implications. The reported data is in a public domain. No privacy impact assessment has been conducted. |
| **Risk Management:** | No current risks identified. |
| **Access to Information :** | The background papers relating to this report can be inspected by contacting Slawomir Pawlik, Quality and Patient Safety Lead, by: |

Telephone: 07788647611

e-mail: slawomir.pawlik1@nhs.net

## 1. PURPOSE

1.1 The purpose of this report is to provide the Strategic Commissining Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services they commission; to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns. The report covers data up to the end of November 2017.

## 2. TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST (Tameside &Glossop Integrated Care Foundation Trust): Acute and Community Services

**Issues of concerns/remedy**

2.1 The last Integrated Care Foundation Trust (ICFT) Contract Quality and Performance Assurance meeting was held on the 8 February 2018; the main areas of concern related to an ongoing issue with stroke repatriation and a decrease in performance in the Health Visiting service.

*Stroke*

2.2 The issue with the stroke repatriation relates to those patients admitted to other hospitals as a result of a stroke, who are then experiencing a delay in being repatriated to ICFT due to a shortage of available beds. As this has been an ongoing issue it was requested that a deep dive is now undertaken into the ICFT stroke pathway. The aim is to understand the issues, particularly in relation to repatriation and discharge, and for actions to be agreed to improve the areas of concern. It was agreed that the Executive Stroke Team would be best placed to facilitate this deep dive with the outcome being brought back to the contract quality and performance assurance group. If the issue continues, it will be escalated to the man ICFT Contact Meeting.

*Health Visiting Services*

2.3 The issue with Health Visiting relates to a noted decrease in performance in Quarter 3 for all Public Health England (PHE) Key Performance Indicators (KPIs) for the Health Visiting Service, but particularly in relation to the timeliness of New Birth Visits (NBV). The ICFT have identified an issue with the quality of the data being submitted to EMIS by the service and a priority exercise is being undertaken to ensure that the data quality is improved prior to the PHE submission due mid-February; the expectation is that the data quality exercise should significantly improve the performance data. Alongside the data quality exercise assurance is also been sought as to whether the reduction in timeliness is as a consequence of known capacity issues within the Health Visiting Service.

2.4 A deep dive has previously been presented at the December 2017 meeting which highlighted the service pressures, challenges and risk mitigation the service had put into place whilst it is without a full complement of Health Visitors. The challenge for the service is that the mandated PHE KPIs can only be carried out by a qualified Health Visitor and capacity is a challenge within the service. Work continues in relation to recruitment forecasting and workforce projection. The service expects to recruit to full capacity of Health Visiting posts next year. Health Visiting performance has been escalated to the main contracting meeting.

*Looked After Children (LAC)*

2.5 The December quality report highlighted ongoing concerns in relation to the timeliness of Initial Health Assessments provided for Looked After Children (LAC). The LAC service review has continued, in collaboration with the provider, to ensure Tameside and Glossop CCG has a clear LAC offer to children and young people. Its purpose is to clarify and improve performance and quality for children and young people. The CCG, provider, and Local Authority have continued to work together to resolve issues with timely notification

processes between services and considered how to improve partnership working. Performance in this area has improved with an increase from 45.5% in November 2017 to 90% in December 2017. This will continue to be monitored.

**Good practice**

*Infection Prevention*

2.6 The ICFT Infection Prevention Team, in partnership with the CCG / SCF Quality Team are leading a piece of work aiming to reduce gram negative infections (with a particular focus on Ecoli) across the health and care economy. This work underpins the delivery of the GM ambition to reduce gram negative infections by 50% in the next 5 years and the delivery of 17/18 / 18/19 Quality Premium Scheme.

2.7 A task and finish group, made up of Infection Prevention Leads, Hydration and Continence Specialist Nurses, Public Health and Care Home representation drives the delivery of a range of quality improvement initiatives aiming to reduce gram negative infections. Learning from Ecoli cases has identified that a high number of cases involved adults who did not have any health care involvement and commonly had developed the infections as a result of a Urinary Tract Infection. Therefore consideration has been given as to how the group can influence those people at risk, who may not be accessing any form of heath care establishment. One of the quality improvement focuses is a therefore a hydration campaign which aims to deliver accessible messages, across a range of establishments such as Bingo halls, social settings encouraging the public to increase their fluid intake and maintain good hygiene. This will include posters, leaflets and an awareness raising slot on Tameside Radio. The ICFT Infection Prevention Lead has kindly agreed to present the work of the group at the next Quality, Performance and Assurance (QPAG) meeting.

**Patient Story**

2.8 Please follow the link to a patient story about the care they received at ICFT following their diagnosis of bowel cancer.

**Horizon scanning**

*NHS Improvement (NHSI) CDIF Objectives 2017/18*

2.9 On an annual basis NHSI issue all CCGs with an 'objective' in relation to CDIF bacteraemia cases. The objective sets out the number of cases NHSI expect the CCG not to exceed in the financial year. This figure is then split into acute and community objectives. The ICFT Infection Prevention Service lead on Infection Prevention for both acute and community acquired HCAIs (Health Care Associated Infections), including a programme of audit work with the care home sector. For every CDIF bacteraemia there is a full investigation and any lessons learnt are fed back to individuals, service areas and inform system wide improvement initiatives.

2.10 For the financial year 2017/18 T&G CCG were given a CDIF objective of 97, this was split down to 54 acute and 43 community cases. There has been a slight increase in HCAI's in Quarter 3 2017/18 however we are optimistic of achieving the NHSI objective for 2017/18. To date Tameside &Glossop CCG have reported 79 cases of CDIF against an annual plan of 97 cases. This currently places the CCG 18 cases under plan with 2 months of the financial year remaining.

NHS Staff Survey[1]

2.11 The staff survey results have been released; findings and actions will be discussed at the next quality contract meeting and included in the next QPAG report. Please follow the link to the full report.

[1] The NHS Staff Survey results are predominantly aimed at NHS organisations, to inform local improvements in staff experience and well-being. The results are also used by NHS England to support national assessments of quality and safety. The Care Quality Commission uses the results to inform their Intelligent Monitoring work to help to decide who, where and what to inspect

**Conclusion**

2.12 All aspects relating to the quality and performance of the Integrated Care Foundation Trust contract continue to be managed through the monthly Trust Contract Quality and Performance Assurance meeting and issues of concern escalated to the main contract meeting.

## 3. MENTAL HEALTH (PENNINE CARE NHS FOUNDATION TRUST (PCFT))

**Issues of concerns/remedy**

*Mixed Sex Accomodation (MSA)*[2]

3.1 During December 2017 there were 2 mixed sex accommodation breaches: 1 on Hague Ward and 1 on Summers Ward.

3.2 A Mixed Sex Accommodation proposal was presented to Trust Board in December 2018 this proposes reconfiguration of the curent accomodation across the PCFT geographical footprint over a 2 year period. The proposal aims to ensure there is improved opportunity to reduce incidents and to enable the separation of older people inpatient with mental health inpatient aciltities for service users with organic cause of mental ill health. The Board is now considering next steps and is working with Commissioners regarding the requirement to consult on the proposed approach.

*Care Quality Commission*

3.3 The latest assessment of progress shows that 178 (66%) of actions within the Care Quality Commission action plan are rated Green, 63 (23%) Amber and 31 (11%) Red. This has improved from the position reported at the end of November 2017.

3.4 Clinical Lead/CCG Assurance meeting has moved to 6 weekly monitoring the Compliance and Quality Improvement Plan. CCGs re-introduced the Quality Deep Dive meetings which will be held quarterly.

*Delayed Transfer of Care (DTOC)*

3.5 The Trust has been working internally and externally to increase the prominence and improve management of delayed discharges. A new dashboard has been created within the PCFT Tableau which provides a daily snap shot of delays by ward and reason code. The Trust monitors the rate of DTOCs against the 3.5% target. The target definition is defined as the number of available bed days lost due to DTOC. The dedicated clinical resources aligned to the DTOC improvement work stream are working closely with the wards and bed management to ensure timely and consistent reporting and escalation of the DTOC performance from a ward level, and to provide assurance regarding appropriate plans to move patients on.

**Good practice**

*Healthy Young Minds (HYM) Research Unit*

3.6 HYM has recently established a research unit. Whilst the unit is in its very early stages of development it is an exciting opportunity to conduct research to influence practice, increase engagement in research of both staff teams and Children and young People (CYP) and families and also attract workforce to their services. The Unit has already secured time from several nationally recognised professionals to support the unit and are already in the progress of submitting study applications. A launch event is being planned in spring for relevant partners. This will include opportunities to link with non-clinical research students. It is intended to link to the PCFT vision of developing the use of data in all services.

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[2] MSA- sleeping breaches i.e. defined as instances where patients are admitted into a ward where patients of the opposite sex are also admitted.

**Patient Story**

*Rehabilitation High Support Directorate*

3.7 Thirty mental health service users, carers and staff from Pennine Care NHS Foundation Trusts Rehabilitation and High Support Directorate (RHSD) have been celebrating their achievements after completing a number of courses at the college aimed at helping them to achieve better health and wellbeing. The college is based at two of the Trust's RHSD low secure units. These are Prospect Place in Rochdale and the Tatton Unit in Ashton-under-Lyne.

3.8 The courses are free, recovery-focused and educational and are aimed at supporting service users with their recovery journey during and after hospital. These courses are all designed by someone with professional skills and someone with lived experience. Two service users from the units now have a formal role as volunteer co-facilitators at the college, using their own experiences to help others take control of their recovery.

3.9 Feedback continues to be really positive with one student from Tatton Unit saying,

*'Between 6 and 18 months ago I was depressed very much and just roughly down in the dumps a lot and I could not cope. Since I have started doing the courses and sessions at Tatton I have felt much better.'*

**Horizon scanning**

*Proposals for Strategic Governance, Accountability and Assurance Architecture*

3.10 On 20 December 2017 PCFT Board approved proposed changes to strengthening and streamlining the Trust's current governance arrangements. In line with the proposal approved the Board of Directors will meet in public every month with the option to subsequently meet in closed session if required.

3.11 The Board also approved to develop two new, monthly sub-committees: the Performance and Finance Committee and Quality Committee, to replace the quarterly Performance and Quality Assurance Committee and Finance Strategy Committee. Additionally a new People and Workforce Committee is being established and will meet on a bi-monthly basis. These changes started to take effect from January 2018.

3.12 All Board sub-committees will be chaired by Non-Executive Director, who will provide a Chair's report to each subsequent Board meeting.

*NHS Staff Survey in England, published in March 2018*

3.13 The staff survey results have been released; findings and actions will be discussed at the next quality contract meeting and included in the next QPAG report. Please follow the link to the full report.

**Conclusion**

3.14 All aspects relating to the quality and performance of the Tameside and Glossop Pennine Care Foundation Trust mental health services has been and continue to be overseen through the monthly Pennine Care Foundation Trust Quality and Performance Contract Assurance meeting.

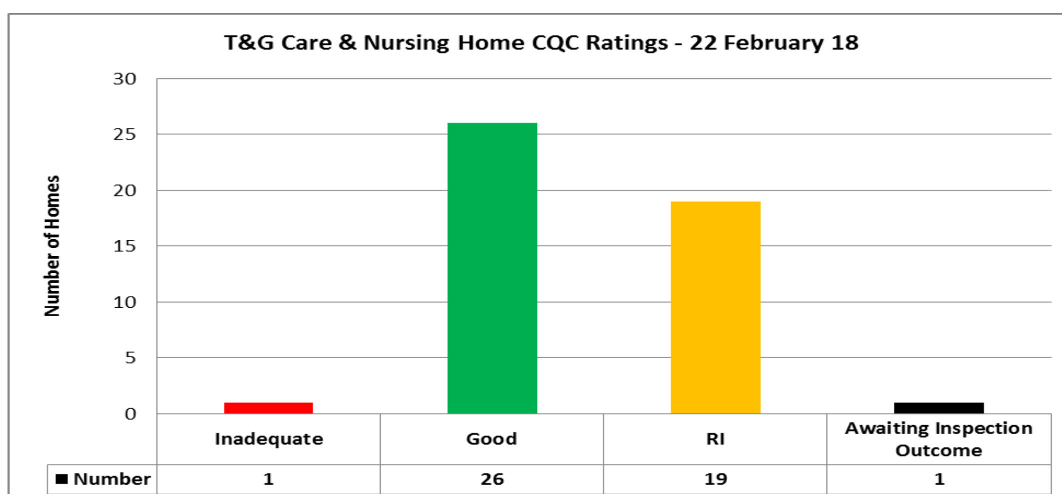
## 4. CARE HOMES/HOME CARE

**Issues of concerns/remedy**

*Care Homes and with Nursing*

4.1 The Care Quality Commission (CQC) picture for Care Homes and with Nursing[3] is provided in the graph below.

[3] The Figure includes Glossop Care and Nursing Homes




4.2 There is currently 1 home rated inadequate within the locality, a short summary of key issues and support provided is given.

**Inadequate CQC Ratings**

*Oakwood Care Centre*

4.3 The Home was initially rated as inadequate by CQC on 22 April 2017 following an inspection 9-11 January 17 (concerns about safe care and treatment, good governance & fit & proper persons employed). Following the CQC inspection the owner voluntarily suspended new admissions to the home. Safe and well checks were undertaken with the feedback from these providing assurances that the resident's needs were being met. A new manager re-established systems and processes and the voluntary suspension was lifted as all appropriate actions had been taken to address concerns identified by CQC. The CQC have recently visited and the provider is waiting for the draft report, this is however likely to remain inadequate due to environmental factors and poor record archiving (now addressed). The Manager has recently been replaced in December 2017. Oakwood Care Centre has been identified as a priority for the new Quality Improvement Team due to its CQC status.

