Tameside & Glossop Care Together

STRATEGIC COMMISSIONING BOARD

Day: **Wednesday**
Date: **23 May 2018**
Time: **9.00 am**
Place: **George Hatton Hall - Dukinfield Town Hall**

Item No.	AGENDA	Page No
1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Strategic Commissioning Board.	
3.	**MINUTES** To receive the Minutes of the previous meeting held on 17 April 2018.	1 - 6
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance.	7 - 22
5.	**COMMISSIONING FOR REFORM**	
a)	**SHARED LIVES CONSULTATION - ACCESS POLICY CHANGE** To consider the attached report of the Assistant Director (Adult Services).	23 - 50
b)	**SHARED LIVES CONSULTATION - BANDED SYSTEM FOR SHARED LIVES PLACEMENTS** To consider the attached report of the Assistant Director (Adult Services).	51 - 70
c)	**PUBLIC HEALTH INVESTMENT - PREVENTING AND MANAGING LONG TERM CONDITIONS** To consider the attached report of the Interim Director of Commissioning and Interim Assistant Director of Public Health.	71 - 88
d)	**MENTAL HEALTH INVESTMENT - MENTAL HEALTH NEIGHBOURHOOD DEVELOPMENTS BUSINESS CASE** To consider the attached report of the Interim Director of Commissioning.	89 - 100
e)	**MENTAL HEALTH INVESTMENT - SELF MANAGEMENT EDUCATION BUSINESS CASE** To consider the attached report of the Interim Director of Commissioning.	101 - 112
f)	**INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP** To consider the attached report of the Interim Director of Commissioning.	113 - 180

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.

g) INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP 181 - 202

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

EXCLUSION OF THE PUBLIC AND PRESS

That under Section 11A of the Local Government Act 1972 (as amended) the public be excluded for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12(A) to the Local Government Act. Information relating to the financial or business affairs of the parties (including the Council) has been provided to the Council in commercial confidence and its release into the public domain could result in adverse implications for the parties involved. Disclosure would be likely to prejudice the Council's position in negotiations and this outweighs the public interest in disclosure.

h) WOMEN AND THEIR FAMILIES SERVICE 203 - 208

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

6. URGENT ITEMS

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

7. DATE OF NEXT MEETING

To note that the next meeting of the Strategic Commissioning Board will take place on Wednesday 20 June 2018 commencing at 1.00 pm.

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

TAMESIDE AND GLOSSOP
STRATEGIC COMMISSIONING BOARD

17 April 2018

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

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

In Attendance:
Sandra Stewart – Director of Governance & Pensions
Kathy Roe – Director of Finance
Stephanie Butterworth – Director of Adult Services
Gill Gibson – Director of Safeguarding and Quality
Jessica Williams – Interim Director of Commissioning
Sarah Dobson – Assistant Director Policy, Performance & Communications
Sandra Whitehead – Assistant Director (Adult Services)
Anna Moloney – Consultant, Public Health Medicine
Tori O'Hare – Head of Primary Care
Ali Rehman – Head of
Pat McKelvey – Head of Mental Health

Apologies:
Councillor Gerald Cooney – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Bill Fairfoull – Tameside MBC
Councillor Jean Wharmby – Derbyshire CC
Councillor Tony Ashton – High Peak BC

54. DECLARATIONS OF INTEREST

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

55. MINUTES OF THE PREVIOUS MEETING

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

56. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance presented a report providing a 2917/18 financial year update on the month 11 financial position at 28 February 2018 and the projected outturn at 31 March 2018. Details of the summary 2017/18 budgets, net expenditure and forecast outturn of the Integrated Commissioning Fund and Tameside and Glossop NHS Integrated Foundation Trust were provided with supporting information contained in Appendix A to the report. Members noted that there were a number of risk had had to be manged within the economy during the current financial year, the key ones being:

- Following transaction of the Integrated Commissioning Fund risk share the Clinical Commissioning Group was able to show a balanced financial position in 2017/18. However, this ignored significant underlying pressures in individualised commissioning of approximately £6.4m compared to the opening budget.
- The Integrated Care Foundation Trust was working to a planned deficit of £23.7m for 2017/18. However, it was noted that efficiencies of £10.4m was required in 2017/18 in order to meet this sum.

The Director of Finance outlined the risk share arrangements in place and contributions transacted for 2017/18 and contributions transacted. There were a number of additional risks which each partner organisation was also managing during the current financial year, which the Director of Finance outlined and provided within Appendix A of the report.

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 of the report.

In terms of the efficiency plan, the economy has a efficiency sum of £35.1m to deliver in 2017/18, of which £24.7m was a requirement of the Strategic Commissioner. Appendix A to the report provided supporting analysis of the delivery against this requirement for the whole economy. It was noted that there was a forecast £0.3m under achievement of this efficiency sum by the end of the financial year. It was essential therefore that additional proposals were considered and implemented urgently to address this gap and on a recurrent basis thereafter.

RESOLVED

(i) That the 2017/18 financial year update on the month 11 financial position at 28 February 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 acknowledged.

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

57. COMMISSIONING IMPROVEMENT SCHEME 2018/19

The Interim Director of Commissioning presented a report describing a two element Commissioning Improvement Scheme being proposed to support Tameside and Glossop General Practice in 2018/19. The report outlined the two elements of the proposal the aim of which was 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. It was proposed that the Commissioning Improvement Scheme be moved to a neighbourhood focus and alongside this make available up front via investment in neighbourhoods to test or continue schemes which addressed pressures, quality and financial or maintain elements of the 2017/18 Commissioning Improvement Scheme model so that those previously successful practices could work in their neighbourhoods to create stability and expand the current Commissioning Improvement Schemes.

The two approaches were outlined as follows:

Neighbourhood Commissioning Improvement Scheme

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

2018/19 Invest to Save Project

In addition to the Neighbourhood Commissioning Improvement Scheme it was proposed to make £125,000 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. It would be for each neighbourhood to determine:

- How their funding would be invested;
- How the funding would be transacted to the neighbourhood;
- How the plan would be achieved; and
- How the impact and success of the plan would be measured and any reviews and adjustments made as required in year.

The Strategic Commissioning Board members provided their views on the proposals and the experiences and outcomes with the scheme in previous years. Following discussion and a vote on the proposals it was felt that this was the appropriate direction of travel to invest in practices working together for the benefit of the neighbourhood population. However, there would need to be engagement and communication with practices to develop an outcomes framework with appropriate structures in place to ensure accountability.

RESOLVED

(i) That the proposal for 2018/19 be approved and communication take place with GP practices.

(ii) That 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 be supported.

(iii) That the cap on Commissioning Scheme Improvement payments per neighbourhood of £100,000 and the proposed continuation of the Panel process for approval of spend proposals be supported.

(iv) That the proposal of a Panel approval process for the Invest to Save element of the scheme be supported.

58. PROVISION OF CALL HANDLING SYSTEM FOR COMMUNITY RESPONSE SERVICE

Consideration was given to a report of the Assistant Director (Adult Services) 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. The lease on the current call handling system that supported the service was due to expire on 13 August 2018.

It was explained that Tameside Adult Services operated an in-house telecare service and the aims of the service were outlined. Staff were employed to provide an emergency response service 24 hours a day, 365 days a year to residents who were vulnerable or at risk. In December 2017, there were 3,547 customers connected to the service receiving approximately 18,000 calls every month.

The rationale and benefits to enter into a call off agreement with the current provider for the continued delivery of this service offered the Council was outlined in the report. Disaster recovery for this service was currently shared with Stockport MBC and this arrangement would continue until it was reviewed as part of the wider integration of social care and health.

To inform this decision a wider benchmarking exercise had been undertaken to establish what the needs of the Community Response Service going forward to support this service function, what other call handling systems were being used elsewhere and their effectiveness.

There was a requirement to re-commission the call handling system for the Community Response Service to ensure compliance with Procurement Standing Orders. The service and support provided by the current provider had been very satisfactory. However, based on current and future service and system needs functionality needed updating to provide a wider range of information to inform performance management.

The report centred on market testing and procuring a new call handling system through a review of providers contained with the framework 203-15. The review of the framework identified three providers who could potentially provide this system. However, on further review, one of these could not currently support digital technology which was a future requirement of the system, leaving two providers, including the current provider. The indicative costs of the two providers were detailed in the report.

Based on cost, additional extras that would enhance the service offer and to reduce risk in terms of disaster recovery arrangements, it was recommended that the current provider be maintained.

RESOLVED

(i) That approval be given to the direct award of the contract for the provision of a community response service call handling system from the existing provider from the ESPO Framework 203_15 for a five year contract commencing 14 August 2018.

(ii) That approval be given to the service leasing an upgraded call handling system to support the Community Response Service no later than 13 August 2018 when the current lease expires.

59. PROVISION OF E-ROSTERING AND ALLOCATION SYSTEM FOR REABLEMENT SERVICE, COMMUNITY RESPONSE AND LONG TERM SUPPORT SERVICE

Consideration was given to a report of the Assistant Director (Adults) 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 and Scheduling. There were a number of providers who had already demonstrated that they would meet a required standard to be included on the framework. The aim of the Reablement Service was to provide an intensive short term period of rehabilitation (up to 6 weeks) when someone had a period of ill health or trauma. The service had 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.

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

The services were constantly reviewing their ongoing effectiveness and regularly had regard for new developments in the social care system. The introduction of a number of electronic staff rostering and work allocation systems over the past few years had led to greater efficiencies in this area of the market. After reviewing many of the systems on the market it was felt by officers working closely with these services and result in better outcomes for users of the services as well as opportunities to realise possible budget savings.

RESOLVED

(i) That approval be given to spend for the provision of an e-rostering and allocation system for the Reablement Service, Community Response Service and Long Term Support Service.

(ii) That approval be given to carrying out a procurement exercise using the existing ESPO framework.

60. PROVISION OF A LEARNING DISABILITY RESPITE SERVICE

Consideration was given to a report which explained that Adult Services had provided a specialist respite / short stay service for people with a learning disability for more than three decades with the

aim of enabling people to live as independent and fulfilling lives as possible in the community whilst ensuring their carers received breaks to enable them to continue with their caring duties. The current contract for the provision of five beds (comprising four respite and one emergency bed) at one building base in Stalybridge commenced on 1 December 2013 and was due to expire on 30 September 2018 following a two year extension.

This valued service was currently accessed by 55 families and all service users had been assessed as having eligible needs as defined in the Care Act 2014. Authorisation was being sought to re-tender for the provision of a learning disability respite service with a contract commencement date of 1 October 2018 for a period of five years with the continued delivery of a domiciliary care model.

RESOLVED
That approval be given to tender for the provision of a Learning Disability Respite Service commencing from 1 October 2018 for a period of five years.

61. QUALITY ASSURANCE

The Director of Safeguarding and Quality presented a report providing the Strategic Commissioning Board with assurance that robust quality assurance mechanisms were in place to monitor the quality of the services commissioned, highlight any quality concerns and providing assurance as to the action being taken to address such concerns. The report covered data and issues of concern / remedy, good practice including patient stories and surveys and horizon scanning for the following:

- Tameside and Glossop Integrated Care NHS Foundation Trust Acute and Community Services;
- Mental Health (Pennine Care NHS Foundation Trust);
- Care Homes / Home Care;
- Safeguarding;
- Primary Care;
- Public Health; and
- Small value contracts.