**Published CQC Ratings**

*Charnley House Residential Home*

4.4 There has been an improvement rating made by the CQC from Inadequate to Requires Improvement (Published January 2018)

4.5 The Home was initially suspended in September 2016 following an inadequate CQC inspection. Key issues highlighted included medicines management, risk assessment, staffing and recruitment and IPC. Support to the home has been ongoing and the suspension was lifted in August 2017. The home was re-inspected again in November 2017 and the report published in January 2018 has moved performance from Inadequate to Requires Improvement. Key issues which were seen to improve related to recording of information. Significant support has been provided to this Home and improvements noted specifically around care planning. The care home fell short of receiving a Good rating due to a failure to record diet for a service user requiring a modified diet.

*Hyde Nursing Home*

4.6 There has been an improvement rating, made by CQC from Requires Improvement to Good (published February 2018). This home has now been rated as having good performance across all the CQC domains.

*Polebank Hall Residential Home*

4.7 There has been an improvement rating made by CQC from Requires Improvement to Good (published February 2018). This home has now been rated as having good performance across all the CQC domains.

*Balmoral Care Home*

4.8 There has been an improvement rating made by CQC from Inadequate to Requires Improvement (published February 2018).

4.9 Following the inspection undertaken in May 2017 the Commissioners have supported the home, with a specific emphasis on medication administration. Support was also given around care planning. The providers purchased the Cared4 Quality Assurance system to help demonstrate compliance with the CQC Regulations. The home marginally failed to achieve a Good rating due to being unable to demonstrate compliance with Legionella checks.

*Parkhill Nursing Home*

4.10 No change in CQC Performance – remained Good (published January 2018).

*Yew Trees*

4.11 There has been an improvement rating made by CQC from Inadequate to Good (published February 2018).

4.12 The Home was originally rated inadequate following a CQC visit on 03 July 2017 (publication 11 October 2017). Several issues were highlighted in relation to training of staff and safeguarding of residents. From this visit a number of safeguarding concerns were raised, which prompted a number of safe & well checks to be undertaken. The overall outcome was that residents' needs were being met, with some examples of good practice noted. The safeguardings raised by the CQC Inspector were not substantiated. A re-inspection was undertaken in December 2017 and the Home has been rated Good in all domains, with the exception of Well-led which has been rated as Requires Improvement. The rationale provided is that a longer term track record of sustainable good practice would need to be demonstrated for a Good rating in this domain.

*The Lakes Care Centre*

4.13 A reduction in rating by the CQC to Requires Improvement from Good was made (published January 18). A themed inspection was undertaken following receipt of a Regulation 28 Coroners Report. Issues noted related to the timeliness of actions being taken in relation to falls prevention at mealtimes, and a breach in notification to CQC in line with the regulations.

Kingsfield Care Centre

4.14 No change in CQC Performance – remained Requires Improvement (published January 2018). Requires Improvement in all domains except Well-Led, which was Inadequate due to continual breaches in regulations that had not been addressed.

**Suspensions Update**

*Carson House*

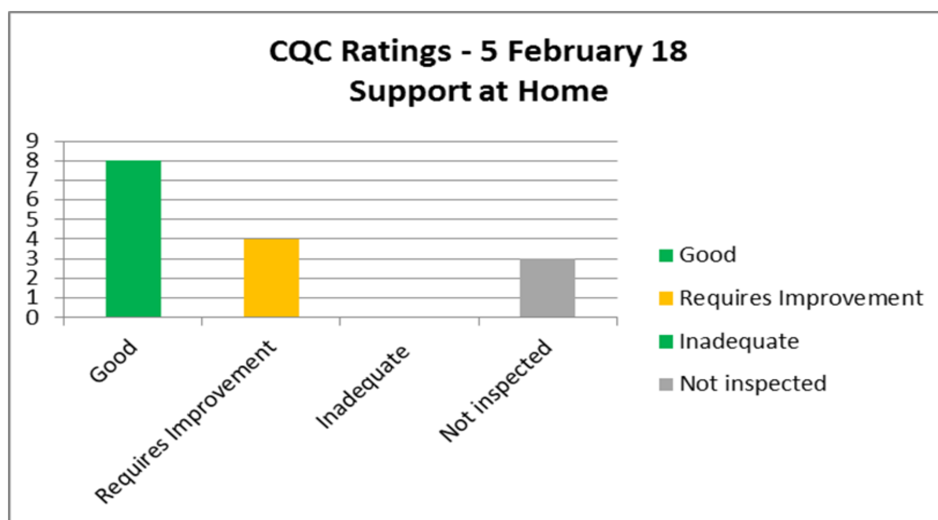
4.15 This home is no longer under voluntary suspension and as part of the usual process of lifting a suspension there is a restriction in place i.e. only accepting one new service user per week. Evidence from families who have provided positive feedback about the care received at Carson House. Ongoing close monitoring continues with this Home. Issues with paying the provider appropriately have occurred but now been resolved.

*Regency Hall (Glossop)*

4.16 The home has been suspended on a voluntary basis following a recent CQC inspection (publication is awaited). However, the suspension was lifted on 12 March 2018, but admissions remain limited to one per week for the next four weeks.

*Support in the community*

4.17 The CQC picture of the providers used to supply support in the community in Tameside is noted in the graph below (please note this includes the providers used for the general support at home service (even if the office is not registered in Tameside) and supported living providers):




4.18 During this reporting period no new CQC reports have been published for providers of support in the community.

4.19 Laurel Bank Support at Home has been a deregistered service since October 2017. No concerns or complaints have been received since the transfer of service users to other facilities.

4.20 The new support at home model is being rolled out across all six zoned providers (phase 1 started date in February 2018) so the providers will be working to two models of care initially whilst the new model embeds.

*Quality Improvement Team (QIT)*

4.21 A Quality Improvement Team is being established to support independent providers across the health and social care sector in Tameside to improve the quality of service provision delivered to vulnerable people. All posts have now been recruited to and the Quality Improvement Team Manager is now in post. The primary focus of the work will initially be on the Care and Nursing Home sector, with a particular focus on those homes rated "inadequate" by the CQC, and an overall aim that with the support on offer from the team all homes will achieve good or outstanding ratings. The team would then programme in time to extend the work across the Support at Home Service and more widely across supported accommodation.

**Patient story**

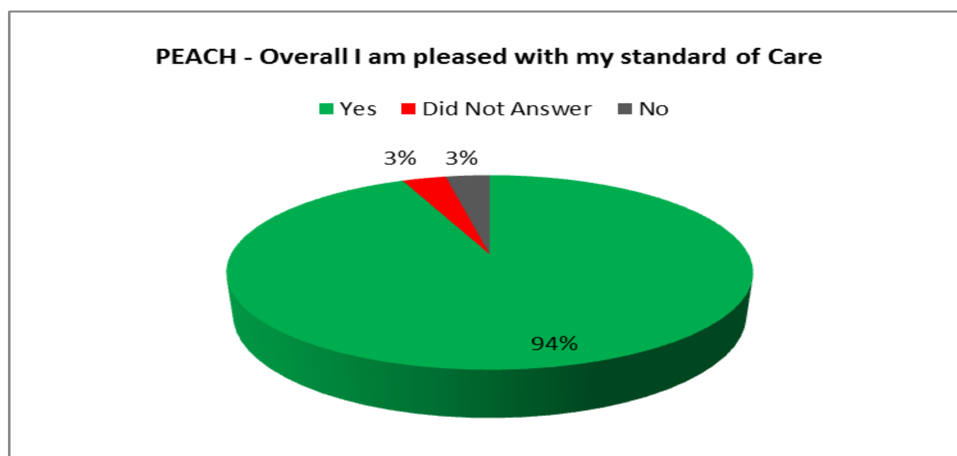
*Oakwood Care Centre*

4.22 Daughter of a resident at Oakwood Care Centre has thanked the Home for the support given to her mother who has mental health needs including anxiety and depression. After moving to Oakwood Care Centre she is now coming out of her room and engaging with other residents after a long period of time remaining in her room. The daughter has reported this has been extremely positive step for both her mother and herself.

**Good Practice**

*Patient Experience and Continuing Healthcare (PEACH)*

*4.23* The Patient Experience measure for Continuing Health Care has now been fully embedded into existing processes with every person in receipt of CHC and/or their being asked about their experience of their care provision at their reviews. Feedback is overall positive and more detailed results are being used by the Care Home data-set in conjunction with other data and soft intelligence. A summary for the period from 1 November to 31 January 2018 is provided below (29 responses).




**Conclusion**

4.24 The new monthly contractual returns have now been implemented for Care Homes and the Care Home data-set will now be meeting monthly. A full Action Log is updated following each meeting and the Group is utilising the data provided by the Homes including trend analysis supported by Business Intelligence. Key actions will be reported to QPAG on a bi-monthly basis.

## 5. SAFEGUARDING

*Children's Safeguarding*

5.1 There are currently no serious case reviews. Two deaths of children were reviewed at the January 2018 Serious and Significant Screening Panel. It was agreed that these did not fit the criteria for undertaking serious case review. The Ofsted (Office for Standards in Education, Children's Services and Skills) Improvement plan for Tameside has been revised and the corresponding health plan is being revised to ensure that it meets new requirements. New Safeguarding Children Board arrangements are currently being considered in line with proposed changes to legislation and the incorporation of the Wood Review recommendations in to local safeguarding governance and scrutiny arrangements.

*Looked After Children (LAC)*

5.2 The Improvement Board, whose function is to review the multi-agency action plan for the authority since it was allocated an inadequate judgement, is overseeing the progress being made to ensure that children and young people who are looked after receive appropriate help and support. The progress made so far has been considered satisfactory and outstanding actions are due for completion in February 2018

*Adult Safeguarding*

5.3 There are no Safeguarding Adult Reviews (SARs) currently underway or for consideration in Tameside & Glossop. Work is ongoing to ensure that care homes are supported in undertaking their safeguarding duties.

*Learning Disability Mortality Review Programme (LeDer)*

5.4 Tameside and Glossop LeDer Implementation plan has now been submitted to NHS England. Tameside Local Authority and Tameside and Glossop CCG is working with NHSE to convene a Greater Manchester LeDer conference. This has been arranged for 23 March 2018.

## 6. PRIMARY CARE

**Issues of concerns/remedy**

*Medlock Vale Medical Practice*

6.1 Medlock Vale Medical Practice's CQC report was published on 16 January 2018. The publication confirmed that the practice had been placed in special measures. The practice submitted an action plan to CQC on 5 February 2018. The CQC report findings have been mapped across to the practice's GMS contract and six remedial notices have been issues in the following areas:

- Clinical Governance;
- Infection Control;
- Compliance with Legislation and Guidance;
- Premises;
- Provision of drugs, medicines and appliances for immediate treatment or personal administration;
- Storage of Vaccines.

6.2 Remedial notices are issued where a practice is in breach of its GMS contract but where there is a belief that the breaches can be remedied. Consequently, a compliance plan is issued to the practice. The practice then has a period of 28 days to comply with the compliance plan and evidence how it has remedied the highlighted breaches. Medlock Vale submitted its completed compliance plan, including all its evidence, on 20 February 2018.

6.3 As the practice has been placed in special measures it is automatically eligible to access the support of the Royal College of General Practitioners within the Greater Manchester GP Excellence Programme. The support the practice receives is bespoke to the issues raised in its CQC report. The initial diagnostic meeting took place on 16 February 2018.

6.4 Support from the primary care team, for the practice, is ongoing throughout the whole of this process.

**Good practice**

*Haughton Thornley Medical Centres*

6.5 Haughton Thornley Medical Centres, Hyde, was inspected by CQC on 6 December 2017. It has been rated as *outstanding* by CQC. In the five key lines of enquiry the practice was rated outstanding for services being responsive to people's needs and for services being well-led. It was rated good for services being safe, effective and caring.

6.6 CQC found the following to be areas of outstanding practice at Haughton Thornley Medical Centres:

- The practice and Patient Participation Group (PPG) were proactive in encouraging patients to sign up to have full online access to their medical records; to date the practice have 62% of patients signed up for access. The practice were in the process of evaluating the impact and monitoring usage to assess the benefits to patients and the practice,

- The PPG in partnership with Hyde Community Action ran an ESOL course (English for Speakers of Other Languages) with a health theme for 16 female patients in

which they taught them how to access a GP and other health services, how to sign up for online services, medical records access and how to use “My Medication Passport”. Evaluations of this project showed, by the end of the course, 100% of the women reported increased confidence, knowledge, awareness of online access to health records, healthy eating, exercise, pharmacy and other local services and they shared the information with their family and friends. There was a waiting list of 60 patients for future courses,

- The practice secured funding in 2015 for the Hyde Healthy Living project which was to benefit all patients over 75 years of age across the neighbourhood including those registered with other practices. Although the formal funding for the project ended in August 2017 the practice had maintained the social prescribing, additional GP time, and the pharmacist and were working with the local Health and Well-being team to co-ordinate future reviews. Evaluation of the programme to date showed 102 patients and their carers benefitted from the programme and their goals were monitored and outcomes measured using a nationally recognised evaluation tool. We saw from the evaluation, following intervention 53% said they felt more positive, 56% were managing their symptoms. Outcomes for individuals included a review of benefits received, disability badges issued, stair lifts and mobility aids being fitted to help prevent falls and support to attend social events. Hyde Healthy Living Project was awarded the BMJ Primary care team of the year 2016.