Particular reference was made to issues of recruitment and data quality for Health Visiting Service and a deep dive had previously highlighted service pressures, challenges and risk mitigation the service had put in place whilst it was without a full complement of Health Visitors. Although work continued in relation to recruitment and workforce projection, the Strategic Commissioning Board was keen to understand why the service was not able to recruit to its full capacity.

RESOLVED
That the content of the update report be noted.

62. PERFORMANCE UPDATE

The Assistant Director (Policy, Performance and Communications) submitted a report providing he Strategic Commissioning Board with a Health and Care Performance update at April 2018 covering:

Health and Care Dashboard
The following were 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.

Other Intelligence / Horizon Scanning
Updates on issues were providing on the following:

- Winter Crisis – Influenza and uptake of vaccines;
- NHS 111.

In Focus
At its meeting on 30 January 2018 and 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 focused approach to monitoring was ongoing at both a Greater Manchester level and within the Pennine Care footprint. Pat McKelvey presented a mental health in focus report providing a snapshot of performance and outcome information against the life course as follows:

- Starting Well
    - Parent Infant Mental Health;
    - Off the Record;
    - Healthy Young Minds (CAMHS);
    - Children and Young People Eating Disorder Service;
    - MIND Support to Children and Young People;
- Living Well
    - Pennine Care Services;
    - IAPT Access and Waiting Times;
    - Mental Health Crisis Care;
    - Mental Health In-patient Care;
    - Health and Wellbeing College;
    - Tameside, Oldham and Glossop MIND;
- Ageing Well
    - Memory Assessment Service;
    - Dementia 65+ Diagnosis Rate;
- Pennine Care Foundation Trust Integrated Performance Dashboard

RESOLVED
That the content of the performance report and mental health in-focus progress report be noted.

28. URGENT ITEMS

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

CHAIR

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 May 2018
Officer of Strategic Commissioning Board	Kathy Roe – Director Of Finance – Tameside & Glossop CCG and Tameside MBC
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2017/18 CONSOLIDATED FINANCIAL MONITORING STATEMENT AT 31 MARCH 2018**

Report Summary:

This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the consolidated financial position of the Economy at 31 March 2018.

The Tameside & Glossop Care Together Strategic Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG 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 end position.
- Acknowledge the significant level of savings required during the period 2018/19 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 This report provides the consolidated year end financial position statement for 2017/18 for each of the three partner organisations. The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy. 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 :

Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council

Telephone:0161 342 3726

e-mail: stephen.wilde@tameside.gov.uk

Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group

Telephone:0161 342 5626

e-mail: tracey.simpson@nhs.net

David Warhurst, Associate Director Of Finance, Tameside and Glossop Integrated Care NHS Foundation Trust

Telephone:0161 922 4624

e-mail: David.Warhurst@tgh.nhs.uk

1. INTRODUCTION

1.1 This report aims to provide an update on the year end financial position of the care together economy in 2017/18 and to highlight the increased risk of achieving financial sustainability over the long term. Supporting details are provided in **Appendix 1**.

1.2 The report includes the details of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2017/18 financial year. The total ICF is £485.47m in value.

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

1.4 It should be noted that the report also 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 overall Tameside and Glossop Care Together economy position.

1.5 Board members should also note that the outturn net expenditure details for the three Council services within the ICF (Adult Services, Children's Social Care, Public Health) are provisional at this stage and are subject to external audit validation.

1.6 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 and net expenditure for the ICF and Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT). Supporting details of the outturn variances are explained in **Appendix 1**. While financial control totals have been achieved by the three statutory organisations in 2017/18, members should be aware of significant pressures within the economy during the financial year, the key ones being:-

- Following transaction of the ICF risk share the CCG was able to show a balanced financial position in 2017/18. However this ignores significant underlying pressures in individualised commissioning of approximately £6.393m 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 £8.609m when compared to the available budget

2.2 **Table 2** provides details of the Strategic Commission risk share arrangements in place for 2017/18. Under this arrangement the Council agreed to increase its contribution to the ICF by up to £5.0m in 2017/18 and 2018/19 in support of the CCG's QIPP savings target. There is a reciprocal arrangement where the CCG will increase its contribution to the ICF in 2019/20 and 2020/21. For 2017/18 an increased Council contribution of £4.2m has been transacted in line with this agreement.

2.3 Any variation beyond 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.

2.4 The Strategic Commission net funding gap of £7.885m 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

	Year End				
Organisation	**Budget**	**Actual**	**Variance**	**Previous Month**	**Movement in Month**
	£000's	**£000's**	**£000's**	**£000's**	**£000's**
Strategic Commission	485,466	493,351	-7,885	-7,429	-456
ICFT	-22,088	-22,054	34	0	0
Total	**463,378**	**471,297**	**-7,851**	**-7,429**	**-456**

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

2.5 There are a number of additional risks which each partner organisation has managed during the financial year, the details of which are provided within **Appendix 1.**

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

Table 3 – 2017/18 ICF Financial Position

	Year End Position		
Service	**Budget**	**Actual**	**Variance**
	£'000	**£'000**	**£'000**
Acute	203,291	206,251	- 2,960
Mental Health	29,954	29,940	14
Primary Care	83,109	81,777	1,332
Continuing Care	13,623	14,329	- 706
Community	27,451	27,477	- 26
Other	26,756	26,138	619
QIPP	-	-	-
CCG Running Costs	5,197	3,469	1,728
Adult Services	44,185	43,642	543
Children's Social Care	35,192	43,801	- 8,609
Public Health	16,708	16,527	181
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
CCG Expenditure	389,381	389,381	0
TMBC Net Expenditure	96,085	103,970	- 7,885
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
A: Section 75 Services	265,511	264,721	790
B: Aligned Services	186,721	195,926	- 9,205
C: In Collaboration Services	33,234	32,704	530
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**

2.7 **CCG Surplus –** The significant change to the CCG position since M11 is a change to the CCG surplus. On 20 March Paul Baumann, Chief Finance Officer, NHS England sent a letter to all CCGs which resulted in two changes:

- **System Risk Reserve**. In line with guidance The CCG retained £1.722m of resource on reserves to offset any wider system pressures across the NHS. The CCG has been asked to release this reserve and increase the value of our reported surplus. Nationally commissioner surpluses will increase by around £560m as a result of this which will be used to offset the deficit position in the provider sector.

- **Category M Drugs**. As reported previously a clawback arrangement has been in operation in 2017/18, where the benefit of price reductions for Cat M drugs has sat with NHS England rather than the CCG. In light of other pressure faced by CCG (most notably around NCSO drugs), Paul Baumann has agreed that the Cat M rebate will be returned to all CCG to improve the bottom line position.

2.8 The net impact of these changes is an increase in the surplus to £9.347m. It is important to note that there is no mechanism through which the CCG would be able to draw down any of this surplus in 2018/19:

	£'000s
Planned Surplus (i.e. 1% plus carry forward from 16/17)	7,174
System Risk Reserve	1,722
Category M Drugs	451
Total 2017/18 Surplus	**9,347**

2.9 **Acute** - Against a full year budget of £203.291m, there was expenditure of £206.251m. This represents an overspend of £2.960m. The acute position has deteriorated by £0.394m since last month, driven by an increased number of out of area admissions and demand for treatment in the private sector. Emergency admissions and critical care continue as the chief contributors to the overall pressure:

	(Over) / Under Performance
POD	**£'000**
A & E	(180)
Urgent Care	(1,165)
Excess Bed Days	(85)
Outpatients	(539)
Planned Care	336
Critical Care	(588)
Other	48
Total	**(2,173)**

The year end position in includes settlement positions on associate provider contracts. For Stockport, Salford, The Christie, Pennine Acute and Bolton these are fixed final agreements which will not change to reflect actual activity in February/March. For all other providers, while the position is fixed in terms of income & expenditure for the 2017/18 accounts, we will make post reconciliation adjustments based on actual activity when final data is available in June.

2.10 **Mental Health** – There is a £0.014m underspend against core budgets. This is a £0254m favourable movement on the position reported last month due to slippage in implementation of schemes reaching a settlement with Pennine Care.

The CCG has achieved the Mental Health Investment Standard (MHIS) for 2017/18, with an increase in mental health spend over 2016/17 of 2.8% against a target of 2.00%

2.11 **Primary Care** – Total underspend in 2017/18 was £1.332m, which is broadly consistent with the position forecast at M11.

2.12 **Continuing Care** – There is a £0.706m overspend against core budgets which is broadly consistent with the position forecast at M11. This 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 Health Care and individually commissioned packages in mental health and neuro rehab there is a total pressure of £6.393m, £4.200m of which is mitigated by the increased Council contribution to the risk share.

2.13 **Community** - The majority of spend within this directorate is within the block contract for the ICFT. The final outturn was broadly consistent with the position forecast at M11.

2.14 **Other** – This area includes the Better Care Fund, estates, transformation funding and reserves. The movement of £1.590m against this directorate is largely presentational and relates to the accounting treatment required in order to increase the surplus as discussed earlier in the report, offset by the forecast QIPP reserve naturally dissipating at year end.

2.15 **QIPP** – Against an annual savings target of £23.9m, all £23.9m has been fully achieved in year. However less than half of this was achieved on a recurrent basis, leading to a 2018/19 requirement of £19.8m.

2.16 **CCG Running Costs** – While the table shows an in month movement of £1.72m against this directorate, this movement is presentational. It relates to required adjustments to ensure the correct year-end accounting for QIPP schemes (running costs and estates savings relating to New Century House).

2.17 **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 £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.

2.18 **Children's Services** – Net expenditure in excess of revenue budget of £8.61m – primarily due to increased expenditure on children's placements and agency social workers as a result of increased demand. In addition there were appointments to senior posts to the approved budget allocation which were necessary to support the implementation of required improvements within the service.

As reported in previous periods, there is an ongoing strategy within the service to transition agency social workers onto permanent contracts as this is a lower cost alternative and also improves the quality and stability of service delivery. For context, the number of Looked After Children increased from 519 at April 2017 to 613 in March 2018 (590 in January 2018).

An additional non recurrent £18m budget allocation has been approved by the Council to support the levels of unprecedented service demand, £10 million of which has been allocated in 2018/19. The details of the demand management and reduction strategy will be reported during the 2018/19 financial year ICF monitoring reports.

3 2017/18 EFFICIENCY PLAN

3.1 The economy has an efficiency sum of £35.07m to deliver in 2017/18, of which £24.67m is a requirement of the Strategic Commissioner.

3.2 **Appendix 1** provides supporting analysis of the delivery against this requirement for the whole economy. It is worth noting that there was a £0.360m under achievement of this efficiency sum at the end of the financial year and the Control Totals were delivered.