- The Healthy Hyde project have integrated social prescribing pathways and templates into the clinical system allowing staff to quickly refer patients for additional support in the community where required, for example to Age UK and the community response team. Data provided by the practice showed 180 social referrals were made by the practice, meaning a quicker more streamlined system for patients.

**Patient story**

6.7 The feedback from patients regarding the extended access service has been very positive. Patients like the convenience of being able to see a GP beyond core hours of 8am – 6.30am and the speed at which they can access these appointments

**Horizon scanning**

*The Greater Manchester GP Excellence Programme*

6.8 The Greater Manchester GP Excellence Programme has been developed to support General Practice and act as a programme for improvement. There is a Memorandum of Understanding in place with Royal College of General Practitioners (RCGP). This partnership between GM and the RCGP will support the delivery of the GP Excellence Programme, drawing on the knowledge and expertise of the College while working with the strengths and experience of primary care within Greater Manchester.

6.9 The GP Excellence Programme supports GP practices through delivery of a wide menu of support that helps practices to become more sustainable and resilient, better placed to tackle the challenges they face now and into the future, and securing continuing high quality care for patients. This programme supplements existing mechanisms of support to General Practice and will work with localities to ensure that it aligns with existing quality improvement initiatives.

6.10 The programme focuses on both clinical and non-clinical members of a practice and is providing support to strengthen the skills of all staff within practices by offering and providing majority funding for development courses such as the National Association of Primary Care’s Diploma in Advanced Primary Care, Level 3 and Level 5 diplomas in leadership management. There are also shorter one day courses in leadership and working at scale being offered. The aim of these courses is to develop the current and

future leaders of primary care to be able to manage the strategic direction of travel.

6.11 Tameside and Glossop practices have expressed much interest in the courses made available so far.

## 7. PUBLIC HEALTH

**Issues of concerns/remedy**

*Substance misuse*

7.1 Substance misuse provider CGL have been named in a Manchester Evening News report relating to archive case records found by the owner of their former premises in Katherine Cavendish House in Ashton. The records do not relate to CGL activity and have been collected by Tameside Metropolitan Borough Council (TMBC) for safe keeping whilst an investigation is completed. The owner is in dispute with CGL about the future of the lease for the building originally let to former substance misuse service provider Lifeline. The lease is currently held by Lifeline receivers FRP.

**Conclusion**

7.2 Quality assurance will continue to be sough via monthly contract monitoring meetings.

## 8. SMALL VALUE CONTRACTS (<5MLN)

(Please note that below contracts are monitored on the quarterly or biannual bases)

*Broomwell Healthwatch, Specsavers (Audiology, NWCATS, GM Primary Eyecare Ltd: Tameside and Glossop Glaucoma Repeat Reading Service, Minor Eye Conditions Service and gtd Healthcare[4].*

8.1 No quality issues in Quarter 3.

**Good practice**

*Gtd Healthcare*

8.2 in Quarter 3 following a series of listening exercises conducted with gtd staff members, it was decided by the Senior Management Team that a deep dive exercise looking at gtd services would take place. The aim of the exercise would be to gather more detail around some of the specific issues raised by staff members in the listening exercises as well as identify areas of service delivery which require improvement.

8.3 The exercise took place between Wednesday 13th September and Tuesday 19th September and covered services in Chorley, Preston, Oldham, Southport, Litherland, Wythenshawe, *Ashton*, Central Manchester, North Manchester and at head office in Denton. Each shift in the morning, afternoon and evening was observed by a manager for three hours and an update teleconference took place during each shift to discuss issues and problems which may have arisen.

8.4 Feedback was gathered using a survey and an observation sheet. Specific questions taken from the listening exercises were gathered in the survey. The outcome from the exercise has been pulled together in to a report and actions identified. Action plans are being overseen by Senior Management Team and specific actions assigned to the relevant teams. Themes that have emerged are:

- IT issues especially at remote sites which can impact on service delivery,
- Improving communication between head office and satellite sites,
- Quality of facilities in some of our shared sites,
- Delays in being able to refer patients to secondary care services

[4] gtd Healthcare- the company uses this spelling in their reports.

**Horizon Scanning**

*Homeless Friendly*

8.5 Gtd Healthcare has signed a pledge making it one of the first organisations in the country to be Homeless-Friendly. While gtd Healthcare has already undertaken numerous initiatives to support the homeless community over the past few years including offering and administering free flu vaccines and distributing free dental hygiene packs, being a Homeless Friendly organisation demonstrates their commitment and drive to ensuring gtd Healthcare workforce has the knowledge and understanding of the needs of homeless people. They have been involved in the Manchester Shoe Box appeal. They are liaising with homeless charities, outreach workers and Greater Manchester Combined Authority to arrange how and when they can administer free flu vaccines to the homeless community.

## 9. SUMMARY

9.1 Quality must be the organising principle of our health and care services. It is what matters most to people who use services and what motivates and unites everyone working in health and care. However, quality challenges remain, alongside new pressures on staff and finances. The Quality Team believes that the areas which matter most to people who use services are: Safety - people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned through effectiveness, where people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence; and that people have a positive experience where staff involve and treat patients with compassion, dignity and respect. The services are responsive and person-centred meaning services respond to people's needs and choices and enable them to be equal partners in their care.

# Agenda Item 6b

| | |
|---|---|
| **Report to:** | **STRATEGIC COMMISSIONING BOARD** |
| **Date:** | 17 April 2018 |
| **Officer of Strategic Commissioning Board** | Sarah Dobson, Assistant Director Policy, Performance and Communications. |
| **Subject:** | **DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – PERFORMANCE UPDATE** |

**Report Summary:**


This report provides the Strategic Commissioning Board with a Health and Care performance report for comment.

This report provides the Strategic Commissioning Board (SCB) with a health and care performance update at April 2018 using the new approach agreed in November 2017. The report covers:

- Health & Care Dashboard – including exception reporting for measures which are 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 (SCB) members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board (SCB) are asked to note, and any other data or performance issues that Strategic Commissioning Board (SCB) need to be made aware.
- In-focus – a more detailed review of performance across a number of measures in a thematic area.

This is based on the latest published data (at the time of preparing the report). This is as at the end of January 2018.

The content of the report is based on ongoing analysis of a broader basket of measures and wider datasets, and looks to give the Strategic Commissioning Board (SCB) the key information they need to know in an accessible and added-value manner. The approach and dashboard are aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group (QPAG).

The following have been highlighted as exceptions:

- A&E Standards were failed at Tameside Hospital Foundation Trust;
- Diagnostics over 6 weeks;
- Referral To Treatment- 18 weeks
- Proportion of people using social care who receive self-directed support, and those receiving direct payments
- Total number of Learning Disability service users in paid employment

Attached is **Appendix 3** on Mental Health.

| | |
|---|---|
| **Recommendations:** | The Strategic Commissioning Board are asked:<br>• Note the contents of the report, in particular those areas of performance that are currently off track and the need for appropriate action to be taken by provider organisations which should be monitored by the relevant lead commissioner<br>• Support ongoing development of the new approach to monitoring and reporting performance and quality across the Tameside & Glossop health and care economy |
| **How do proposals align with Health & Wellbeing Strategy?** | Should provide check & balance and assurances as to whether meeting strategy. |
| **How do proposals align with Locality Plan?** | Should provide check & balance and assurances as to whether meeting plan. |
| **How do proposals align with the Commissioning Strategy?** | Should provide check & balance and assurances as to whether meeting strategy. |
| ***Recommendations / views of the Professional Reference Group:*** | This section is not applicable as this report is not received by the professional reference group. |
| **Public and Patient Implications:** | Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care. |
| **Quality Implications:** | As above. |
| **Financial Implications:**<br>**(Authorised by the statutory Section 151 Officer & Chief Finance Officer)** | The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance. |
| **Legal Implications:**<br>**(Authorised by the Borough Solicitor)** | As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all part sot account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality. |
| **How do the proposals help to reduce health inequalities?** | This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact. |

| | |
|---|---|
| **What are the Equality and Diversity implications?** | None. |
| **What are the safeguarding implications?** | None reported related to the performance as described in report. |
| **What are the Information Governance implications? Has a privacy impact assessment been conducted?** | There are no Information Governance implications. No privacy impact assessment has been conducted. |
| **Risk Management:** | Delivery of NHS Tameside and Glossop's Operating Framework commitments 2017/18 |
| **Access to Information :** | • **Appendix 1** – Health & Care Dashboard;<br>• **Appendix 2** – Exception reports;<br>• **Appendix 3** – Mental Health in-focus report.<br>The background papers relating to this report can be inspected by contacting Ali Rehman by:<br> Telephone: 01613425637<br> e-mail: alirehman@nhs.net |

## 1.0 BACKGROUND

1.1 This report provides the Strategic Commissioning Board (SCB) with a health & care performance update at April 2018 using the new approach agreed in November 2017. The report covers:

- Health & Care Dashboard – including exception reporting for measures which are 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 (SCB) members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board (SCB) are asked to note, and any other data or performance issues that Strategic Commissioning Board (SCB) need to be made aware;

- In-focus – a more detailed review of performance across a number of measures in a thematic area.

1.2 The content of the report is based on ongoing analysis of a broader basket of measures and wider datasets, and looks to give the Strategic Commissioning Board (SCB) the key information they need to know in an accessible and added-value manner. The approach and dashboard are aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group (QPAG).

## 2.0 HEALTH & CARE DASHBOARD

2.1 The Health & Care Dashboard is attached at **Appendix 1**, and the table below highlights which measures are for exception reporting and which are on watch.

| | | |
|---|---|---|
| EXCEPTIONS (areas of concern) | 1 | A&E 4 hour wait |
| | 3 | Referral To Treatment-18 Weeks |
| | 4 | Diagnostics |
| | 39 | Direct Payments |
| | 40 | LD |
| ON WATCH (monitored) | 2 | DTOC |
| | 44 | 65+ at home 91days |

2.2 Further detail on the measures for exception reporting is given below and at **Appendix 2**.

**A&E waits Total Time with 4 Hours at Tameside and Glossop Integrated Care Foundation Trust (ICFT)**

2.3 The A&E performance for January was 85.2% for Type 1 & 3 which is below the target of 95% nationally, and the 90% target. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. T&G ICFT are ranked second in GM for the month of January 2018.

**Diagnostics 6+ week waiters**

2.4 This month the CCG failed to achieve the 1% standard with a 1.09% performance. Of the 51 breaches 33 occurred at Central Manchester (Colonoscopy, Gastroscopy, Cardiology, Audiology, Cystoscopy, Urodynamics and MRI), 13 at Salford Trust (MRI and Gastroscopy),1 at Pennine Acute (MRI), 1 at Stockport (Cardiology) and 3 at Other

(Neurophysiology and CT). Central Manchester performance is due to an ongoing issue with endoscopy which GM are aware of. Salford Trust have had increased demand for MRI causing a pressure. The trust has implemented a recovery plan and trajectory to get back on track. Expect to be back on track April 2018. Future report will feedback on recovery plan and impact.

**18 Weeks Referral To Treatment**

2.5 Performance for January is below the Standard for the Referral to Treatment 18 weeks (92%) achieving 91,96%. This is an improvement in performance compared to the previous month, December which also failed to achieve the standard at 91.5%. The national directive to cancel elective activity was expected to reduce performance in January. The impact for Tameside and Glossop was expected to be greatest at Manchester Foundation Trust (MFT) and the recovery plan submitted to GM reflected that fact that failure at MFT could mean Tameside and Glossop performance would be below the required standard. MFT is failing to achieve the RTT national standard. MFT (formerly University Hospital of South Manchester) revised its improvement trajectory and is currently on track. MFT (formerly Central Manchester FT) is slightly below target although there have been improvements in children's services. We will discuss with lead commissioners the need for comprehensive recovery plans.

**Proportion of people using social care who receive self directed support, and those receiving Direct Payments**

2.6 Performance for Q3 is below the threshold for total proportion of people using social care who receive self-directed support, and those receiving direct payments (28.1%) achieving 13.48%. This is a deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 13.65%. Tameside performance in 2016/2017 was 12.47%, this is a decrease on 2015/2016 and is below the regional average of 23.8% for 2016/2017. Nationally the performance is 28.3% which is above the Tameside 2016/17 outturn. Additional Capacity to be provided within the Neighbourhood teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the Adult Social Care transformation funding. The project post was not successfully recruited too therefore in order to increase capacity a different approach has been implemented. We use to have 2 Direct Payment workers this has now been increased to 4 Direct Payment Workers, one in each neighbourhood. A publicity campaign will now be developed to increase numbers over the coming months

**Total number of Learning Disability service users in paid employment**

2.7 Performance for Q3 is below the threshold for total number of learning disability users in paid employment (5.8 %%) achieving 4.39%. This is deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 4.50%. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. In order to improve performance, additional resource is required to increase capacity. An additional post has been funded through the Adult Social Care transformation funding and a vacant post that was held in the team has also been released to increase capacity in the team with an expectation that more people will be supported into paid employment. Work has been undertaken with Routes to Work to strengthen their recording of Supported Employment services and to clarify the links with this indicator.

## 3.0 OTHER INTELLIGENCE / HORIZON SCANNING

3.1 Below are updates on issues raised by Strategic Commissioning Board members from previous presented reports, any measures that are outside the Health and Care Dashboard but which Strategic Commissioning Board are asked to note, and any other data or performance issues that Strategic Commissioning Board need to be made aware.

**'Winter crisis' - Influenza**

3.2 The provisional January 2018 Tameside and Glossop CCG vaccine uptake for this period was 75.9% against a target of 75% meaning that the CCG has met the target set by NHS England (NHSE). There were 39 GP practices participating in the 2017-18 seasonal flu campaign. Of these, 24 GP practices (62%) either met or exceeded the target set by NHSE and 15 GP practices (38%) were below the target. We are currently performing better than GM and England averages and ranked 3rd amongst GM CCGs for data up to Week 52.

**Children aged 2,3 &4**

3.3 Performance in January 2018 has shown a remarkable increase in all preschool age groups compared to January last year. The CCG has achieved the 40% ambition in children aged 2, 3 and 4 year old. This has been a national and local focus of the 17/18 flu campaign.

For data up to Week 52 we have been performing better than GM and England averages; and are ranked against other GM CCGs as 4th for 2 year olds and 3rd for 3 year olds.

**Under 65 (at risk only), Pregnant Women and Carers**

3.4 The national ambition is 55% for under 65s at risk. A downward trend is observed from last year's performance; however, the absolute number of patients vaccinated has increased during 17/18. To achieve the 75% target 6,934 people who would need to be vaccinated but it is important to note that if we vaccinated the current shortfall of 92 people we would achieve the 55% ambition.

We are ranked 2nd against other GM CCGs (week 52).

3.5 The latest flu surveillance report for influenza like illness at upper tier local authority level shows that there is an increasing trend in Tameside over the last 10 weeks. Currently ranked sixth in GM for the rate per 100,000 population.

**NHS 111**

3.6 The North West NHS 111 service performance has improved in all of the key KPIs for January but none of the KPIs achieved the performance standards:

- Calls Answered (95% in 60 seconds) = 72.14%
- Calls abandoned (<5%) = 9.05%
- Warm transfer (75%) = 33.63%
- Call back in 10 minutes (75%) = 41.09%

Average call pick up for the month was 2 minutes 27 seconds. Performance was particularly difficult to achieve over the weekend periods. There is a remedial action plan in place with Commissioners.

**4.0 IN-FOCUS – Mental Health**

4.1 The thematic in-focus area for this report is Mental Health. The key headlines from the in-focus are summarised below and the full report is attached at **Appendix 3**.

**5.0 RECOMMENDATIONS**

5.1 As set out on the front of the report.

Appendix 1

# Health and Care Improvement Dashboard

## April 2018

| | Indicator | Standard | Latest | Previous 2 data points | | Latest | Direction of Travel | Trend |
|---|---|---|---|---|---|---|---|---|
| 1 | Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours | 95% | Jan-18 | 90.2% | 88.6% | 85.2% | | |
| 2 | * Delayed Transfers of Care - Bed Days | 3.5% | Dec-17 | 4.6% | 3.8% | 3.9% | | |
| 3 | * Referral To Treatment - 18 Weeks | 92% | Jan-18 | 91.9% | 91.6% | 92.0% | | |
| 4 | * Diagnostics Tests Waiting Times | 1% | Jan-18 | 1.4% | 1.1% | 1.2% | | |
| 5 | Cancer - Two Week Wait from Cancer Referral to Specialist Appointment | 93% | Jan-18 | 96.8% | 96.7% | 95.9% | | |
| 6 | Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected) | 93% | Jan-18 | 98.3% | 94.9% | 90.1% | | |
| 7 | Cancer - 31-Day Wait From Decision To Treat To First Treatment | 96% | Jan-18 | 98.8% | 100.0% | 98.8% | | |
| 8 | Cancer - 31-Day Wait For Subsequent Surgery | 94% | Jan-18 | 100.0% | 100.0% | 100.0% | | |
| 9 | Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen | 98% | Jan-18 | 100.0% | 100.0% | 100.0% | | |
| 10 | Cancer - 31-Day Wait For Subsequent Radiotherapy | 94% | Jan-18 | 100.0% | 100.0% | 100.0% | | |
| 11 | Cancer - 62-Day Wait From Referral To Treatment | 85% | Jan-18 | 86.1% | 88.6% | 86.1% | | |
| 12 | Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service | 90% | Jan-18 | 83.3% | 100.0% | 100.0% | | |
| 13 | Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade | | Jan-18 | 93.3% | 83.3% | 73.1% | | |
| 14 | MRSA | 0 | Dec-17 | 0 | 0 | 0 | | |
| 15 | C.Difficile (Ytd Var To Plan) | 0% | Dec-17 | -1.0% | -1.0% | -1.0% | | |
| 16 | Estimated Diagnosis Rate For People With Dementia | 66.7% | Jan-18 | 82.5% | 81.8% | 81.5% | | |
| 17 | Improving Access to Psychological Therapies Access Rate | 1.25% | Aug-17 | 3.8% | 4.0% | 3.8% | | |
| 18 | Improving Access to Psychological Therapies Recovery Rate | 50% | Nov-17 | 48.6% | 46.6% | 37.0% | | |
| 19 | Improving Access to Psychological Therapies Seen Within 6 Weeks | 75% | Nov-17 | 89.2% | 89.5% | 83.3% | | |
| 20 | Improving Access to Psychological Therapies Seen Within 18 Weeks | 95% | Nov-17 | 100.0% | 100.0% | 100.0% | | |
| 21 | Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral | 50% | Dec-17 | 50.0% | 0.0% | 50.0% | | |
| 22 | Mixed Sex Accommodation | 0 | Jan-18 | 0.37 | 0.93 | 0.38 | | |
| 23 | Cancelled Operations | | 17/18 Q3 | | 1.0% | 1.1% | | |
| 24 | Ambulance: Red 1 Calls Responded to in 8 Minutes | 75% | Jul-17 | 62.0% | 57.1% | 63.3% | | |
| 25 | Ambulance: Red 2 Calls Responded to in 8 Minutes | 75% | Jul-17 | 64.9% | 60.6% | 62.9% | | |
| 26 | Ambulance: Category A Calls Responded to in 19 Minutes | 95% | Jul-17 | 91.6% | 88.2% | 89.7% | | |
| 27 | Cancer Patient Experience | | 2016 | 9.10 | 8.70 | 8.77 | | |
| 28 | Cancer Diagnosed At An Early Stage | | 16/17 Q3 | 43.7% | 54.2% | 54.6% | | |
| 29 | General Practice Extended Access | | Sep-17 | | 74.4% | 84.2% | | |
| 30 | Patient Satisfaction With GP Practice Opening Times | | Mar-17 | | 74.4% | 76.0% | | |

* data for this indicator is provisional and subject to change

Appendix 1

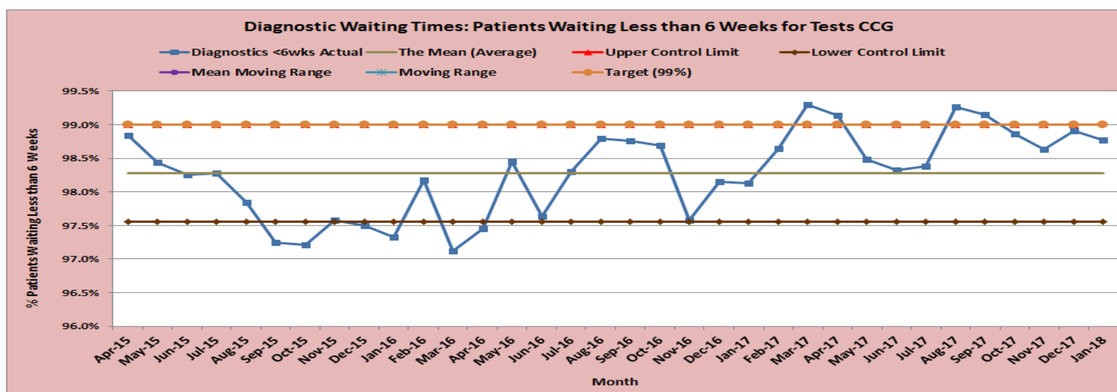
| | Indicator | Standard | Latest | Previous 2 data points | | Latest | Direction of Travel | Trend |
|---|---|---|---|---|---|---|---|---|
| 31 | Maternal Smoking at delivery | | 17/18 Q2 | 15.7% | 15.1% | 14.6% | | |
| 32 | %10-11 classified overweight or obese | | 2013/14 to 2015/16 | 33.3% | 33.6% | 33.6% | | |
| 33 | Personal health budgets | | 17/18 Q1 | 3.60 | 4.50 | 5.30 | | |
| 34 | % of deaths in hospital | | 16/17 Q2 | 47.60 | 49.80 | 50.40 | | |
| 35 | LTC feeling supported | | 2016 03 | 62.90 | 62.40 | 61.40 | | |
| 36 | Quality of life of carers | | 2016 03 | 0.80 | 0.77 | 0.78 | | |
| 37 | Emergency admissions for urgent care sensitive conditions (UCS) | | 16/17 Q4 | 2906 | 3212 | 3066 | | |
| 38 | Patient experience of GP services | | Jul-05 | 81.2% | 83.2% | 83.5% | | |
| | **Adult Social Care Indicators** | | | | | | | |
| 39 | Part 2a - % of service users who are in receipt of direct payments | 28.1% | 17/18 Q3 | 12.76% | 13.65% | 13.48% | | |
| 40 | Total number of Learning Disability service users in paid employment | 5.7% | 17/18 Q3 | 4.71% | 4.50% | 4.39% | | |
| 41 | Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64 | 13.3 | 17/18 Q3 | 3.71 (5 Admissions) | 10.38 (14 Admissions) | 11.86 (16 Admissions) | | |
| 42 | Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+ | 628 | 17/18 Q3 | 43.77 (56 Admission | 277.27 (108 Admissions) | 454.42 (177 Admissions) | | |
| 43 | Total number of permanent admissions to residential and nursing care homes aged 18+ | | 17/18 Q3 | 61 | 122 | 193 | | |
| 44 | Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital | 82.7% | 17/18 Q3 | 81.8% | 81.8% | 81.8% | | |
| 45 | % Nursing and residential care homes CQC rated as Good or Outstanding (Tameside and Glossop) | | Jan-18 | 50% | 49% | 49% | | |
| 46 | % supported accomodation CQC rated as Good or Outstanding (Tameside and Glossop) | | Jan-18 | 80% | 80% | 80% | | |
| 47 | % Help to live at homes CQC rated as Good or Outstanding (Tameside and Glossop) | | Jan-18 | 67% | 53% | 53% | | |

Performance detiorating and failing standard
Performance improvinging and failing standard
Performance improving and achieving standard
Performance detiorating and achieving standard
Performance detiorating no standard
Performance improving no standard
No change in Performance and achieving standard
No change in Performance and failing standard
No change in Performance and no standard

# Exception Report

## Health and Care Improvement- April

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






**Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG**

| | Jan-18 | | | |
|---|---|---|---|---|
| **CCG** | **Waiting > 6 Weeks** | **Total Waiting List** | **Performance** | **Standard** |
| NHS Bolton CCG | 299 | 3878 | 7.71% | 1% |
| NHS Salford CCG | 180 | 5155 | 3.49% | 1% |
| NHS Trafford CCG | 156 | 5164 | 3.02% | 1% |
| NHS Manchester CCG | 237 | 12133 | 1.95% | 1% |
| NHS Oldham CCG | 100 | 5666 | 1.76% | 1% |
| NHS Wigan Borough CCG | 90 | 5588 | 1.61% | 1% |
| NHS Heywood, Middleton & Rochdale CCG | 70 | 4648 | 1.51% | 1% |
| NHS Bury CCG | 61 | 4057 | 1.50% | 1% |
| NHS Tameside and Glossop CCG | 51 | 4689 | 1.09% | 1% |
| NHS Stockport CCG | 41 | 5472 | 0.75% | 1% |

**Key Risks and Issues:**

**As a CCG**
This month the CCG failed to achieve the 1% standard with a 1.09% performance.
Of the 51 breaches 33 occurred at Central Manchester (Colonoscopy, Gastroscopy, Cardiology, Audiology, Cystoscopy, Urodynamics and MRI), 13 at Salford Trust (MRI and Gastroscopy),1 at Pennine Acute (MRI), 1 at Stockport (Cardiology) and 3 at Other (Neurophysiology and CT).

Manchester University Foundation Trust (MFT)performance is due to increased demand and issues around decontamination have impacted endoscopy performance .

Salford Trust demand for MRI has increased causing a pressure.

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

**Actions:**

Commissioner and GM are aware of issues at Central Manchester in MFT and working with them to improve. However performance is expected to be further impacted when work is undertaken to ensure they achieve the JAG rating as 6 week waits may build up again.