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

4 RECOMMENDATIONS

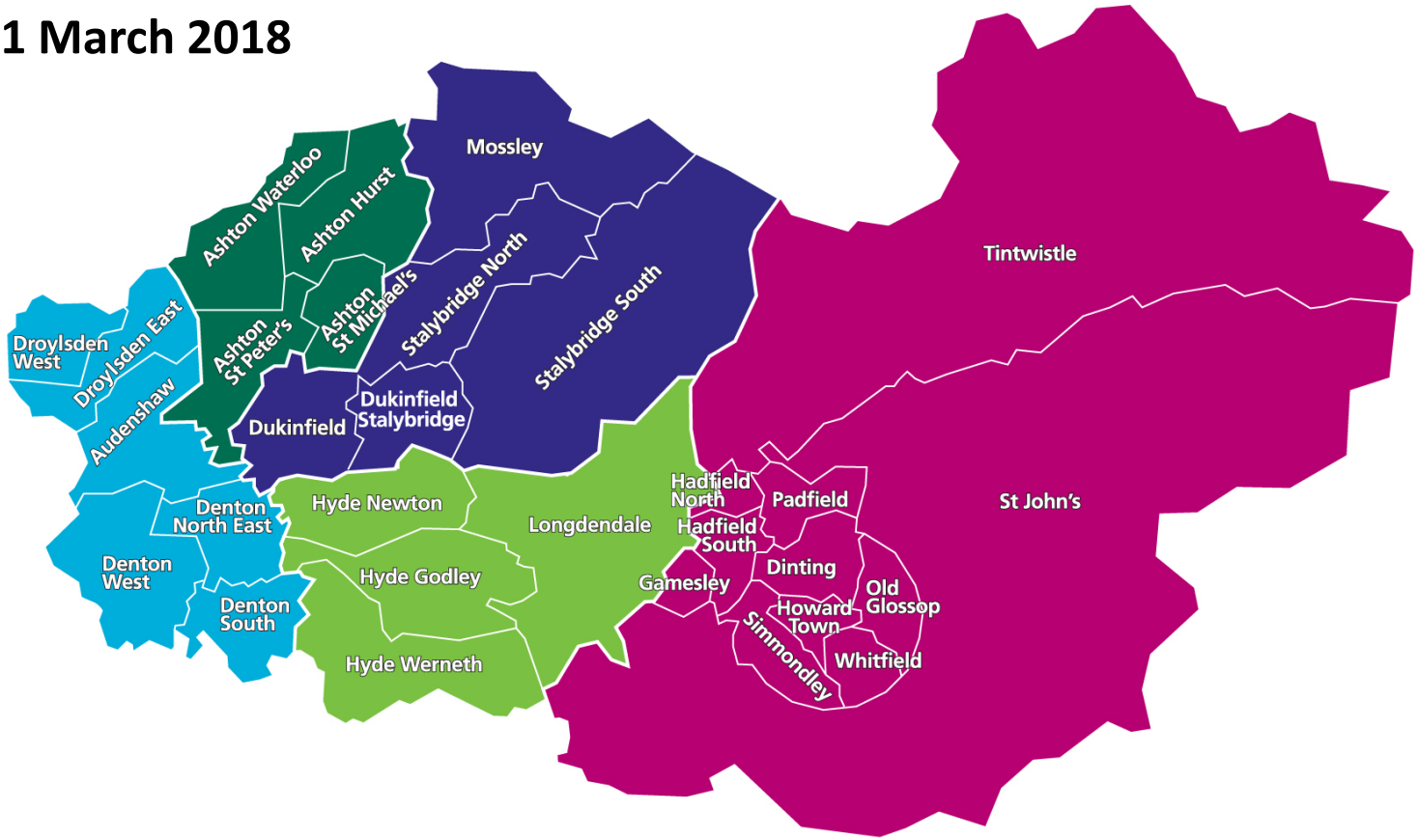
4.1 As stated on the report cover.

TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position

financial monitoring statements

Period Ending 31 March 2018
Month 12



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

The 2017/18 financial gap has been closed but approximately half as a result of non recurrent funds.
Significant challenges remain in order to recurrently balance 2018/19.

Organisation	Year End Budget	Year End Actual	Year End Variance	Previous Month	Movement in Month
	£000's	£000's	£000's	£000's	£000's
Strategic Commission	485,466	493,351	-7,885	-7,429	-456
ICFT	-22,088	-22,054	34	0	0
Total	**463,378**	**471,297**	**-7,851**	**-7,429**	**-456**

- Following transaction of the Integrated Commissioning Fund risk share, the Strategic Commission funding position shows a gap of £7,851k. This gap relates primarily to 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 Trust has delivered against its Planned net deficit of £23.7m, this is c£4k favourable to plan
- 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 1.7% 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 CCG has met financial control totals.
- CCG surplus has increased to £9,347k in line with national planning guidance.
- Risk Share contributions transacted
  > £3,700k – Continuing Care
  > £500k – MH Non-CHC
  > **£4,200k Sub Total**
  > £500k Children's Social Care
- CHC/MH Non-CHC and Neuro Rehab has overspent by £2,193k. However, it is important to recognise this includes the increased contribution from the risk share highlighted above. The underlying position is a £6,393k cost pressure in this area.
- £8,609k overspend on Children's Services predominantly driven by out of area placements & agency social workers. £500k from the risk share contribution was transacted in this area as outlined above.
- £2,960k overspend on acute, driven by increased activity (mainly emergency admissions) at providers other than the ICFT
- £23.7m ICFT Control total was delivered

Tameside and Glossop Strategic Commissioner Financial Position

- Overspend of £7,885k is driven by significant pressures in children's services, which has seen further deterioration of £456k in M12. This deterioration relates primarily to an increase in the number of looked after children.
- Both organisations are currently reporting that statutory duties and financial control totals have been met. The CCG is reporting that the QIPP target has been fully achieved, with post mitigation risks of zero. The significant change since M11 is a change to the CCG surplus. On 20 March Paul Baumann, Chief Finance Officer, NHS England sent a letter to all CCGs which resulted in two changes
  - System Risk Reserve. In line with guidance The CCG kept £1,722k of resource on reserves to offset any wider system pressures across the NHS. We have been asked to release this reserve and increase the value of our reported surplus. Nationally commissioner surpluses will increase by around £560m as a result of this, which will be used to help offset the deficit position in the provider sector.
  - Category M Drugs. As reported previously a clawback arrangement has been in operation in 2017/18, where the benefit of price reductions for Cat M drugs has sat with NHS England rather than the CCG. In light of other pressure faced by CCG (most notably around NCSO drugs), Paul Baumann has agreed that the Cat M rebate will be returned to all CCGs to improve the bottom line position.
  - The net impact of these changes is an increase in the surplus to £9,347. It is important to note that there is no mechanism through which the CCG would be able to draw down any of this surplus in 2018/19:

	£'000s
Planned Surplus (i.e. 1% plus carry forward from 16/17)	7,174
System Risk Reserve	1,722
Category M Drugs	451
Total 17/18 Surplus	**9,347**

Service	Year End Position		
	Budget	Actual	Variance
	£'000	£'000	£'000
Acute	203,291	206,251	- 2,960
Mental Health	29,954	29,940	14
Primary Care	83,109	81,777	1,332
Continuing Care	13,623	14,329	- 706
Community	27,451	27,477	- 26
Other	26,756	26,138	619
QIPP	-	-	-
CCG Running Costs	5,197	3,469	1,728
Adult Services	44,185	43,642	543
Children's Social Care	35,192	43,801	- 8,609
Public Health	16,708	16,527	181
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
CCG Expenditure	389,381	389,381	0
TMBC Net Expenditure	96,085	103,970	- 7,885
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**
A: Section 75 Services	265,511	264,721	790
B: Aligned Services	186,721	195,926	- 9,205
C: In Collaboration Services	33,234	32,704	530
Integrated Commissioning Fund	**485,466**	**493,351**	**- 7,885**

Tameside Integrated Care Foundation Trust Financial Position

High level financial overview

	Month 12			Outturn		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Normalised Surplus/(Deficit)	(1,642)	(1,672)	(30)	(23,730)	(23,726)	4
Capital Expenditure	1,269	2,375	1,106	4,825	4,827	2
Cash and Equivalents	1,190	1,415	225	0	0	0
Trust Efficiency Savings	1,263	1,306	43	10,397	10,038	(359)
Use of Resources Metric	3	3	0	3	3	0

Outturn Net position is £23.7m deficit, the Trust delivered against its 2017/18 plan.

Trust Efficiency Programme is c. £0.36m behind the in year Target. In Month, it delivered £43k above plan

Cash is £0.2m above the planned balance

Key risks and highlights

Key Risks – I&E

- **Control Total –** The Trust has delivered against its Planned net deficit of £23.7m, this is c£4k favourable to plan.
- **Medical Staffing -** The level of medical agency expenditure is providing a financial pressure for the Trust, particularly within ED, T&O and Medicine.
- **Winter Schemes** – Funding for Tranche 2 Winter schemes has ceased at the end of March, therefore all winter schemes/initiatives not ceased will cause a financial pressure into the new financial year.
- **IT Outage –** The Trust has incurred costs relating to the unexpected IT outage at the end of March
- **Rates (PFI)** – The Trust incurred c£150k in rates for periods 2015-2018 for retail outlets in the PFI, this is unfunded.
- **Activity levels -** Income on smaller clinical contracts is falling, but no corresponding reduction in costs.
- **TEP –** The Trust reported an in year shortfall to TEP of c£0.36m

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 £75.4m 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 March month end cash balance was £0.2m above the expected £1.2m plan.
- **Winter Tranche 1 & 2** – The Trust have been in receipt of Tranche 1 & 2 monies of £618k & £725k. T1 will reduce the Trusts Planned deficit to £23.7m. The Tranche 2 monies of £725k have been used to support winter schemes
- **Agency Cap -** The NHSI requirement is for the Trust to reduce medical agency expenditure by £1.2m. The Trust outturn in 2017/18 is £10.8m which is c£0.7m better than the NHSI target.

Pressure/High Risk Improvement/Low risk

Overall Risk Rating - Medium

Integrated Commissioning Fund Risks

Individualised Commissioning (A)

- While the 17/18 financial position is now balanced, growth in individualised packages of care remains one of the CCGs biggest financial risks going forward. 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.

Children's Services (R)

- Net expenditure in excess of revenue budget of £8.61m – primarily due to increased expenditure on children's placements and agency social workers as a result of increased demand. In addition there were appointments to senior posts to the approved budget allocation which were necessary to support the implementation of required improvements within the service..
- The number of Looked After Children has increased from 519 at April 2017 to 613 in March 2018.
- An additional non recurrent £ 18m budget allocation has been approved, £10 million of which has been allocated in 2018/19. The details of the demand management and reduction strategy will be reported during 18/19

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. Post optimism bias, we have schemes in place to deliver approximately £13m of savings in 18/19. Further work is required to identify new schemes to close this gap and enable 18/19 control totals to me delivered.

Acute services (A)

- Demand Management for emergency services at the associate providers remains a key risk for the CCG. Total overspend of £2,173k is driven by emergency admissions and critical care

£000's	(Over)/Under Spend
A&E	-180
Urgent Care	-1,165
Excess Bed Days	-85
Outpatients	-539
Planned Care	336
Critical Care	-588
Other	48
Total	-2,173

- This risk will continue into 18/19, where a QIPP planning assumption has been made that future growth can be contained and activity will not increase over 17/18 levels.

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)

- In 17/18 there is an underspend of £543k , however, 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 17/18

- 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 achievement against this target. In total, savings of £34,710k were delivered, which left a shortfall of £360k on the TEP within the ICFT. However, the provider planned deficit will still be met as a result of other means.
- For the commissioner, the full £23,900k QIPP target has been reported as achieved in full since month 10. The council delivered the full target of £773k.