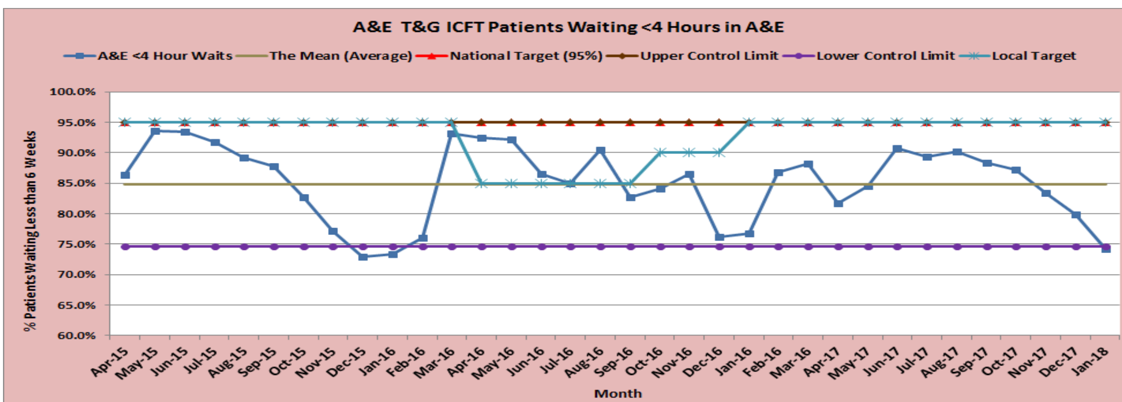
Salford have implemented a recovery plan and trajectory but do not expect to achieve the standard until April 2018.

**Operational and Financial implications:**

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

Unvalidated -Next month FORECAST

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




January Performance: 85.2%

16/17 ytd: 85.31%

17/18 ytd: 90.95%

**Key Risks and Issues:**

The A&E Type1 and type 3 performance for January was 83.9% which is below the National Standard of 95% and below the GM agreed target of 90%.
Late assessment due to lack of capacity in the department is the main reason for breaches.
• Lack of physical capacity in the ED to see patients during periods of surge and high demand;
• An increase of 300 attendances (4%) in January, compared to January 2017;
• Medical bed-pool occupancy was routinely at 98% leading to reduced capacity on AMU and IAU;
• Demand continues to grow, a consequence of increased acuity.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.
A&E Streaming is in place but staffing of rotas challenging at times.

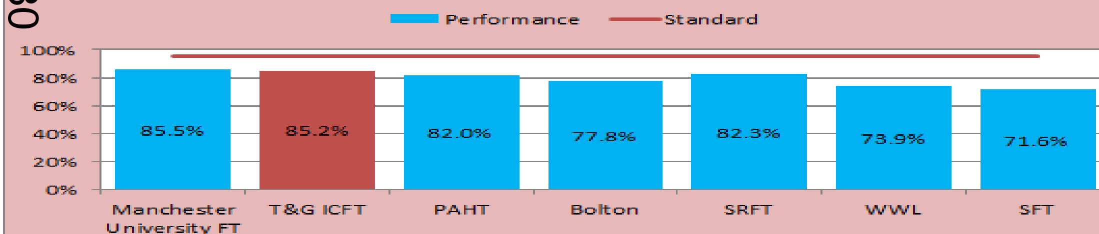
**Actions:**

• Regular ED patient reviews by coordinator- of- day and lead consultant; • Remodelling of consultant roles to support better the focus on performance and supervision; • Recruitment of specialty doctors for ED and ANPs for Ambulatory Care; • Expansion of the ambulance triage area; • ED streaming to GP available from 10 am to 8 pm; • Complete roll-out of electronic Casualty Card in February/ March to improve quality of data/ record keeping and support improved flow; • Ambulatory Care project aimed at improving the flow of urgent- care patients and reducing follow- up activity that could be located elsewhere; • ANP and trainee ANP commenced in Ambulatory Emergency Care (AEC) in January to enable improved weekend and evening working; • GP call handling by Digital Health piloted in three localities; • ED Delivery Board reviewing the actions needed to improve, and then sustain performance, in line with GM requirements.
We are working on a GM level recovery plan to achieve 90% by Q1.

**Operational and Financial implications:**

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

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

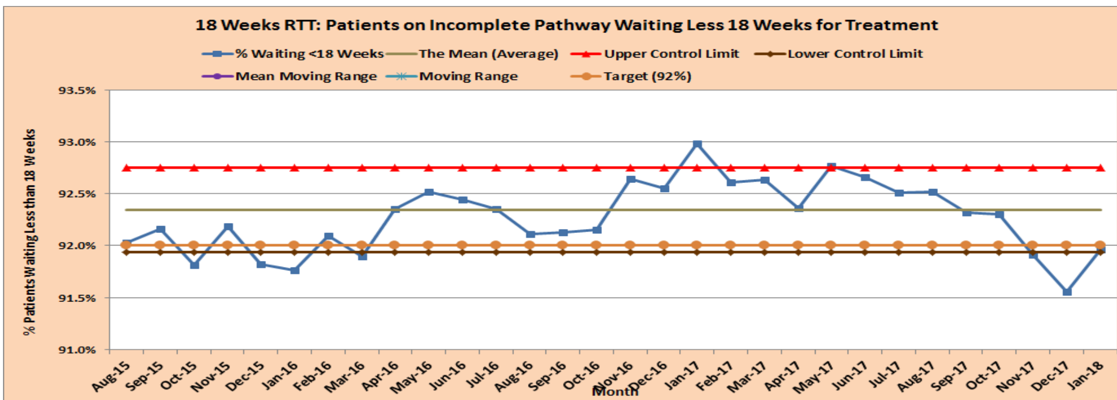



Unvalidated-Next month FORECAST



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

18 Weeks RTT: Patients on incomplete pathway waiting less than 18 weeks for treatment | **Lead Officer:** Elaine Richardson | **Lead Director:** Jess Williams | **Governance:** Contracts




**Key Risks and Issues:**

The RTT 18 weeks performance for January was 91.96% which is below the National Standard of 92% .
Failing specialties are, Trauma & Orthopaedics (85.35%), Oral Surgery (0.00%), Neurosurgery (91.30%), Plastic Surgery (69.06%), Cardiothoracic Surgery (63.64%), General Medicine (91.67%), Rheumatology (89.72%), Gynaecology (88.94%).
The national directive to cancel elective activity was expected to reduce performance in January. The impact for T&G was expected to be greatest at MFT and the recovery plan submitted to GM reflected that fact that failure at MFT could mean T&G performance would be below the required standard.
The performance at MFT at 89.08% is the key reason for the failure in January with 327 people breaching. Stockport and Pennine trusts also contributed to the failure accounting for a further 142 breaches.
T&O continues to be a challenge across most providers. In MFT our biggest concerns are around plastics, cardio theracic, gyneocology and cardiology.
As lead Commissioner.
T&G ICFT as a provider are achieving the standard.

**Actions:**

MFT is failing to achieve the RTT national standard. MFT (formerly UHSM) revised its improvement trajectory and is currently on track. MFT (formerly CMFT) is slightly below target although there have been improvements in children's services.

We will discuss with lead commissioners the need for comprehensive recovery plans.

**Operational and Financial implications:**

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

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



**Monthly Referral to Treatment (RTT) waiting times for incomplete pathways.**

| | Jan-18 | | | |
|---|---|---|---|---|
| CCG | Total number of incomplete pathways | Total within 18 weeks | % within 18 weeks | Target |
| NHS Wigan Borough CCG | 18359 | 17195 | 93.66% | 92% |
| NHS Salford CCG | 22074 | 20443 | 92.61% | 92% |
| NHS Tameside and Glossop CCG | 16451 | 15128 | 91.96% | 92% |
| NHS Stockport CCG | 23706 | 21646 | 91.31% | 92% |
| NHS Trafford CCG | 15488 | 14095 | 91.01% | 92% |
| NHS Oldham CCG | 14771 | 13415 | 90.82% | 92% |
| NHS Manchester CCG | 36178 | 32563 | 90.01% | 92% |
| NHSE North of England | 1000980 | 894267 | 89.34% | 92% |
| NHS Bury CCG | 12546 | 11177 | 89.09% | 92% |
| NHS Bolton CCG | 21654 | 19212 | 88.72% | 92% |
| NHS Heywood, Middleton & Rochdale CCG | 16676 | 14791 | 88.70% | 92% |

Unvalidated-Next month FORECAST

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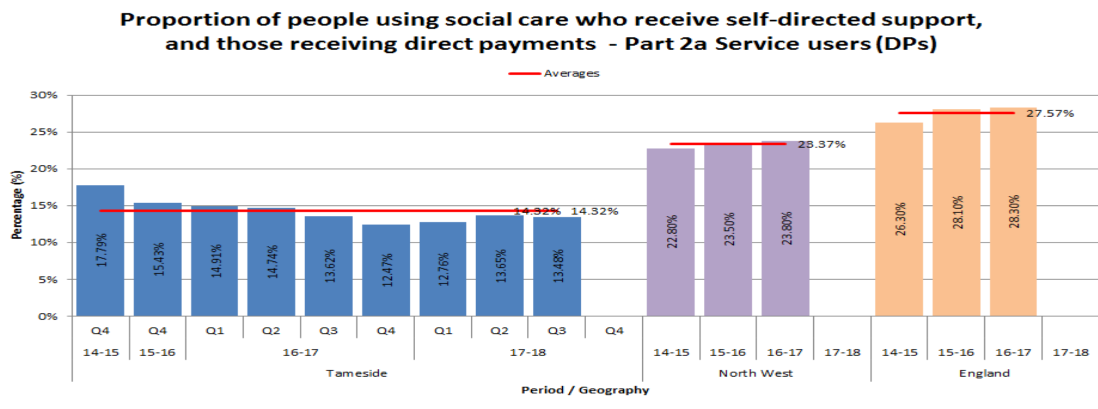
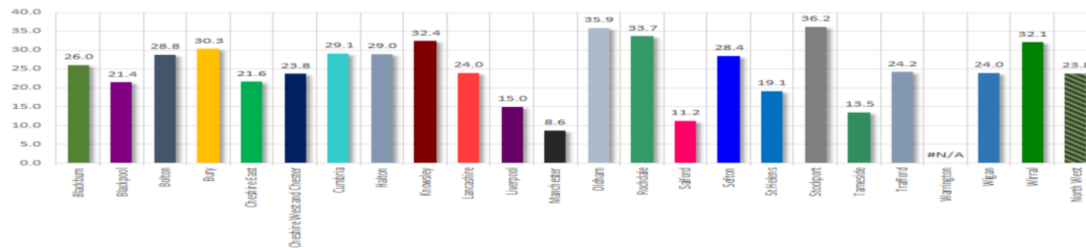
# Exception Report

## Health and Care Improvement- April

**ASCOF 1C- Proportion of people using social care who receive self directed support, and those receiving Direct Payments** **Lead Officer:** Sandra Whitehead **Lead Director:** Steph Butterworth **Governance**: Adults Management team




**Key Risks and Issues:**

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

**Actions:**

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

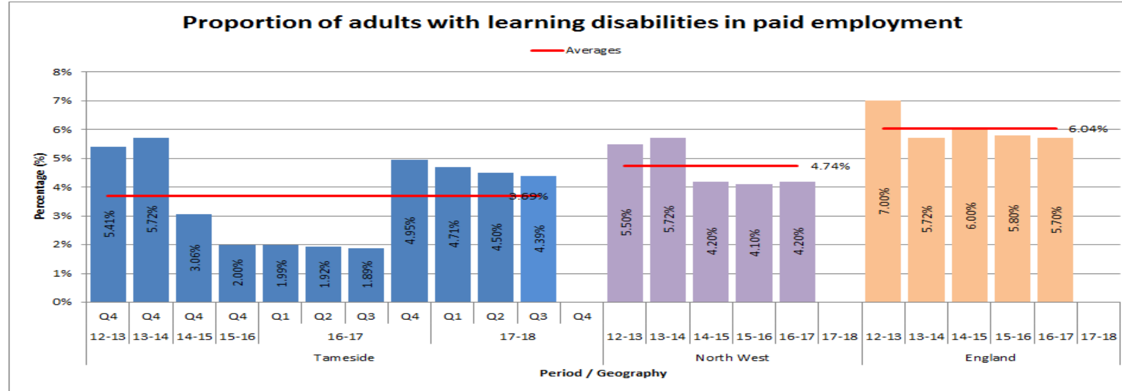
**Operational and Financial implications:**

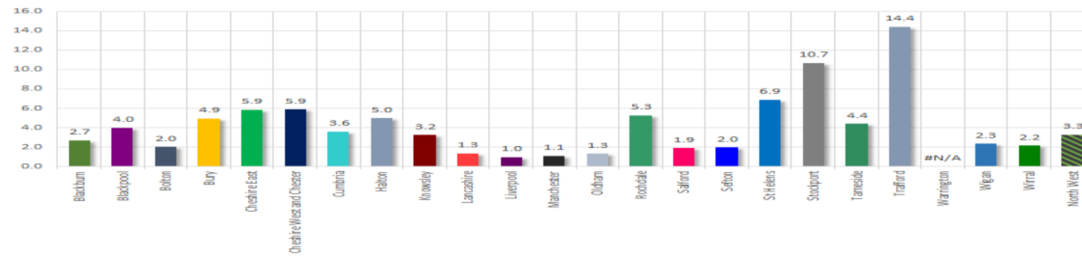
None

Unvalidated Next Quarter FORECAST

* Benchmarking data is as at Q3 17/18.

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




**Key Risks and Issues:**

The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. 3rd Quarter 2017/18 figure is 4.39%

**Actions:**

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

**Operational and Financial implications:**

None

Unvalidated next Quarter FORECAST

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# APPENDIX 3

**MENTAL HEALTH IN-FOCUS**
**STRATEGIC COMMISSIONING BOARD**

## 1.0 INTRODUCTION

In January 2018 in recognition of the importance of mental health the Strategic Commissioning Board agreed to prioritise increasing investment in improving mental health outcomes to improve parity of esteem. Work to develop an outcome focussed approach to monitoring is ongoing at both a GM level and within the Pennine Care footprint. This report aims to provide a snapshot of performance and outcome information against the life course.

## 2.0 STARTING WELL

### 2.1 Parent Infant Mental Health

The Tameside & Glossop Parent Infant Strategy of 2009 identified the benefits of meeting the mental health of both parents and infants. A robust integrated parent infant mental health pathway, led by the award winning Early Attachment Service, has been in operation ever since. This service provides a clinical service which includes seeing families directly, leading and supervising a range of peer support parenting programmes and offering consultations and training to professionals. The Tameside and Glossop model is not being rolled out across GM.

**Case study: Tameside and Glossop Early Attachment Service (EAS)**

*James was already struggling with anxiety and low mood and had sunk into a deeper depression on discovering his partner of 12 years was pregnant. He was adamant he hadn't wanted a baby and didn't feel ready to be a parent. His work was affected, and his relationship with his partner was strained. He had been referred for therapy to address his depression and anxiety but had begun to feel increasingly suicidal and presented as being at significant risk of harming himself which led to further assessment and risk monitoring by adult mental health services.*

*The EAS took a whole family approach to addressing these issues encouraging him to bring his partner Alice to appointments. With James and Alice's agreement EAS linked up with the adult mental health practitioners and enhanced midwifery team to support them as they prepared for the baby's birth.*

*Working with them as a couple allowed some of the difficult feelings between them to be safely talked about and managed and they were able to discuss plans for the birth and beyond which hadn't been possible previously. Jack was born and both parents were immediately delighted by him and continued to attend sessions together with Jack. Following the birth James and Alice came to understand how aspects of their own early life experiences influenced their feelings about bringing a child into the world and being parents.*

*Extensive work was required to support the family unit, this included sessions with James alone, several antenatal sessions with James and Alice, multidisciplinary case work and contact during the period of time around the birth and finally sessions with James, Alice and Jack in the family home s following the birth. They are now discharged from both Healthy Minds and EAS and are doing well.*

*(All names and identifying details have been changed to protect confidentiality)*

### 2.2 Off The Record

Off the Record is commissioned to provide a counselling service for children and young people. The main counselling service received 284 new referrals in the 12 months to December 2017 and delivered 2035 counselling sessions. In addition 171 young people accessed the one-to-one counselling drop-in at Off the Record headquarters in Hyde and, at Talk Shop, young people's Drop-In at the Anthony Seddon Fund, 260 recorded interventions with young people and family/carers. The interventions include; 1 to 1 counselling, 20 minute brief intervention counselling and general advice, guidance and signposting to other services.

## 2.3 Healthy Young Minds (CAMHS)

The Five Year Forward View for Mental Health laid out ambitious plans to improve mental health support for children and young people. One of the key targets is increasing access and reducing waiting times.

### (a) HYM Waiting times

The team are continuing to work hard to achieve waiting time targets

| KPI | % achievement in February 2018 |
|---|---|
| % of CYP first Contact within 12 weeks | 100% |
| % of CYP commenced treatment within 18 weeks | 88.2% |

### (b) HYM Access

National CYP Increased Access Trajectories

| Objective | 2016/17 | 2017/18 | 2018/19 | 2019/20 | 2020/21 |
|---|---|---|---|---|---|
| At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community Mental Health service. | 28% | 30% | 32% | 34% | 35% |
| Number of additional CYP treated over 2014/15 baseline | 21,000 | 35,000 | 49,000 | 63,000 | 70,000 |

Greater Manchester extract from NHS Digital published data, December 2017

| Area | Actual number of CYP receiving treatment (YTD) | Gap to plan | Total number of CYP with a diagnosable mental health condition | Percentage access rate (annual forecast) |
|---|---|---|---|---|
| ENGLAND | 196,729 | -54,477 | 1,064,328 | 23.2% |
| Greater Manchester | 13,505 | 408 | 59,099 | 28.6% |
| NHS Bolton CCG | 1,365 | -93 | 6,484 | 26.4% |
| NHS Bury CCG | 950 | 50 | 3,877 | 30.7% |
| NHS Oldham CCG | 940 | 60 | 3,965 | 29.7% |
| NHS HMR CCG | 1,530 | 384 | 5,086 | 37.7% |
| NHS Salford CCG | 1,590 | 366 | 5,445 | 36.6% |
| NHS Stockport CCG | 1,220 | 5 | 5,400 | 28.3% |
| NHS Tameside & Glossop CCG | 825 | -380 | 5,485 | 18.9% |
| NHS Trafford CCG | 235 | -795 | 4,593 | 6.4% |
| NHS Wigan CCG | 900 | -401 | 6,400 | 17.6% |

R Cause for Concern and below National Average; A Off Target but above National Average; G Meeting Required Target

Performance in a number of localities, T&G included, is due to data issues and Pennine Care is working with the GM workstream to address improving data quality. In addition to this the system at present only collects NHS activity and therefore support delivered by the VCS and other teams is not collected yet.

A multi-agency Single Point of Entry (SPOE) for CYP has been established and is held daily with representatives from all agencies. This has strengthened inter agency working and understanding which in turn is enhancing the offer between all the agencies involved in supporting young people and their families. In the past around 47% of referrals to CAMHS were ‘rejected’ as inappropriate for a specialist service whereas now, with this development the vast majority of referrals (98%) are supported into an appropriate service.

### 2.4 Children and Young People Eating Disorder Service

A new community eating disorder service was commissioned from Pennine Care in 2015/6. It is achieving all KPIs:-

| KPI Name | Target Va.. | Frequency | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of HYM Staff trained in relevant Childrens Safeguarding -L1 | >=95% | Monthly | 100% | 100% | 100% | 100% | 90.9%.. | 88.2%.. | 83.3%.. | 84.8%.. | 100%.. | 100%.. | 91.4%.. |
| % referrals screened within 24 hours | >=80% | Monthly | 100% | 100% | 100% | 100% | 100% | 100% | 100%.. | 100% | 100% | 100% | 100% |
| % urgent (emergency) referrals seen same day | >=50% | Monthly | | | | | | 100% | 0 / 0 | | | | |
| % of those that show positive distance travelled to their GBO. | TBD | Quarterly | Not Due | Not Due | 84% | Not Due | Not Due | 31.8% | Not Due | Not Due | 85.7% | Not Due | Not Due |
| % CYP successfully redirected upon referral | TBD | Quarterly | Not Due | Not Due | | Not Due | Not Due | 100% | Not Due | Not Due | | Not Due | Not Due |
| % of Discharge Letters with Summaries sent to GPs within 10 wo.. | >=80% | Quarterly | Not Due | Not Due | | Not Due | Not Due | 100% | Not Due | Not Due | 100% | Not Due | Not Due |
| % of those in treatment completing Outcome Rating Scale (ORS) | >=25% | Quarterly | Not Due | Not Due | 36% | Not Due | Not Due | 31.3% | Not Due | Not Due | 36.1% | Not Due | Not Due |
| % of those in treatment completing Session Rating Scale (SRS) | >=25% | Quarterly | Not Due | Not Due | 52% | Not Due | Not Due | 40.6% | Not Due | Not Due | 41.7% | Not Due | Not Due |
| % of those that show achievement of their GBO. | TBD | Quarterly | Not Due | Not Due | 84% | Not Due | Not Due | 0% | Not Due | Not Due | 85.7% | Not Due | Not Due |
| % of presentations/ referrals to medical and mental health inpati.. | TBD | Quarterly | Not Due | Not Due | 0% | Not Due | Not Due | 0% | Not Due | Not Due | 50%.. | Not Due | Not Due |
| Application of EDE-Q | >=25% | Quarterly | Not Due | Not Due | 31.9% | Not Due | Not Due | 53.1% | Not Due | Not Due | 50% | Not Due | Not Due |
| No of inpatient bed days utilised for ED - Horizon unit. | TBD | Quarterly | Not Due | Not Due | 276 | Not Due | Not Due | 0 | Not Due | Not Due | 0 | Not Due | Not Due |
| No. of CYP with an agreed transition plan where clinically approp.. | TBD | Quarterly | Not Due | Not Due | 0 | Not Due | Not Due | 4 | Not Due | Not Due | 1 | Not Due | Not Due |
| No. of of sessions undertaken by CYP's keyworker. | TBD | Quarterly | Not Due | Not Due | 69 | Not Due | Not Due | 105 | Not Due | Not Due | 117 | Not Due | Not Due |
| No. of presentations/ referrals to medical and mental health inpa.. | TBD | Quarterly | Not Due | Not Due | 0 | Not Due | Not Due | 0 | Not Due | Not Due | 4 | Not Due | Not Due |
| Proportion of CYP who have a named keyworker(s), with contact .. | TBD | Quarterly | Not Due | Not Due | 100% | Not Due | Not Due | 100% | Not Due | Not Due | 100% | Not Due | Not Due |
| % of CYP successfully discharged | TBD | Bi-annual | Not Due | Not Due | Not Due | Not Due | Not Due | 100% | Not Due | Not Due | Not Due | Not Due | Not Due |
| % of CYP in treatment offered/completed a CHI-ESQ at every 6 m.. | TBD | Bi-annual | Not Due | Not Due | Not Due | Not Due | Not Due | 92% | Not Due | Not Due | Not Due | Not Due | Not Due |
| % of those in treatment who have completed the CHI-ESQ reporti.. | >=25% | Bi-annual | Not Due | Not Due | Not Due | Not Due | Not Due | 33.2% | Not Due | Not Due | Not Due | Not Due | Not Due |
| No of home visits | TBD | Annual | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due |
| % of families completing adapted CHI-ESQ | >=10% | Annual | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due |
| % of home visits | TBD | Annual | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due | Not Due |
| % of those in treatment initiated Goal based outcomes (GBO) wi.. | >=25% | Quarterly | Not Due | Not Due | 24% | Not Due | Not Due | 21.9% | Not Due | Not Due | 27.8% | Not Due | Not Due |

### 2.5 Mind support to Children and Young People

Mind have been commissioned by Public Health to deliver 50 wellbeing workshops including therapeutic art sessions and psychoeducational courses and 3000 children and young people have accessed emotional wellbeing and mental health support in schools via their educational service. In addition more than 300 staff and parents accessed training to enable better support for children and young people’s emotional wellbeing and mental health needs

## 3.0 LIVING WELL

### 3.1 Pennine Care services

An overview of access and waiting times for Pennine Care services is shared below, showing information from other localities for comparison.

# APPENDIX 3

ACCESS AND WAITING TIME MONTHLY DASHBOARD : February 2018 - Primary

| Service | Instance Name | Target | Reported as | Bury | | HMR | | Oldham | | Stockport | | Tameside | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MAS | MAS 6 weeks assessment (CCG) Cumulative | 80% per quarter update for T&G & Oldham Q4 | Cumulative Qtr | 98.3% 58 / 59 | ▼ | 100% 80 / 80 | ► | 99.2% 119 / 120 | ▲ | 94.1% 64 / 68 | ▲ | 100% 35 / 35 | ▲ |
| | MAS 12 Weeks Referral (CCG) Cumulative | 80% per quarter update for T&G & Oldham Q4 | Cumulative Qtr | 100% 29 / 29 | ► | 96.1% 49 / 51 | ▲ | 63% 34 / 54 | ▲ | 97.8% 45 / 46 | ▲ | 95.7% 22 / 23 | ▲ |
| EIP | EIT Access Target (CCG) ** Cumulative | 50% per quarter | Cumulative | 6.7% 1 / 15 | ▼ | 0% 0 / 7 | ▼ | 12.5% 1 / 8 | ▲ | 75% 6 / 8 | ▲ | 60% 6 / 10 | ▲ |
| | EIT Access Target (CCG) in month | 50% per quarter | Cumulative | 0% 0 / 8 | ▼ | 0% 0 / 5 | ▼ | 16.7% 1 / 6 | ▲ | 100% 4 / 4 | ▲ | 75% 3 / 4 | ▲ |
| HEALTHY YOUNG MINDS | % of CYP first Contact within 12 weeks | 95% | In month | 98.7% 78 / 79 | ▼ | 98.2% 55 / 56 | ▼ | 100% 39 / 39 | ▲ | 100% 71 / 71 | ▲ | 100% 24 / 24 | ► |
| | % of CYP commenced treatment within 18 weeks | 98% | In month | 98.9% 89 / 90 | ▼ | 100% 71 / 71 | ▲ | 100% 25 / 25 | ▲ | 100% 65 / 65 | ▲ | 88.2% 30 / 34 | ▼ |
| A&E | A&E - Seen within 1 hr of referral | 75% | In month | 48.5% 50 / 103 | ▼ | 48.5% 48 / 99 | ▼ | 70.1% 101 / 144 | ▼ | 53.3% 40 / 75 | ▼ | 76.8% 106 / 138 | ▲ |
| | A&E - Seen within 2 hrs of referral | 95% | In month | 75.7% 78 / 103 | ▼ | 65.7% 65 / 99 | ▼ | 86.1% 124 / 144 | ▲ | 78.7% 59 / 75 | ▲ | 88.4% 122 / 138 | ▼ |
| | A&E - Discharged within 4 hours | 95% | In month | 94.3% 66 / 70 | ▲ | 90.1% 64 / 71 | ▲ | 85.4% 88 / 103 | ▼ | 95.3% 81 / 85 | ▲ | 97.2% 103 / 106 | ▲ |