Key Headlines:

- Final projected economy savings are £360k lower than target.
- £19,592k (56%) of expected savings are due to be delivered on a recurrent basis.

£000's	Annual Target	Risk Rated Forecast Position				Savings	Variance
		Posted	Low	Medium	High		
ICFT	**10,397**	**10,037**	**-**	**-**	**-**	**10,037**	**- 360**
Strategic Commissioner	**24,673**	**24,673**	**-**	**-**	**-**	**24,673**	**- 0**
Technical Target	1,875	10,611	-	-	-	10,611	8,736
Primary Care	1,748	2,279	-	-	-	2,279	532
Single Commissioning	1,137	1,221	-	-	-	1,221	84
Neighbourhoods	781	781	-	-	-	781	-
Acute Services - Elective	1,116	586	-	-	-	586	- 530
Other	1,324	724	-	-	-	724	- 600
Effective Use of Resources	1,500	815	-	-	-	815	- 685
Mental Health	994	296	-	-	-	296	- 698
GP Prescribing	2,516	1,185	-	-	-	1,185	- 1,331
Back Office Functions	2,024	562	-	-	-	562	- 1,463
Demand Management	8,885	4,840	-	-	-	4,840	- 4,045
Adult Social Care	336	336	-	-	-	336	-
Public Health	437	437	-	-	-	437	-
Total Economy Position	**35,070**	**34,710**	**-**	**-**	**-**	**34,710**	**- 360**

Financial Gap and Efficiency Position 18/19

- In 18/19 there is a QIPP target of £19.8m for the CCG. The latest QIPP position for the CCG is detailed below.

Summary of 2018/19 QIPP Achivement	R	A	G	B	Grand Total	Expected Saving
Tameside ICFT	**0**	**0**	**2,480,000**	**0**	**2,480,000**	**2,480,000**
Reverse Demographic Growth	0	0	2,480,000	0	2,480,000	2,480,000
GP Prescribing	**180,000**	**1,645,000**	**175,000**	**0**	**2,000,000**	**1,015,500**
Individualised Commissioning Recovery Plan	**0**	**700,000**	**626,552**	**0**	**1,326,552**	**976,552**
Dementia Care Home Tender	0	495,000	0	0	495,000	247,500
Chairing of MDT	0	205,000	0	0	205,000	102,500
Broadcare/Liaison	0	0	200,000	0	200,000	200,000
Fast Track Recovery plan	0	0	132,000	0	132,000	132,000
CareTech 10% reduction	0	0	104,552	0	104,552	104,552
Dowry Income	0	0	190,000	0	190,000	190,000
Other Established Programme Related Schemes	**0**	**2,918,607**	**1,329,848**	**0**	**4,248,455**	**2,789,152**
Associate Provider Demand Management Schemes	0	1,300,000	0	0	1,300,000	650,000
Urgent Treatment Centre/Urgent Primary Care	0	133,333	0	0	133,333	66,667
VCS Grants	0	0	65,122	0	65,122	65,122
Estates Strategy	0	250,000	0	0	250,000	125,000
QPP Achivement	0	500,000	0	0	500,000	250,000
Budget Management	0	600,274	399,726	0	1,000,000	699,863
Running Costs Savings	0	135,000	865,000	0	1,000,000	932,500
Technical Financial Adjustments	**0**	**1,000,000**	**5,471,000**	**0**	**6,471,000**	**5,971,000**
Release of reserves	0	0	3,500,000	0	3,500,000	3,500,000
Release 0.5% contingency	0	0	1,971,000	0	1,971,000	1,971,000
Slippage on Mental Health	0	1,000,000	0	0	1,000,000	500,000
Capped Expenditure Process	**2,185,000**	**0**	**0**	**0**	**2,185,000**	**218,500**
Activity related policy changes	2,052,000	0	0	0	2,052,000	205,200
Transforming Care for people with learning disabilities	98,000	0	0	0	98,000	9,800
TARGET	35,000	0	0	0	35,000	3,500
FSG	**0**	**0**	**0**	**0**	**0**	**0**
Grand Total	**2,365,000**	**6,263,607**	**10,082,400**	**0**	**18,711,007**	**13,450,704**

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 May 2018
Reporting Member / Officer of Single Commissioning Board	Brenda Warrington - Executive Leader, Executive Member Adult Social care and Wellbeing Sandra Whitehead Assistant Director Adult Services
Subject:	**SHARED LIVES ACCESS AGE CONSULTATION ON PROPOSED POLICY CHANGE**
Report Summary:	This report seeks permission to enter into consultation to change the Shared Lives Service age of entry from 18 years of age to 16 years of age. This is part of a wider piece of work with Shared Lives Plus which is the national Shared Lives umbrella body and the Department of Education (DoE) to expand the offer of Shared Lives services to younger people. This is supported by a DoE grant to assist in supporting the development. This policy change is part of the Adult Services Transformation Programme. It was highlighted that Shared Lives could provide an alternative service to young people leaving care from the age of 16+. This could be as an alternative to other traditional services offered via Children's Services which could prepare young people for independent living. It would also support the work of Shared Lives in terms of encouraging a smoother transition of young people with complex needs transitioning into Adult services.
Recommendations:	To undertake consultation to change the Shared Lives age of service entry from 18 to16 years of age on the basis set out in this report.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The average gross cost of a long term Shared Lives placement is £405 per week which is partially offset by housing benefit income for working age adults. The proposed policy change outlined in this report will enable the Shared Lives placements to be made from the age of 16. Whilst it may not be possible to charge service user contributions under the age of 18, a Shared Lives placement is a considerably lower cost alternative than a Children's independent sector residential care placement which currently averages £3,600 per week depending on the needs of the individual. Recent work undertaken alongside the Social Care Institute of Excellence (SCIE) also highlighted wider benefits to the health and social care economy in terms of reduced attendances in both primary and secondary healthcare. The potential financial benefits of this proposed policy change will be quantified once the outcome of the consultation is known.
Legal Implications: **(Authorised by the Borough**	The Shared Lives Scheme is regulated under Health and Social Care Act 2008. The change to access age to the scheme attracts the duty to consult on the proposed change.

Solicitor)	The legal requirements as to consultation must be followed to ensure that the decision that is made is lawful and takes into account the consultation.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well programmes for action.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care • Locality-based services • Planned care services
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commission for the 'whole person'.
Recommendations / views of the Health and Care Advisory Group	Reported directly to the Strategic Commissioning Board.
Public and Patient Implications:	Carers banded at level 1 could lose income which could impact on willingness to be carers. It is anticipated that the impact and probability of this being very low.
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. Shared Lives Services will continue to be regulated by CQC, and are subject to internal audit and quality inspection.
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 impact positively on some of the protected characteristic group(s) within the Equality Act. These include people with Disability, Mental Health, Age (16-18 year olds) and Carers. The service will be available to Adults who meet Adult Services access criteria 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?	A privacy impact assessment has not been completed. Services adhere to the Data Protection Act when handling confidential personally identifiable information.

Risk Management:	Risks associated with the change in access age are anticipated to be low. The primary risks identified relate to the failure to appropriately communicate with all stakeholders on the proposed change thus impacting on the validity of information to inform decision making.
Access to Information :	The background papers relating to this report can be inspected by contacting: Mark Whitehead – Head of Operations Telephone: 0161 342 3791 e-mail: mark.whitehead@tameside.gov.uk

1 INTRODUCTION

1.1 This report seeks permission for Tameside Shared Lives service to change their age of service from 18+ to begin working with young people from the age of 16+. This is part of a wider piece of work with Shared Lives Plus which is the national Shared Lives umbrella body and the Department of Education (DoE) to expand the offer of shared lives services to younger people. We are currently trying to secure a grant from DoE to support this work.

1.2 This policy change is part of the Adult Services Transformation Programme. It was highlighted that Shared Lives could provide an alternative service to young people leaving care from the age of 16+. This could be as an alternative to other traditional services offered via Children's services which could prepare young people for independent living. It would also support the work of Shared Lives in terms of encouraging a smoother transition of young people with complex needs transitioning into Adult Services through early engagement with services and families.

1.3 Working with young people leaving care is one element of the transformation plan which is aimed at improvement and diversification of the service through expansion of provision, creating better choice and outcomes for young people while also working with partners to improve the efficiency and effectiveness of community based services. This will better support the wider health and social care system as we continue to integrate health and social care services.

2. SHARED LIVES BACKGROUND

2.1 Shared Lives is a regulated social care service delivered by Shared Lives carers. The service is registered with the Care Quality Commission (CQC). Shared Lives (formerly Adult Placement) has been providing support to individuals in Tameside since 1992. The service is managed and delivered by the Council.

2.2 The aim of Shared Lives currently is to offer people aged 18 years and older, an alternative and highly flexible form of accommodation and support. Individuals who need support are matched with compatible Shared Lives carers who support and include the person in their family and community life.

2.3 Shared Lives primarily works with adults with learning disabilities but more recently have started to diversify and promote services to other vulnerable groups such older people who for example have dementia. Shared Lives carers are approved to provide a range of community support services to individuals who meet the access criteria for Adult Services.

2.4 There are currently 125 service users being supported by 88 carers (April 2018). Any person aged 18 or over who meet eligibility criteria for services may use Shared Lives. This report seeks permission to amend the entry age for Shared lives to 16.

2.5 Shared Lives carers provide a range of services dependent upon the needs and health of the individuals. The scheme currently provides:

Long Term Support	This service enables people to live with approved Shared Lives carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families.
Interim Placements	A service user can live with a Shared Lives carer for up to 12 months. These placements will focus on promoting skills and independence, with a view to moving towards more independent living. There is the potential for interim placements to become long term placements after 12 months based on assessed needs.
Respite	A service enabling users to take either regular short breaks or one off periods e.g. to allow for convalescence after a hospital stay or for family members to go on holiday or have a break from their caring role.
Day Support	This is a flexible service enabling people to do activities of their choice, to use community facilities or to visit approved Shared Lives carers in the carer's home.
Emergency placements	We are also able to provide emergency respite placements, dependent on carers available and the needs of the service user.

2.6 All individuals using Shared Lives have been assessed by Adult Services and are then referred to Shared Lives as part of their commissioned support plan to meet eligible needs.

2.7 Shared Lives carers are self-employed. To become approved, they are DBS checked and complete an in-depth assessment and approval process, and are required to undertake regular mandatory training. They are paid expenses for the care and support provided and qualify for a Carers tax relief.

3. POLICY CHANGE CONTEXT

3.1 Shared Lives Plus were awarded a £365.000 grant to embark on a new project to develop and raise the profile of Shared Lives to young care leavers. This project is funded by the Department of Education (DoE) as part of the Children Social Innovation Programme, which funds innovative and different approaches in care which are currently limited in this area. Tameside Shared Lives scheme is being considered as a pilot area for this project and if successful will receive a small bursary to achieve its aims.

3.2 The project aims to offer Shared Lives to young people leaving care who have learning or physical disabilities and/or additional needs which have not been met by traditional service provision. These are likely to be young people who have not entered into further education or training or started work and would benefit from experiencing a home-based care environment. They would receive support in developing life skills as well as help to manage risk and make informed choices about their future direction, including education and career pathways. This support will help them move successfully into independent living where appropriate. The Council would also like to extend this support to young people leaving care who may not have additional needs and meet social care access criteria. We propose to offer Shared Lives arrangements as an alternative to other accommodation options such as supported lodgings and stay put arrangements.

3.3 Adult Services are experiencing a significant increase in young people with very complex needs coming through transition (30+ over the next three years). This is placing significant strain on existing services and is resulting in an increase in people being placed out of area in placements that can meet the young person's needs. This is disruptive for the young person and their family and is at a significant cost to the Council. Shared Lives provides an option for young people to access care and support with a family locally at a significantly reduced cost.

3.4 There are also a number of young people with complex needs that reside with foster carers and as they transition into Adult Services they may require placement in residential care which can be out of area because there may not be Shared Lives carers who can meet their needs. Part of the Shared Lives transformation programme is to work with foster carers to transition with the young person to become Shared Lives carers to offer continuity and stability for the young person. The Shared Lives banding report (presentation at May 2018 SCB) financial recompense to carers providing complex support. This policy change would assist with smoothing the transition process with foster carers at a much earlier point in the transition process.

3.5 Shared Lives can make positive, lasting changes in people's lives. Evidence shows that a Shared Lives arrangement can improve health outcomes (SLP Health Report 2015). The Shared Lives sector nationally has seen a 31% growth over three years despite the downward pressures on social care. The positive outcomes experienced by people using Shared Lives is reflected in a 92% good or outstanding rating awarded to Schemes by CQC. Tameside is currently due an inspection and was inspected on the previous system and received a rating of meets all standards.

3.6 Over 200 Shared Lives carers responded to a 2015 survey, which asked how the health of the people they supported had been improved by being in a Shared Lives household. The survey discovered that 73% had received positive feedback from an NHS colleague about the difference their support was making to an individual's health and 87% of people who responded said that Shared Lives has had a positive effect on the mental health of the person/s they were supporting.

3.7 Key national policy drivers in health and social care have placed well-being and independence at the centre of support which sets an ambition for a strategic shift in how services are delivered. The Care Act 2014 places a duty on local authorities to promote individuals well-being by preventing and reducing the need for care and support. Evidence shows that young people who are living in a high cost inappropriate setting often feel isolated. Enabling increased choice for people to move into family-based Shared Lives placements promote independence, reduce isolation and act as an early intervention approach to prevent admission to acute settings later in life.

3.8 We have consulted with Children's Services and discussed the legislative requirements of this change of policy and have only identified specific training and screening requirements of carers and staff in terms of working with young people 16-18 years of age. The identified training requirements are detailed in **Appendix 1** of this report. Our intentions are to have a specific targeted recruitment campaign for carers interested in working with young people and will link with Children's Services training and development programme in terms of providing necessary training and development requirements.

3.9 This report also supports the Council's corporate priorities of caring and supporting adults and young people by working with health services to ensure efficiency and equity in the delivery of excellent services to meet the needs of the community.

4. FINANCE

4.1 The service is attempting to secure a small grant over a three year period to help provide support to this piece of work. We also hope to discuss match funding with Children's Services to also contribute to the available resource available to fund this development. The service will explore and present predicted cost avoidance across Children's and Adult's as part of the final decision report.

4.2 There is potential for significant cost avoidance through this project in terms of reducing out of area placements of young people with complex needs and also in addressing increasing demand from looked after children and young people leaving care.

5. EQUALITIES

5.1 An Equality Impact Assessment has been undertaken see **Appendix 2**. It is anticipated that the proposal does affect certain protected characteristic group(s) within the Equality Act. We do not envisage the impact of this change in policy will be significant in terms of the Equality Act. Shared Lives services are provided to all individuals who meet Adult Service's access criteria so this is a qualifying requirement for access.

6. PROPOSED CONSULTATION PLAN AND METHOD

6.1 The service is currently working with the Policy, Performance and Communications Team to put several questions on the Big Conversation for public consultation on this policy change. Specific proposed questions are:

- We are proposing to expand Shared Lives to people aged 16+. Do you think it's a good idea? Agree/neutral/disagree as the options to tick.
- And then a follow up asking, 'have you got anything else to add?' which would be free text.

6.2 In order to consult with the public we propose to use The Big Conversation to establish wider population views. Consultation will also be undertaken with the Children in Care Council to seek their views and comments on the proposals.

6.3 The consultation plan and documents, including public information and a description of the proposed work (see **Appendix 3**) and questionnaire (see **Appendix 4**) have been developed with support from the Policy, Performance and Communications team to ensure that best practice is followed.

6.4 Communication approaches will be made accessible in terms of people who have sensory or cognitive difficulties. Where appropriate individual meetings can be arranged or people can contact the scheme via telephone also.

6.5 A combination of focus groups and drop in sessions will be arranged to run in parallel with Carer Forums over a range of day / evening sessions. These will allow individuals to speak openly about their concerns with staff and management to inform the final report.

6.6 The consultation will also be posted on the Big Conversation online to ensure the wider public are made aware of the proposed changes and can contribute to the consultation process. Foster Carers and young people will be directed to the dedicated consultation web pages supporting the Shared Lives consultation.

6.7 All feedback will be used to inform the final report, recommendations and final Equality Impact Assessment.

7. RISK

7.1 There are a number of risks identified as a result of undertaking this review:

Risk	Consequence	Impact	Likelihood	Action to Mitigate Risk
Failure to effectively communicate policy change to customers and public	This would impact on the validity of the consultation and results, impacting on decision making	High	Low	To ensure that a range of different consultation approaches are used to fully inform consultees and subsequent decision making. To offer support for individuals who require support understanding or answering questions.
To ensure that individuals being consulted with have capacity and fully understand what they are being consulted on.	This would impact on the validity of the consultation and results, impacting on decision making. Impact on response rates.	High	Low	To offer a range of consultation methods including face to face discussions to ensure support is available to respondents.

7.2 To try and mitigate these risks Shared Lives will utilise a range of consultation and engagement methods with all stakeholders to ensure they are fully informed and engaged in the decision making process and to ensure that decisions are informed and valid.

8. RECOMMENDATIONS

8.1 As stated on the report cover.

APPENDIX 1

Mandatory Training
Safeguarding Children Awareness Training Level 1 **(There is a requirement to update Safeguarding every 3 years)** This training is endorsed by the Tameside Safeguarding Children Board The course will raise awareness of child abuse and neglect and its impact on Children and Young People. It will enable participants to understand their role in keeping children safe and look at ways to promote and safeguard the welfare of Children & Young People. It will identify children who may be more vulnerable to abuse and neglect and provide guidance of how to respond to a Child's disclosure of abuse.
Understanding Child & Adolescent Development **(No requirement to update)** This course has been specifically designed to enable Carers to develop their knowledge of Child Development Theory in order to assist in identifying Children and Young People's needs and make appropriate responses to those needs. This course will help participants to recognise the developmental milestones throughout childhood and adolescence and increase awareness of the factors that can hinder healthy development. Participants will have increased understanding of the holistic nature of Children's and Adolescent's developmental needs.
"Voice and Experience of the Child" – Effective Communication with Children & Young People **(No requirement to update)** This course will increase awareness of the importance of communicating on an effective level with Children and Young People. In addition it will cover the importance of observation, active listening and involvement of Children & Young People. It will look at the ways in which we can ascertain the wishes and feelings of Children and Young People and reflect those in our recordings and communications. It will promote good practice when working with Children and Young People and emphasise the importance of empowering them to have "a voice" in the decisions that affect their lives.
Introduction to First Aid (Morning Event) **(There is a requirement to update every 3 years)** This course will raise awareness of the priorities in Emergency situations and how to respond to various incidents of Emergency. These will include responding to an unconscious individual (including seizures), choking, shock, bleeding, burns & scalds. It will look at the administration of CPR and participants will have opportunity to practice the CPR process on the resuscitation doll.
Attachment Training Level 1 (Date 1) **(No requirement to update)** This course will provide an understanding of attachment theory and attachment styles. It will help participants to recognise some of the ways in which attachment difficulties present in the behaviour of Children & Young People and also provide ideas for managing behaviour that stems primarily from the development of unhelpful early attachments.

Additional Training as Required

Equality, Diversity and Identity for Looked After Children

(No requirement to update)

This course will introduce participants to the principles of working with equality, diversity and identity. It will provide an overview of the Law and help to explore our own values and where they come from. It will consider the influence of prejudice and stereotyping and look at how we can best meet Children's needs and promote a positive sense of identity.

Advanced Attachment (2 Parts)

(No requirement to update)

"It is an expectation that participants will have attended the Level 1 Training or received some basic training in Attachment Theory and presentation before accessing this course"

The Course will briefly revisit the origins of various Attachment Presentations in Children & Young People. It will enable participants to explore and practice a "child-centred" behaviour management approach to challenging oppositional/withdrawn behaviour in Children & Young People and relate that approach to the emotional and physical development needs of Children & Young People.

Child Sexual Exploitation Awareness

(No requirement to update)

This course will provide an understanding of what Child Sexual Exploitation is and how children can be vulnerable to it. It will help participants recognise the signs of Child Sexual Exploitation in children and young people and support them in how to respond appropriately to safeguard potential or actual victims of Child Sexual Exploitation.

Anti-Bullying /Cyber Safety Training

(No requirement to update)

This course will raise awareness about Bullying….what it is and the different types of Bullying. This course will enable participants to increase their understanding of on-line Bullying and E-Safety and the link between Bullying and Hate Crime. It will explore good practice when dealing with Bullying and best ways to support children and young people to keep themselves safe.

Promoting and Managing Family Contact

(No requirement to update)

This course will provide an understanding of the meaning and significance of contact for the Young Person, their family and significant others.

It will provide an understanding of the role and responsibilities in supporting contact and the importance of being in touch with the young person's needs and promoting a "child focus".

Participants will gain awareness of how they can help Young People to manage their feelings, how they can promote the well-being of young people in their care and support them to develop a positive identity.

Behaviour Support

(No requirement to update)

This course will provide an understanding of positive approaches to take when presented with behaviour from young people. It will help participants to recognise challenging behaviour and gain understanding of the reactions of yourself and others in crisis situations. The course will provide

awareness of positive and proactive responses to use in crisis situations.

Healthy Weight Brief Intervention Awareness

(No requirement to update)

This course will raise awareness of the causes and implications of being above a healthy weight. It will recognise the approach used to identify the clinical level of overweight/obesity in young people and empower and support carers to talk to young people about their weight and share key messages for weight management.

Booking Link:

Sex Relationship Education

(No requirement to update)

This course has been specifically designed to meet the needs of Foster/Connected Person Carers and Residential Workers.

This course will enable participants to increase their understanding of the changes that children go through during puberty and help them to talk positively about relationships, sex and contraception according to the age of the young person. It will support participants to deal with their own embarrassment of approaching / discussing these areas and break down some of the common barriers in a non-threatening and fun way.

Self-Harm Awareness

(No requirement to update)

This course aims to increase awareness and understanding of self-harm behaviours in young people. It will explore myths and realities regarding self-harm and will examine potential triggers and risk factors. Participants will consider both practical and emotional responses to young people who harm themselves with the aim of developing good practice.