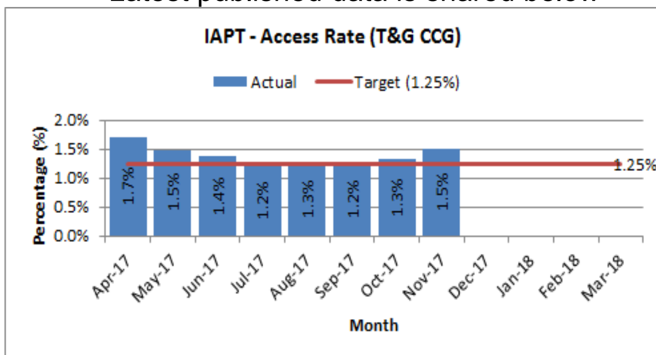
| Service | Instance Name | Target | Reported as | Bury | | Oldham | | Stockport | | Tameside | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IAPT | IAPT Prevalence - Monthly | 4.2% per quarter / (PCFT Stockport 2.2%) | In month | 412 | ▲ | 360 | ▼ | 418 | ▲ | 523 | ▲ |
| | IAPT Prevalence - quarterly | 4.2% per quarter / (PCFT Stockport 2.2%) | Cumulative Qtr | Not Due | – | Not Due | – | Not Due | – | Not Due | – |
| | IAPT Prevalence % - quarterly | 4.2% per quarter / (PCFT Stockport 2.2%) | Cumulative Qtr | Not Due | – | Not Due | – | Not Due | – | Not Due | – |
| | IAPT Recovery | 50% per month | In month | 54.4% 74 / 136 | ▼ | 50.8% 94 / 185 | ▼ | 58.9% 56 / 95 | ▲ | 47.5% 85 / 179 | ▼ |
| | IAPT 6 Week completed Treatment (CCG) ** | 75% | In month | 86.8% 125 / 144 | ▼ | 87.2% 164 / 188 | ▼ | 89.9% 89 / 99 | ▲ | 86.1% 161 / 187 | ▼ |
| | IAPT 18 Week completed Treatment (CCG)** | 95% | In month | 100% 144 / 144 | ► | 97.3% 183 / 188 | ▼ | 100% 99 / 99 | ► | 100% 187 / 187 | ▲ |

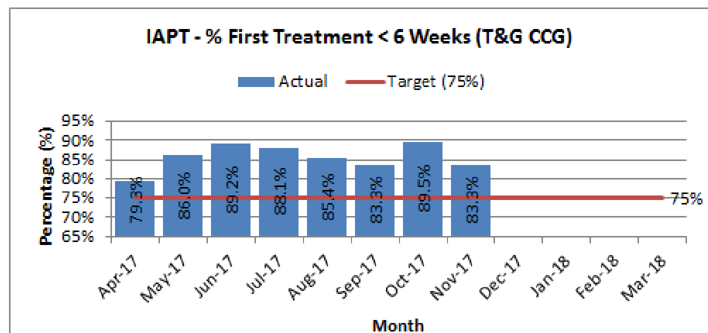
| Service | Instance Name | Target | Reported as | Bury | | HMR | | Oldham | |
|---|---|---|---|---|---|---|---|---|---|
| RAID | RAID - A&E Breach Target | 98% | Quarterly | Not Due | – | Not Due | – | Not Due | – |
| | RAID - OP Assessed by end of the next day | 95% | Quarterly | Not Due | – | Not Due | – | Not Due | – |

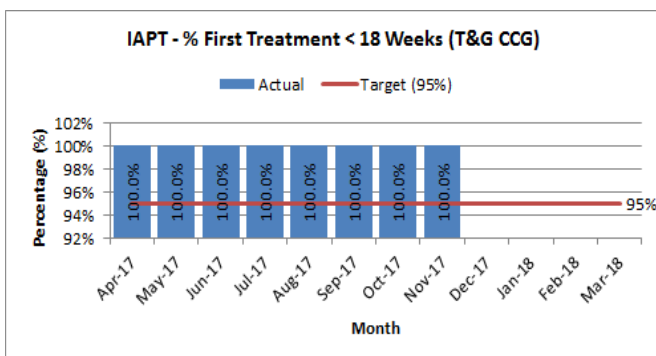
| Service | Instance Name | Target | Reported as | Bury | | HMR | | Oldham | | Stockport | | Tameside | | Trafford | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EATING DISORDERS | % Urgent ED Cases seen within 1 week | 95% | In month | 0% 0 / 0 | – | No Cases | – | No Cases | – | No Cases | – | No Cases | – | No Cases | – |
| | % Routine ED Cases seen within 4 weeks | 95% | In month | 100% 1 / 1 | ► | 100% 2 / 2 | ► | 100% 2 / 2 | ► | No Cases | – | No Cases | – | 100% 2 / 2 | ► |

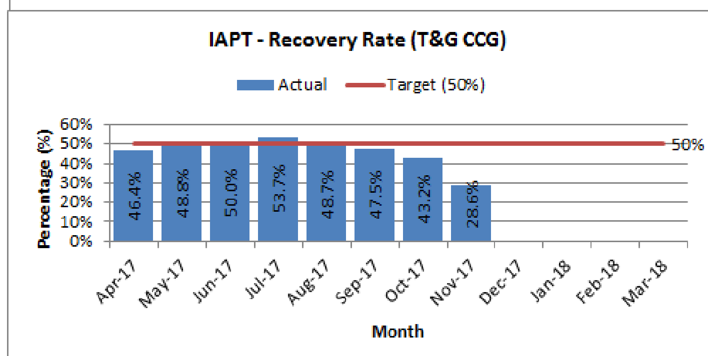
## 3.2 IAPT Access and Waiting Times

Latest published data is shared below

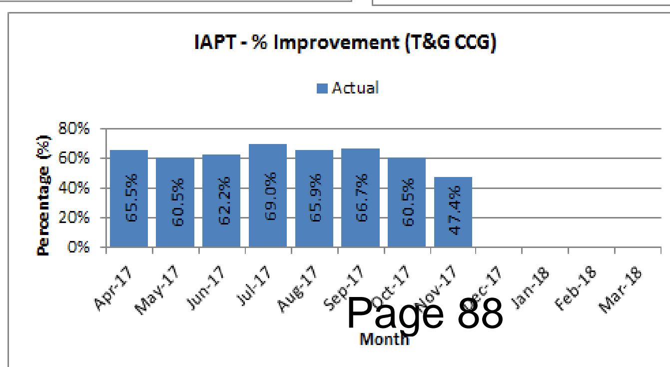



The reduction




in performance in November

was due to a waiting list initiative within a review of secondary waits for higher levels of therapy. The Recovery Rate was achieved in December and January and performance in February is described below:-

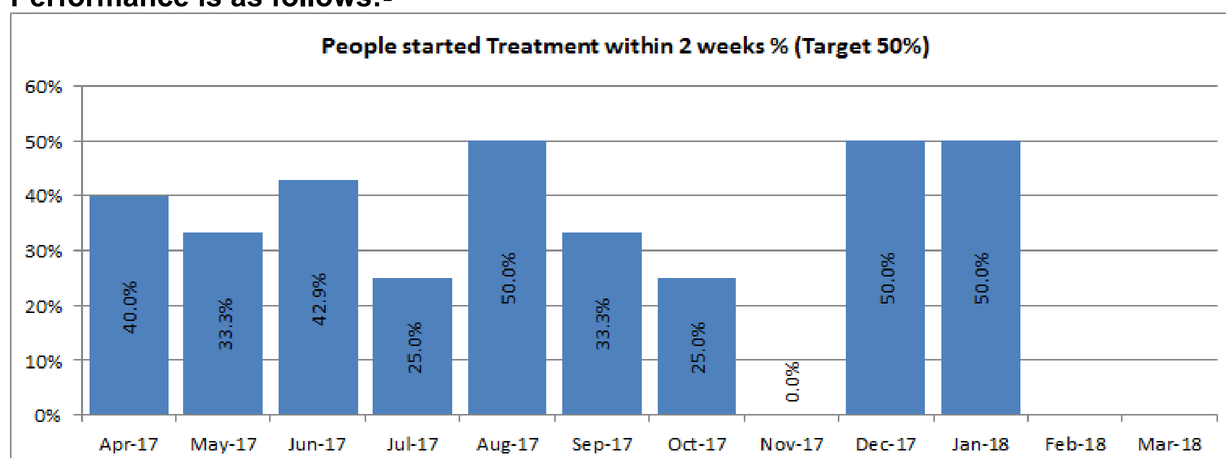
**3.21 IAPT (Healthy Minds) Performance in Feb 2018**

| KPI | Target | Performance |
|---|---|---|
| Prevalence | 502 patients | 523 patients |
| Recovery | 50% | 47.5% |
| Reliable Improvement | 65% | 64.7% overall<br>79.2% planned ending |
| 6 week wait for first appointment (Completed Treatment RTT) | 75% | 86.1% |
| 18 week wait for first appointment (Completed Treatment RTT) | 95% | 100% |

**3.3 Early Intervention in Psychosis**

The Early Intervention Team provides a specialist service for people aged 14 to 65 experiencing a first episode of psychosis. The team receive a high number of referrals, all of whom have a comprehensive assessment, with less than a quarter translating into cases.

**Performance is as follows:-**




**3.4 Mental Health Crisis Care**

**3.41 Winter Pressures Pilots**

Funded by NHSE two pilots were established in order to facilitate rapid access to mental health support and divert pressure away from the Emergency Department. The 2 pilots were

1. Placing a mental health practitioner alongside the triage practitioner within the Emergency Department to facilitate early identification of those presenting with mental health difficulties, and increasing diversion
2. Practitioners from the Pennine Care NHSFT Home Treatment Team working alongside a community voluntary organisation (The Anthony Seddon Fund) providing an afternoon drop in to access professional advice and support.

**ED Pilot -** Early findings from data have supported that the scheme has reduced the numbers of people entering the department, and the duration of stay. In the first 4 weeks of the project the following outcomes were noted

| Outcome | direct to MHA Assessment | deflected to urgent outpatient clinic | direct for informal inpatient admission | assessed by triage practitioner due to high demand on both ED and RAID | referred directly to OPHTT | signposted to support services as no need for RAID at time of present'n | seen by RAID |
|---|---|---|---|---|---|---|---|
| Numbers of patients | 3 | 3 | 4 | 11 | 2 | 38 | 43 |
| | 2.8% | 2.8% | 3.8% | 10.7% | 1.9% | 37% | 41% |

**The Anthony Seddon Fund Pilot - i**n the first 23 days of Drop In's

- At least 70 people took up appointments with CMHT nurse
- At least 50 different people have seen CMHT nurse
- 3 – 8 appointments per day

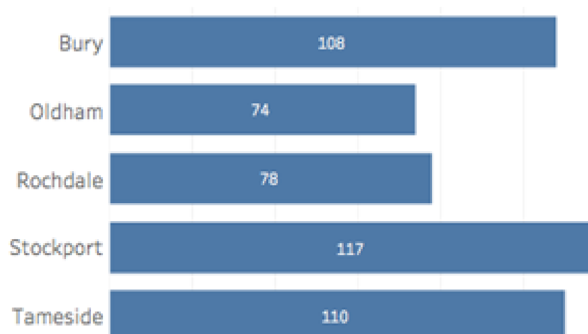
Both of these pilots are showing promising results and a request to extend the pilots, with additional outcome data, is being prepared.

### 3.5 Mental Health In-patient Care

Due to pressures on mental health beds a Task and Finish group has been set up to identify the causes and options to reduce. The first task was to ascertain the bed base commissioned by the CCG within the Pennine Care block contract and activity. The findings are:-

#### 3.51 Pennine Care Bed days 2017/18

| | Indicative no of beds | Allocated Bed Days | Actual Bed Days | Over Or (Under) Usage |
|---|---|---|---|---|
| Bury CCG | 33 | 12,045 | 15,056 | 3,011 |
| HMR CCG | 40 | 14,600 | 15,028 | 428 |
| Oldham CCG | 41 | 14,965 | 16,582 | 1,617 |
| Stockport CCG | 38 | 13,870 | 13,427 | (443) |
| T&G CCG | 40 | 14,600 | 14,068 | (532) |



The group is now working to ascertain reasons why there is such a discrepancy in admissions and lengths of stay between CCGs

**3.6 Health and Well-being College**

The College moves away from the clinical focus offered by many traditional mental health support services; instead offering an educational approach designed to empower people to take control of their own health and wellbeing, while learning new skills, making friends and connecting with others. The recovery-focused courses support people to recognise their potential and make the most of their talents and resources, through self-management. The early outcomes are promising in terms of impact on people's mental health and lives as well as a reduction in use of NHS services.