Drug and Substance Awareness

(No requirement to update)

This course will raise awareness of the main substances that young people experiment with. It explores why young people use drugs and alcohol and where they get it from

and explores the potential signs and symptoms of drug and alcohol use. The course will provide opportunity to explore how to talk to young people about drugs and alcohol and provide information about how to make a referral to Lifeline Branching Out.

APPENDIX 2

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

Subject / Title	Shared Lives Scheme Change of service age to 16+

Team	**Department**	**Directorate**
Shared Lives	Adult Services	People

Start Date	**Completion Date**
30/04/18	

Project Lead Officer	Mark Whitehead
Contract / Commissioning Manager	
Assistant Director/ Director	Sandra Whitehead /Stephanie Butterworth

EIA Group (lead contact first)	**Job title**	**Service**
Mark Whitehead	Head of Service	Adults
Alison White	CQC Registered Manager	Shared Lives, Long Term Support and Reablement
Giovanna Surico- Hassall	Assistant Team Manager	Shared Lives
Sue Ward	Team Manager	Shared Lives
Sean Lawton	Team Manager	Shared Lives
Adam Lomas	Social worker	Shared Lives
Reyhana Khan	Programme Manager	Transformation Adults

PART 1 – INITIAL SCREENING

An Equality Impact Assessment (EIA) is required for all formal decisions that involve changes to service delivery and/or provision. Note: all other changes – whether a formal decision or not – require consideration for an EIA.
The Initial screening is a quick and easy process which aims to identify:

- *those projects, proposals and service or contract changes which require a full EIA by looking at the potential impact on any of the equality groups*
- *prioritise if and when a full EIA should be completed*
- *explain and record the reasons why it is deemed a full EIA is not required*

A full EIA should always be undertaken if the project, proposal and service / contract change is likely to have an impact upon people with a protected characteristic. This should be undertaken irrespective of whether the impact is major or minor, or on a large or small group of people. If the initial screening concludes a full EIA is not required, please fully explain the reasons for this at 1e and ensure this form is signed off by the relevant Contract / Commissioning Manager and the Assistant Director / Director.

1a.		Tameside MBC Shared Lives service to change their age of service from 18+ to begin working with young people from age 16+. Shared Lives currently supports 129 adult service users utilising 84 approved carers from across all areas of Tameside. Through a service review as part of the Adult Services Transformational Fund it was highlighted that Shared Lives could provide an alternative service to young people leaving care from the age of 16+. This could be as an alternative to other traditional services offered via Children's services which could prepare young people for independent living, or smooth the transition from Children's services to adult services. Working with young people leaving care is one element of a transformation plan aimed to improve the service and expand its provision, creating better outcomes for service users while also working with partners to improve the efficiency and effectiveness of community based services. This will better support the wider health and social care system as we continue to integrate health and social care services.
	What is the project, proposal or service / contract change?	Shared Lives is proposing to offer the following services to young people: • **Transitional Placements** - for those transitioning from fostering care to shared lives placements. • **Respite Care** – short breaks • **Interim placements** – as an alternative to foster arrangements / residential placements. • **Alternatives to supported lodgings placements**. • **Peer support model** – This is a pilot idea working with Jigsaw Housing Association. Jigsaw has provisionally agreed to provide prospective Shared lives Carers with two bedroom properties to give them the physical space to provide support. We aim to identify previous care leavers to become Shared Lives Carers and provide peer support for young people leaving care. • **Day support / kinship support.**

1b.	**What are the main aims of the project, proposal or service / contract change?**	Shared lives may be able provide a cost effective alternative to semi supported accommodation for young people. Shared Lives are currently moving exploring a banded payment system with the high needs band being set at £405.54 per week. This is comparatively more cost effective than a cheapest cost semi- supported accommodation which is currently £850 per week. Another additional benefit is that Shared Lives can offer people an alternative personalised and highly flexible form of care. It enables vulnerable young people to live full and active lives, and have their health and well-being promoted within a normal family setting. People using Shared Lives are part of a family and share in all aspects of everyday life. They are encouraged to explore their aspirations and ambitions, regardless of their perceived limitations. They and their families are fully involved with making decisions that affect them and matching individuals to their potential carers is a key element of the Shared Lives Service. Shared Lives outperforms all other forms of regulated social care (CQC annual report 2015/16) and makes significant financial savings when compared to other forms of regulated care (Social Finance: Investing in Shared Lives 2013). The cost for an individual with mild to moderate learning disabilities to use Shared Lives instead of another form of regulated care could be on average £26,000 cheaper per year (around £8,000 for people with mental ill health). These figures are cash savings and do not include any additional monies or efficiencies which often come with a Shared Lives match. The Key concern with implementing a change in service is a potential impact to the support services provided to the adult service users. Shared Lives carers would be able approved to support any potential service users referred to the scheme and supporting young people within their home may impact on potential adult service users with assessed needs being appropriate matches. This may lead adult service users to require alternative provision. This however would be mitigated as Shared Lives carers will be recruited specifically to support young people leaving care.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?
Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	x			Shared Lives Services are targeted at the adults age group (18+). This change would target all people aged 16+

Disability	X			Service Users for Shared Lives have services commissioned due to qualifying needs.
Ethnicity		x		Shared Lives Service users come from a range of ethnic backgrounds.
Sex / Gender			X	Shared Lives is not a gender specific service.
Religion or Belief			X	
Sexual Orientation			X	
Gender Reassignment			X	
Pregnancy & Maternity			X	
Marriage & Civil Partnership			X	
Other protected groups determined locally by Tameside and Glossop Single Commissioning Function?				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Mental Health	X			Shared Lives supports service users with mental health needs
Carers	X			Shared Lives services provide respite for carers.
Military Veterans		X		There are some Shared Lives Carers who are Military Veterans
Breast Feeding			X	
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

Wherever a direct or indirect impact has been identified you should consider undertaking a full EIA or be able to adequately explain your reasoning for not doing so. Where little / no impact is anticipated, this can be explored in more detail when undertaking a full EIA.

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
		X	
1e.	**What are your reasons for the decision made at 1d?**	Proposed service changes have a direct impact on Service users with the protected characteristics of Disability, Mental Health, Age and Carers.	

If a full EIA is required please progress to Part 2.

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

2b. Issues to Consider

2c. Impact

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Impact1 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 2 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 3 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 4 (Describe)	*Consider options as to what we can do to reduce the impact*

2e. Evidence Sources

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Required	*Required*	*Required*

Signature of Contract / Commissioning Manager	Date
Signature of Assistant Director / Director	**Date**

APPENDIX 3

Tameside MBC Shared Lives Information on Shared Lives Access Age Policy Change.

What is Shared Lives?

Shared Lives, is a regulated form of social care delivered by Shared Lives Carers who are approved by a Care Quality Commission (CQC) registered scheme. The CQC is the independent regulator of all health and social care services in England and monitors and checks all care services to make sure they meet fundamental standards of quality and safety.
The aim of Shared Lives is to offer people an alternative and highly flexible form of accommodation and support. Individuals who need support, and choose Shared Lives, are matched with compatible Shared Lives Carers who support and include the person in their family and community life.

All Shared Lives Carers are subject to *Disclosure and Barring Service* (DBS) checks and complete an assessment and approval process, and are required to undertake regular mandatory training. They are paid expenses for the care and support provided.

Service Currently Offered by Shared Lives

The services Tameside MBC Shared Lives currently offers are;

- **Long-term** - This service enables people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families.
- **Interim -** A service user can live with a Shared Lives Carer for up to 12 months. These placements focus on promoting skills and independence, with a view to moving towards more independent living. There is the potential for interim placements to become long term placements after 12 months based on assessed needs.
- **Respite -** A service enabling users to take either regular short breaks or one off periods e.g. to allow for convalescence after a hospital stay or for family members to go on holiday or have a break from their caring role.
- **Day Support -** This is a flexible service enabling people to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home**.**
- **Emergencies** - We may also able to provide emergency respite placements, dependent on Carers available and the needs of the service user.

Current Age Access Policy

Tameside MBC Shared Lives is currently offers a service to people aged 18 and over who meet the criteria for adults social care services.

What are the Proposed Changes?

Tameside MBC Shared Lives service is aiming to expand their provision to support young people aged 16+. We aim to provide a range of different services working with young people who will transition into adult services, and also with young people leaving care to provide a step down service to help support their preparation for independence. The areas we aim to support are as follows:

Transitional Placements: Improving the transitional pathway for young people with additional needs leaving care, this will mean that young people and foster carers will have an understanding that Shared Lives could be a future option should they wish to pursue this. Young people could be identified from 15, introduced to concept of Shared Lives placement and begin transition at 16 if this is their chosen future support.

Respite Care: We could also offer respite placements for young people from 16+ as an alternative to fostering family links. This would also allow service users with additional needs who would be

eligible for respite from Adult Services to be introduced to carers who could provide support post 18.

Interim Placements: Interim placements with Shared Lives families as an alternative to foster arrangements / residential placements for young people ages 16+ using the traditional Shared Lives model. Young people accessing this service would not need to have additional needs and may be eligible to use Shared Lives as an alternative to supported lodgings post 18.

Alternative to supported lodgings: This is a potential option for young people leaving care who do not meet the criteria for adult services. Shared lives placements could be funded as an alternative to supported lodgings/ bedsits provision which is currently offered.

Day Support/ Kinship support: Commissioned day support hours for care leavers to provide support to develop links with local community and develop tenancy management skills within their independent accommodation. This will be time limited to support young people into independence.

We hope that by developing Shared Lives as a service for young people we can achieve positive outcomes through earlier planning at what can be a very stressful time for a young person and their family. Shared Lives can support young people to have new and rewarding experiences in the community, develop independence skills and confidence and support families while a young person goes through a transition from children's to adult services.

We hope that by providing services for young people we can offer stability in periods of high stress which will reduce the need for additional services in later life.

Shared Lives For Young People Leaving Care and Young People With Additional Needs Transitioning Into Adult Services.

What is Shared Lives?

Shared Lives, is a regulated form of social care delivered by Shared Lives carers who are approved by a CQC registered scheme. Individuals who need support are then matched with compatible Shared Lives carers who support and include the person in their family and community life. Shared Lives primarily work with adults with learning disabilities but more recently have started diversifying into offering services to other vulnerable adults. A lot of Shared Lives Schemes around the country are offering to place young people aged 16+ who are in the transition process and are developing pathways which would create systematic planning for young people as they move into adult services.

Types of Service Offered

- **Short-term** - where carers look after young person for a few weeks or months, while plans are being made for the next steps, e.g., family breakdown.
- **Short-breaks** - where disabled young person can enjoy a short stay on a pre-planned, regular basis with a shared lives carer while their parents have a respite break.
- **Long-term placement** – the person remains with a shared lives carer until they are ready to move on into their own home, supported accommodation or to live with another Shared Lives family.
- **Day Support** – offering day services from the Shared Lives home to develop skills away from the family environment and develop new skills and independence.

How Shared Lives supports Transition

Shared Lives is relatively unknown to children's services but currently provides some 13,500 arrangements for adults in the UK through 153 schemes. In Tameside we currently have a network of 83 carers supporting over 130 service users. These arrangements may be long-term arrangements, short breaks or day support. Shared Lives have primarily offered services for adults with learning disabilities, but over the last couple of years, many schemes around the UK have diversified into other areas e.g. young people under 18 years old, unaccompanied asylum seekers, vulnerable young adults, young mother and baby, etc

Shared Lives schemes can provide transition arrangements from as early as 16 years old and can start to look at potential matches from 15 years old. Shared Lives Plus (national organisation) have employed a Transition Development Officer, Denise Nygate, whose role is to look at the ways that Shared Lives for opportunities for young people in transition.

Their role has included promoting Shared Lives within children's services, leaving care services, supporting Shared Lives schemes to work with 16-18-year-olds and developing networks across the country. Tameside MBC is currently working with Shared Lives Plus to develop their offer to young people across the borough.

As part of the transition development, CQC and Ofsted have put together guidance to help Shared Lives Schemes register with CQC for anyone under 18 years old but not any lower than 16 years old.

Flexible outcomes for young people

Developing Shared Lives as a service for young people can achieve better results through earlier planning at what can be a very stressful time for a young person and their family.

Shared Lives can enable young people to live in ordinary homes with families who can include other young people. Shared Lives can support young people to have new and rewarding experiences in the community, develop independence skills and confidence and support families while a young person goes through a transition from children's to adult services. It can also provide families with a much-needed break during the school holidays.

Shared Lives also provides short term placements for young people to prevent them from becoming homeless by offering an alternative to fostering/ Children's homes at 16 years old when it can be hard to place young adults for a couple of years. Agreements have been in place where the Leaving Care Teams have agreed payments up to 21 years old.

Supporting a range of ages

Shared Lives can negotiate with the Leaving Care Team (LCT) on funding a placement. Some LCT fund through to over 21 years old. Some LCT offer support with the top up benefits to enable the young person to be in a Shared Lives home until they reach 18 years old and their benefits can be established.

Shared Lives can provide support from 16 years old ongoing into adulthood. If a foster carer cannot provide the Staying Put arrangement, then some schemes have offered support for the young person to stay in a family home until they are ready to move into their accommodation through working with the LTC and personal assistants.

Shared Lives Carers.

All Shared Lives Carers are self-employed in their role. They have an agreement to carry out certain duties and responsibilities in their role. Shared Lives Carers get a payment for the placement, the payment is made up payment for the SL carer as well as housing benefit for their bedroom and costs for food and utilities. All Shared Lives Carers are registered with and contracted to a Shared Lives Scheme. Shared Lives Scheme visit every three months for support and monitoring visits and training is an ongoing part of the work offered.

Carer Approval process

- All shared lives carers go through an approval process similar to that of a foster carer as set by national standards- CQC.
- The focus is on caring for an adult rather than a child.
- Schemes always aim to complete the assessment in a sensitive way and take in to account prospective carers knowledge, experience and training.
- The assessment may be for a named service user or to be available to support unknown service users
- References from DBS, GP, work and personal references will be taken and Mandatory training completed e.g. safeguarding adults and scheme practicalities. This is usually done via e learning and one to one training with a scheme social worker.
- Once the assessment is complete, a report will be written up, and Carers will be asked to comment on it.
- The assessment is presented to the Shared Lives panel who invite Carers along or the assessor can present on their behalf.
- There may be an expectation that Carers would complete the Care Certificate.
- Foster carers need to apply to be assessed and approved as Carers by a registered Shared Lives scheme. This may be up to 6 months and many foster carers feel that they are currently doing this role they cannot understand why they will need to complete a different assessment.

- Even though Foster Carers and Shared lives assessment may be seem very similar, the aim of the Shared Lives assessment is to help foster carers understand their different role which is helping the young adult prepare to leave the family home
- Assessment is looking at choices, capacity and abilities to support a young person to move on from a Shared Lives scheme where appropriate or to study help the young person to have a life outside of the family home, connecting the young person with their community and support to develop and grow as a young adult
- Training takes place both pre assessment and post assessment. Pre-assessment covers safeguarding under adults safeguarding policy, mental capacity, court of protection, etc. Post assessment training may be additional training that will help Carers in their role to support the young person to become more independent. It can cover offering health passport training, person centred planning, budgeting skills, letting go and moving on, etc

There are some differences between Fostering and Shared Lives?

- Shared Lives carers are expected to provide a clean, warm furnished bedroom which the client will rent from you.
- The person will have their own key to the house
- As the person is renting the room from the carer they may ask for their room to be more personalised to their tastes.
- People living in Shared Lives cannot share their room with another person unless they are a couple and wish to do so.
- The scheme will pay you a fee for the care and support Carers offer to the person. This is solely for Shared Lives Carers.
- The person will receive their benefits directly in to their bank account and will be assisted to manage these by the Shared Lives carer. This includes DLA
- The person will be responsible for buying any personal possessions such as clothing, electronic equipment and holidays from their money.
- The overall income for the placement maybe different. However as the person will hold their money the Shared Lives carer will receive less but will not be responsible for the client's personal expenditure.
- Shared Lives carers are classed as self-employed and are entitled to tax concessions.
- Shared Lives carers are not entitled to Carers Allowance for the person staying with them and are unlikely to be entitled to any means tested state benefits.
- Shared Lives carers are required to keep records of finances, medication and key incidents and present them when requested
- Shared Lives carers will be asked to show they have supported the person with decisions and choices and some schemes are asking Court of Protection if the person does not have capacity to manage their money on their behalf. This area would be discussed as part of the adult social care assessment
- The most important aspect is supporting the service user in an age appropriate way as an adult rather than as a child

Transition from fostering

At 18 young people experience a major change in moving from children's to adult services. Easing the transition for children can help provide more positive long term outcomes and stable placements. They may be eligible to continue to receive the care and support in a familiar environment, For this to happen two strands need to come together:

- The child needs to be assessed by the transitions social worker as having eligible care and support needs to be funded as an adult, and it is there best interest to remain living with carers (if a transition from foster placement to Shared Lives placement).
- If the young person does not meet the eligibility needs for adult social care, then a Staying Put arrangement maybe offered within a Shared Lives Placement.
- If there is no family members for the young person then an IMCA- independent mental capacity assessor- may be brought in to make sure that the young person has a clear

independence in making the decision to take a Shared Lives Placement, If the person lacks capacity under the Mental Capacity Act an IMCA may still be brought in as good practice to show that the best interest of the young person is considered

- It is hoped that Tameside MBC Shared Lives schemes may start the process earlier than their 18th birthday. Tameside MBC Shared Lives schemes are looking at starting transition as early as possible so that the young persons are clear on what choices and opportunities can be available to all parties.

APPENDIX 4

SHARED LIVES CONSULTATION QUESTIONS

QUESTIONS

Q1. Please indicate which of the following best describes your main interest in the Shared Lives consultation (Please tick one box only):

□ I am a Shared Lives Carer (Go to Q2)

□ I am a Shared Lives service user (Go to Q3)

□ I am a relative or friend of a Shared Lives service user. (Go to Q3)

□ I am a member of the public (Go to Q5)

□ I work for Tameside MBC/T&G CCG (Go to Q5)

□ Other (please specify below) (Go to Q5)

Q2. Which Shared Lives services do you currently provide? (Please tick all that apply)

□ Long Term - Where people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families

□ Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living

□ Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights,

□ Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home

□ Emergencies – respite or interim provision due to emergency circumstances.

(Go to Q4)

Q3. Which of the following services provided by Shared Lives do you, your relative or friend use? (Please tick all that apply)

□ Long Term - Where people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families

□ Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living

□ Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights,
□ Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home

□ Emergencies – respite or interim provision due to emergency circumstances.

□ Don't Know

Q4. What impact will the proposed changes to the Shared Lives age of access (i.e. change from working with people from 16 rather than 18 years of age) have on you as a carer / or on you, your relative or friend who uses the Shared Lives service?

(Please state in the box below)

(Go to Q5)

Q5. Do you have any other comments you wish to make about the proposed changes the Shared Lives Service in general? (Please state in the box below)

ABOUT YOU

Q6. Are you…..?

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

Q7. What is your age? (Please state) ☐

Q8. What is your postcode? (Please state) ☐

Q9. What is your ethnic group? (Please tick one box only)

White

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

☐

Mixed / Multiple Ethnic Groups

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

☐

Black / African / Caribbean / Black British

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

☐

Asian / Asian British

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

☐

Other ethnic group

□ Arab
□ Any other ethnic group (Please specify)

☐

Q10. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

□ Yes, limited a lot

□ Yes, limited a little

□ No

Q11. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

□ Yes, 1-19 hours a week

□ Yes, 20-49 hours a week

□ Yes, 50+ hours a week

□ No

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 May 2018
Reporting Member / Officer of Strategic Commissioning Board	Brenda Warrington Executive Leader Sandra Whitehead Assistant Director Adult Service
Subject:	**CONSULTATION ON A BANDED PAYMENT SYSTEM FOR SHARED LIVES PLACEMENTS.**
Report Summary:	This report seeks authority to enter into consultation with Shared Lives Carers and key stakeholders to consider a banded payment system for carers. Shared Lives currently has a fixed rate of pay for carers delivery of services, despite differing levels of need for the people being cared for. The service currently has 88 approved carers providing support to 125 service users in long term, respite and day support placements. The scheme wishes to expand its provision to support service users with more complex needs and young people leaving care. A banding payment system will assist and recognise Carers who support more challenging needs and recompense them accordingly. Various Shared Lives schemes across Greater Manchester have moved onto a banding system, and the introduction of a banding system will support the diversification and expansion of the service in-line with service transformation objectives.
Recommendations:	That the Strategic Commissioning Board support the proposal for the Shared Lives Service to enter into consultation with carers, and key stakeholders about the implementation of a banded payment system for carers.

Financial Implications:

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

ICF **Net Budget**	**£'000**
Tameside Council – Adult Services **Section 75** **Decision to be determined by the Strategic Commissioning Board**	777
Additional Comments The proposed banded payment system outlined in this report acknowledges the different complexities of care provided. It also looks to future proof the service by attracting new carers through a more incentivised payment approach. The proposed banding system will increase expenditure by an estimated £11,500 per annum based on existing service users. However this is subject to the outcome of the consultation. It should be noted that there are wider cost and qualitative	

	benefits that are realised by the Shared Lives service being in place as the service provides improved outcomes and is a more cost effective option when compared to the cost of these placements in the independent sector.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Shared Lives Scheme is regulated under Health and Social Care Act 2008. The change to introduce a banding system within the scheme attracts the duty to consult on the proposed change. The legal requirements as to consultation must be followed to ensure that the decision that is made is lawful and takes into account the consultation.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well programmes for action.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care • Locality-based services • Planned care services
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commission for the 'whole person'.
Recommendations / views of the Health and Care Advisory Group	Reported directly to the Strategic Commissioning Board.
Public and Patient Implications:	Carers banded at level 1 could lose income which could impact on willingness to be carers. We anticipate the impact and probability of this being very low.
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. The service will be available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership. The introduction of a banding system is a more equitable means of reimbursing carers based on complexity of the needs of those cared for.
What are the safeguarding implications?	None

What are the Information Governance implications? Has a privacy impact assessment been conducted?	A privacy impact assessment has not been completed. Services adhere to the Data Protection Act when handling confidential personally identifiable information.
Risk Management:	Risks associated with the introduction of a banding system are anticipated to be low. The primary risks identified relate to the failure to appropriately communicate with all stakeholders on the proposed banding system thus impacting on the validity of information to inform decision making.
Access to Information :	The background papers relating to this report can be inspected by contacting Mark Whitehead – Head of Operations: Telephone: 0161 342 3791 e-mail: mark.whitehead@tameside.gov.uk

1. INTRODUCTION

1.1 This report seeks permission to enter into consultation with Shared Lives carers, service users and key stakeholders of the Shared Lives Service regarding the implementation of a banded payment system for carers.