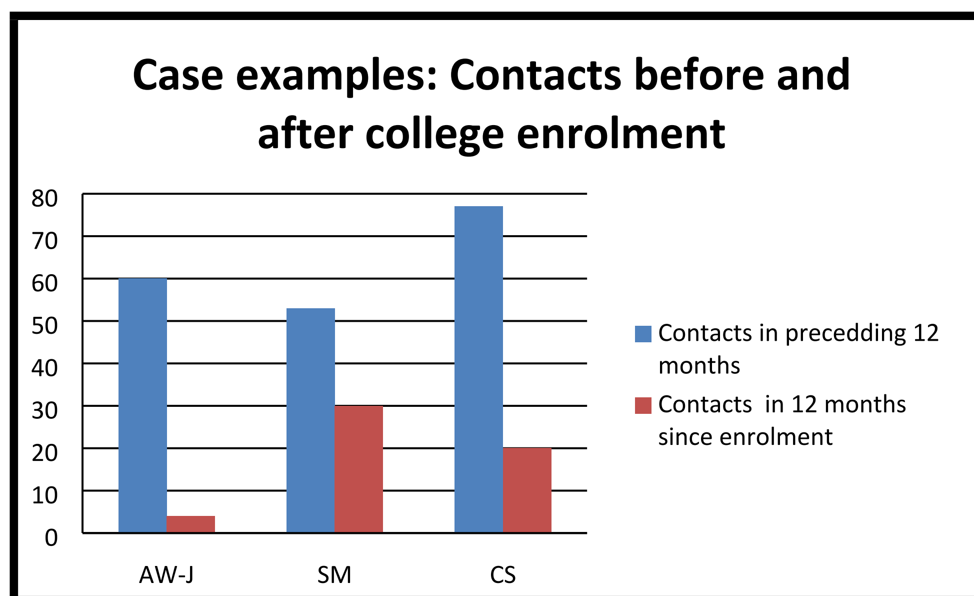
**3.61 Outcomes**

Students improvements in health, as measured by the WEMWBS and PAM, highlight the quality of the intervention being provided (for example, all the case study examples above were more activated in terms of taking control of their health care and feeling able to self manage, as well as reporting improved wellbeing (therefore less likely to come back in to the system as they have the skills to self manage).

This was also the pattern across the whole student cohort as highlighted in the table below:

| Measure | Pre College | After one academic year |
|---|---|---|
| WEMWBS | Below average wellbeing | Average wellbeing (average of 20 point increase)<br>* 3-8 indicates sig. improvement |
| PAM | Level 1 - does not believe they have activation / important role to play in self-mgt. | Level 3 - believing they have a role to play in self-mgt. and beginning to take action |

The three case studies below highlight reduction in secondary care (Community Mental Health Team) contacts since enrolling in the college:




The team have costed what this equates to in monetary terms:-

| Student | Reduction in contacts | CMHT Practitioner time saved | Potential staff cost saving |
|---|---|---|---|
| AW-J | 56 | 112 hours | £2,222.08 |
| SM | 23 | 46 hours | £912.64 |
| CS | 57 | 114 hours | £2,261.76 |

**3.62 Qualitative feedback**

Further narrative / feedback from both students and staff also demonstrates the impact of the college:

- *"I had a lot of difficulty with my mental health during the term, but the staff at the college were always very supportive of me, especially when I went into crisis whilst at the college. Thank you for all your help and support",* **Student**
- *"Thank you very much for accepting me at the Health and Wellbeing College, I'm really enjoying it. I still have my ups and downs (mainly due to my current job mixed in with and anxiety issues,) and I do sometimes still feel anxious, but I want to especially thank Panita for looking after me one afternoon when I felt almost at breaking point, that meant so much and still does. Thank you to everyone else at the college too. It's lovely to be accepted for who you are, and not having to worry about putting a face on or pretending everything's alright when it really isn't. I'd love to volunteer at the end of the year, or even look to be a Peer Mentor. The thing that holds me back is shyness and lack of confidence, but the more I learn at the college, the more I'm realising that I am good enough and I would be okay. Thank you once again everyone. The college is a lovely, happy and positive place, full of some smashing people who I really feel privileged to have met, and I look forward to the rest of my courses this academic year. Thank you also for taking the time to read this",* **Student**
- *"After attending some of the courses I have now taken the opportunity to return back to work and my confidence has come in loads thanks so much for being part of my recovery",* **Student**

**3.7 Tameside, Oldham and Glossop MIND**

TOF Mind provide a wide range of services in Tameside and Glossop. In 2017/18 this included:-

- 498 people attended a drop-ins to find out about our services and to speak to a trained TOG Mind practitioner
- Offering information and signposting to relevant services
- 300 people were provided with support and information at our wellbeing centre
- 2000 initial referrals were received
- 545 people accessed counselling with 86.67% reporting they felt counselling had helped improve the issue presented at their first session and 99.25% who would recommend the service
- 112 participants completed L2 Community Mental Health work
- 105 participants completed Youth Mental Health First Aid

**3.71 Case Stories**

*Before I started the [Community Mental Health Work Level 2] course, I was recovering from my second breakdown. I was taking medication, but not engaging in any other type of treatment, and had become in a bit of a rut. Doing a course at TOG Mind made all the difference, knowing it was provided by an organisation that supports and understands mental health, it gave me the confidence and security in knowing that I wouldn't be judged and would be treated fairly.*

*I was lucky enough to be approached by my line manager who asked me if I'd like to apply for the role of their Health and Social Care apprentice. I jumped at the chance, as I saw this as a great stepping stone. I love that I'm doing a job that can make a massive difference to someone's life, and knowing that I'm helping to make change for the better. I'm also enjoying the learning aspect of my role, every day I'm learning something new, and the training prospects offered by Mind ensure I've always got opportunities to further my knowledge.— Caroline, Health and Social Care Apprentice*

**4.0 AGEING WELL**

**4.1 Memory Assessment Service**

Since taking forward actions agreed in the redesign of the dementia pathway in 2016 the specialist Memory Assessment Service now consistently meets both the 6 and 12 week Access and Waiting

time targets. In February 2018 45 new referrals were received and 100% or people had a first appointment within 6 weeks. 98% of people received a diagnosis within 12 weeks of referral.

### 4.2 Dementia 65+ Diagnosis Rate

Since 2012, the NHS has been seeking to ensure that patients suffering from dementia are given a formal diagnosis so they can receive appropriate care and support, including an annual review in primary care. The national target is for two thirds of people with dementia to be formally diagnosed.

T&G expected prevalence for people living with dementia is 2,482. We have diagnosed 2,015; a rate higher than the national target and the rest of GM:

| | **Rate** |
|---|---|
| Target | 66.7 |
| Greater Manchester STP | 76.6 |
| Tameside and Glossop | 81.2 |

## 5.0 PENNINE CARE FOUNDATION TRUST INTEGRATED PERFORMANCE DASHBOARD

### 5.1 Monthly Quality Reporting

Pennine Care provide a comprehensive monthly performance report. Extracts from this are shared below.

| | DESCRIPTION | No In Month | Month Trend |
|---|---|---|---|
| External | STEIS CASES | 1 | ▼ |
| | NEVER EVENTS | 0 | ◄ |
| | REGULATION 28 | 0 | ◄ |
| Deaths | SUSPECTED SUICIDE | 0 | ▼ |
| | HOMICIDE | 0 | ◄ |
| | GRADE 5 (EXCLUDING SUICIDE) | 4 | ▼ |
| Risk Register | RISK LOW | 1 | ◄ |
| | RISK MODERATE | 3 | ◄ |
| | RISK HIGH | 5 | ▲ |
| | RISK VERY LOW | 0 | ◄ |

| | DESCRIPTION | No In Month | Month Trend |
|---|---|---|---|
| Safety | SELF HARM | 26 | ▲ |
| | AWOLS | 1 | ▼ |
| | SLIPS/TRIPS/FALLS | 16 | ▲ |
| | MEDICATION ERROR | 1 | ▼ |
| SafeGuarding | SAFEGUARDING ADULTS SCR | 0 | ◄ |
| | SAFEGUARDING CHILDREN SCR | 0 | ◄ |
| RCA's | RCA COMPLETED | 0 | ◄ |
| | RCA < 60 DAYS | 0 | ◄ |
| | RCA > 60 DAYS | 0 | ◄ |

### 5.2 Patient Experience

| | DESCRIPTION | No In Month | Month Trend |
|---|---|---|---|
| | PALS TAMESIDE & GLOSSOP | 9 | ▼ |
| | COMPLIMENTS TAMESIDE & GLOSSOP | 1 | ◄ |
| | COMPLAINTS TAMESIDE & GLOSSOP | 4 | ▼ |

| | DESCRIPTION | No In Month | Last Month |
|---|---|---|---|
| Patient Feedback | FFT % Overall | 94% | ◄ |
| | FFT % Mental Health Services | 93% | ▲ |
| | FFT % Tameside & Glossop | 97% | ▲ |

# APPENDIX 3

## 5.3 Tameside & Glossop Pennine Care Mental Health Services Integrated Performance Dashboard

Integrated Dashboard

DOT: ▲ Up ▼ Down ▶ Same - N/A - N/A | RAG: Green, Red, Nothing to report, Not Due

| Category | Measure | Target | Frequency | Period | Value | DOT |
|---|---|---|---|---|---|---|
| Access & Waiting Times Standards | % of CYP commenced treatment within 18 weeks | >=98% | Monthly | Feb-18 | 88.2% | ▼ |
| | % of CYP first Contact within 12 weeks | >=95% | Monthly | Feb-18 | 100% | ▶ |
| | % Routine ED Cases seen within 4 weeks | >=95% | Monthly | Feb-18 | | - |
| | % Urgent ED Cases seen within 1 week | >=95% | Monthly | Feb-18 | | - |
| | EIT Access Target (CCG) ** Cumulative | >=50% | Monthly | Feb-18 | 60% | ▲ |
| | EIT Access Target (CCG) in month | >=50% | Monthly | Feb-18 | 75% | ▲ |
| | IAPT 6 Week completed Treatment (CCG) ** | >=75% | Monthly | Feb-18 | 86.1% | ▼ |
| | IAPT 18 Week completed Treatment (CCG)** | >=95% | Monthly | Feb-18 | 100% | ▲ |
| GM KPI Contract | 30 Day Readmissions | <=10% | Quarterly | Feb-18 | Not Due | - |
| | 30 Day Readmissions Investigations | >=95% | By Exception | Feb-18 | No Exception | - |
| | A&E - Discharged within 4 hours | >=95% | Monthly | Feb-18 | 97.2% | ▲ |
| | A&E - Seen within 1 hr of referral | >=75% | Monthly | Feb-18 | 76.8% | ▲ |
| | A&E - Seen within 2 hrs of referral | >=95% | Monthly | Feb-18 | 88.4% | ▼ |
| | Adult Safeguarding Training | >=90% | Quarterly | Feb-18 | Not Due | - |
| | Children Safeguarding Training | >=90% | Quarterly | Feb-18 | Not Due | - |
| | Discharge Letters to GP within 10 days | >=90% | Bi-annual | Feb-18 | Not Due | - |
| | Discharge Notification within 48 hrs | >=90% | Bi-annual | Feb-18 | Not Due | - |
| | MAS 6 weeks assessment (CCG) Cumulative | >=75% | Monthly | Feb-18 | 100% | ▲ |
| | MAS 12 Weeks Referral (CCG) Cumulative | >=60% | Monthly | Feb-18 | 95.7% | ▲ |
| | Physical Health - Malnourished | >=90% | Bi-annual | Feb-18 | Not Due | - |
| | Physical Health - Nutritional & Weight Assessments | >=90% | Bi-annual | Feb-18 | Not Due | - |
| | Physical Health - Nutritional & Weight Reviewed | >=90% | Bi-annual | Feb-18 | Not Due | - |
| | Physical Health Checks - Inpatients | >=95% | Bi-annual | Feb-18 | Not Due | - |
| | SUI Commissioners Notified (MH) | >=100% | Monthly | Feb-18 | 100% | ▶ |
| | SUI Investigations (MH) | >=100% | Monthly | Feb-18 | 100% | ▶ |
| National Contract_Stan.. | Duty of Candour | >=100% | Monthly | Feb-18 | 100% | ▶ |
| | Mixed Sex Accomodation Breaches | 0 | Monthly | Feb-18 | 1 | ▼ |
| | Never Events | 0 | Monthly | Feb-18 | 0 | ▶ |

| Category | Measure | Target | Frequency | Period | Value | DOT |
|---|---|---|---|---|---|---|
| Safe & Well Led | Sickness & Absence (CCG) | <=5% | Monthly | Feb-18 | 4.6% | ▼ |
| | IPDR Rates (CCG) | >=85% | Monthly | Feb-18 | 62.2% | ▼ |
| | Mandatory Training (CCG) | >=90% | Monthly | Feb-18 | 85.5% | ▼ |
| | Safe Staffing Levels (CCG) | TBD | Annual | Feb-18 | TBD | - |
| | Bank Use (CCG) | TBD | Annual | Feb-18 | Not Due | - |
| | Agency Use (CCG) | TBD | Annual | Feb-18 | Not Due | - |
| | SFF - Treatment | TBD | Annual | Feb-18 | TBD | - |
| | SFF - Place to work | TBD | Annual | Feb-18 | TBD | - |
| | CPA 7 Day Follow Up | >=95% | Monthly | Feb-18 | 92.3% | ▼ |
| Effective & Resp. | Response to Complaints (MH) | >=95% | Quarterly | Feb-18 | Not Due | - |
| Local | HYM Admissions to Adult Wards | 0 | By Exception | Feb-18 | No Exception | ▶ |
| | IAPT Prevalence - Monthly | 503 | Monthly | Feb-18 | 523 | ▲ |
| | IAPT Prevalence - quarterly | 1509 | Quarterly | Feb-18 | Not Due | - |
| | IAPT Prevalence % - quarterly | >=4.2% | Quarterly | Feb-18 | Not Due | - |
| | IAPT Recovery | >=50% | Monthly | Feb-18 | 47.5% | ▼ |
| | IAPT Local Reliable Improvement | >=65% | Monthly | Feb-18 | 64.7% | ▼ |