1.2 Shared Lives currently offers a fixed payment to carers for their services. The service users who are referred to the service vary in complexity of needs and levels of support required. The demographic projections for the locality indicate that people are living for longer whilst managing multiple long term conditions. This indicates that people do have more complex needs and this is forecast to continue. Shared Lives offers a more affordable alternative service for people with complex needs, and is an area we want to expand to improve outcomes and efficiency of service going forward.

1.3 There is a commitment through our Care Together programme to ensure people live healthier lives for longer, and are supported to be as independent as possible with care delivered closer to home. Shared Lives offers a further service option that expands individual choice about how their needs are met and in so doing offers greater control to individuals where Shared Lives may be a viable option.

1.4 In order to maximise the opportunities to offer Shared Lives as an option for the widest range of people, there is a need to review the fixed payments that are currently offered to carers, and consider a payment mechanism that is more reflective of the complexity of service users that carers currently support, and could support in the future as we expand our services.

1.5 Benchmarking across Greater Manchester and the national Shared Lived Plus scheme has also been undertaken to ensure a best model practice is reflected in the proposal in terms of the banding and payment methodology.

2. SHARED LIVES SERVICE – CURRENT SERVICE

2.1 Shared Lives is a regulated social care service delivered by Shared Lives carers. The service is registered with the Care Quality Commission (CQC). Shared Lives (formerly Adult Placement) has been providing support to individuals in Tameside since 1992. The service is managed and delivered by the Council.

2.2 The aim of Shared Lives is to offer people aged 18 years and older, an alternative and highly flexible form of accommodation and support. Individuals who need support are matched with compatible Shared Lives carers who support and include the person in their family and community life.

2.3 Shared Lives primarily works with adults with learning disabilities but more recently have started to diversify and promote services to other vulnerable adult groups such as older people. Shared Lives carers are approved to provide a range of community support services to individuals who meet the criteria for Adult Services.

2.4 There are currently 125 service users being supported by 88 carers (April 2018). Any person aged 18 or over who meet eligibility criteria for services may use Shared Lives.

2.5 Shared Lives carers provide a range of services dependent upon the needs and health of the individuals. The scheme currently provides:

Long Term Support	This service enables people to live with approved Shared Lives carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families.
Interim Placements	A service user can live with a Shared Lives carer for up to 12 months. These placements will focus on promoting skills and independence, with a view to moving towards more independent living. There is the potential for interim placements to become long term placements after 12 months based on assessed needs.
Respite	A service enabling users to take either regular short breaks or one off periods e.g. to allow for convalescence after a hospital stay or for family members to go on holiday or have a break from their caring role.
Day Support	This is a flexible service enabling people to do activities of their choice, to use community facilities or to visit approved Shared Lives carers in the carer's home.
Emergency placements	We are also able to provide emergency respite placements, dependent on carers available and the needs of the service user.

2.6 All individuals using Shared Lives have been assessed by Adult Services and are then referred to Shared Lives as part of their commissioned support plan to meet eligible needs.

2.7 Shared Lives carers are self-employed. To become approved, they are DBS checked and complete an in-depth assessment and approval process, and are required to undertake regular mandatory training. They are paid expenses for the care and support provided and qualify for a Carers tax relief.

2.8 Current payments to Shared Lives carers are as follows:

Long Term Support	£395.65 per week
Respite Support	£44.45 per night
Day Support (typically commissioned in five hour blocks)	£6.89 per hour

2.9 Emergencies and interim payments are determined at the time, and are dependent on the potential length of time required and the type of service (made up from the above).

3. POLICY CONTEXT

3.1 The Shared Lives sector nationally has seen a 31% growth over the past three years. The positive outcomes experienced by people using Shared Lives are reflected in a 92% good or outstanding CQC rating across the country. Tameside Shared Lives scheme is currently due to be inspected by CQC, but was inspected under the previous regime and received a rating of 'meets all standards' in 2012.

3.2 The model promotes independence and supports building relationships with friends and family which promotes wellbeing. Appropriately supporting Shared Lives carers through placements supports community resilience and empowers service users to utilise the support networks within their local communities. This builds on the local health and social care economy and Greater Manchester's priorities to improve our asset / strength based community offer.

3.3 Key national policy drivers in health and social care have placed well-being and independence at the centre of support which sets an ambition for a strategic shift in how services are delivered. The Care Act 2014 places a duty on local authorities to promote individuals well-being by preventing and reducing the need for care and support.

3.4 Evidence shows that service users who are living in a high cost inappropriate setting often feel isolated. Enabling increased choice for them to move into family-based Shared Lives placements will promote independence, reduce isolation and act as an early intervention approach to prevent admission to acute settings.

3.5 This report also supports the Council's corporate priorities of caring and supporting adults and older people by working with health services to ensure efficiency and equity in the delivery of excellent services to meet the needs of the community.

3.6 Shared Lives can play a supporting role in the new Integrated Care Organisation particularly if the current service offer is expanded through the wider review. As an example, there has been a significant increase in the number of people with a mental health issue accessing Shared Lives nationally, a 23% increase in 2017, which we would hope to replicate locally to prevent admission to acute services.

3.7 The introduction of a banding payment system is one element of transformation plans aimed to improve the service and expand its provision, creating better outcomes for service users while also working with partners to improve the efficiency and effectiveness of community based services. This will better support the wider health and social care system as we continue to integrate health and social care services.

3.8 Banding systems of payment are currently utilised by eight of the eleven Greater Manchester schemes and it has been highlighted as a priority recommendation by the Greater Manchester Delivery Group to create an equitable and unified regional approach. Banding will also support the diversification and expansion of the Shared Lives scheme to meet the services transformation objectives.

4. SERVICE REVIEW

4.1 A review of the service began in 2017 with a view to identifying potential areas for expansion of the service taking into consideration the increasing complexity of service users, and attracting more carers. Areas for expansion include supporting young people leaving care and a potential intermediate care service.

4.2 To achieve these aims it has been identified that the rates of payment may need to be adjusted to meet these needs. Benchmarking has been completed with neighbouring boroughs to identify their payment structures. Currently eight of the eleven Greater Manchester schemes utilise a banded system and it has been identified as best practice by the Greater Manchester Shared Lives Action Group.

4.3 A comprehensive carer recruitment campaign was launched in the autumn of 2017. The campaign included promotions on social media, bill boards, bus adverts and the production of leaflets to promote the service. This led to articles on regional TV and local radio. This campaign was awarded Local Government Campaign of the Year 2017, as part of the Public Affairs Awards. The campaign was very successful – 12 people have already been assessed and are ready to accept placements and 6 carers are currently being assessed. As a comparison we normally attract 3-4 new carers to the service per annum. Going forward to meet our intended aims we want to recruit more carers who are interested and have the skills to support adults with complex needs.

4.4 In the vast majority of cases the Shared Lives Scheme pays approved carers one payment irrespective of the level of needs or complexity of the individual/s they support.

4.5 There are a very small number of exceptional cases where a higher weekly fee is paid. This particularly applies for some younger adults transitioning from Children's to Adult Services who have previously been cared for by a foster placement and the foster carer wishes to

continue to care for the young adult and become an approved Shared Lives carer. Foster carers receive a higher payment than Shared Lives carers. In order to maintain continuity for the service user, who often has complex needs, a higher weekly payment rate in line with that previously received by the carer has been agreed. Without this, it is likely that the young adults would be placed in specialist out of borough placements, or supported accommodation, both of which would not deliver the best outcomes for that individual and would cost significantly more when compared to the Shared Lives offer. An example of a highly complex case is an indicative cost avoidance of £100,000 per annum per individual.

4.6 Payments to carers are made up from various funding streams including:

- Housing Benefit
- Tameside Council Adult Services contribution
- Service user contribution (financial assessment)

Increased costs accrued by the introduction of banding particularly in the context of more complex provision is justified in terms of potential costs avoided when considering other alternative means of provision to meet complex needs such as out of area specialist provision.

4.7 An element of care and support is an integral part of the role of a Shared Lives carer. The support provided can range from a little or almost none in a traditional 'supported lodging arrangement' to a high degree of support for someone with complex needs in a 'family placement'. The degree of skill and assistance required by the carer needs to be reflected in the payment system. The proposed banding system addresses this issue.

4.8 In terms of providing choice to new carers in how much assistance they want to provide or are able to take on, it also makes sense to move to a banding system. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role of approved Shared Lives Carers, and support the recruitment of carers with the skills and interest in providing support to individuals with more complex needs.

5. PAYMENT OPTION AND CONSIDERATIONS.

5.1 Following a benchmarking exercise against Greater Manchester and other North West schemes, and consultation with Tameside Finance Team, the following payment bands are being proposed:

Day Support

Band 1	**Band 2**	**Complex Needs**
£7.06 per hour	**£8.47 per hour**	**£12.71 per hour**
In line with current proposed rate for 18/19.	20% premium on band one.	50% premium on band 3.

Respite

Band One	**Band Two**	**Complex Needs**
£45.56 per night	**£80 per night**	**£110 per night**
In line with current proposed rate for 18/19.		

Long Term Support & Interim

	Per week	Per Annum
Band One	**£300**	**£15,600**
Band Two (In line with current proposed rate for 18/19.)	**£405.54**	**£21,088**
Complex Needs - Rate subject to assessment (£800 used for cost modelling purposes only)	**£800**	**£41,600**

5.2 It is assumed that for all long term placements there will be a respite provision of 21 nights per annum which will usually be provided within the scheme. Carers will not be charged for these respite nights, but may choose to purchase additional respite if required.

5.3 Because interim arrangements are dependent on the potential length of time required, and the type of service, it is proposed that the weekly payments are as above, but will be calculated on a case by case basis.

5.4 Emergencies
In an emergency it is expected that carers will receive the higher banding rate until the banding assessment is completed. If the person's banding is lowered, carers will not be expected to refund the difference. This recognises the flexibility and responsiveness of the carer and nature of emergency placements and the increased pressure placed on the carer.

5.5 The decision of which band the service user would fit into would be agreed between the Shared Lives worker and Care Coordinator who has assessed the needs of the service user, using a Banding Toolkit.

6. FINANCIAL POSITION AND IMPLICATIONS

6.1 It is important to highlight that as carer payments change, any shortfall in funding would be subsidised by the Council. The additional costs will not be passed on to the service user. Service users will continue to be assessed on their eligible needs, and their contributions are based on a financial assessment (based on Charging Guidelines).

6.2 From a preliminary desktop exercise, it is anticipated that the majority of current service users would remain on comparable payments to the current position. The benefits of increased carer recruitment would however mean increased availability as an alternative to other more costly services, e.g. Shared Lives respite at £55 per night in comparison to £150 per night for Learning Disability based respite care.

6.3 The Council's Shared Lives Scheme currently costs £1.096 million per annum to operate and generates £0.319 million through charging. The Council currently provides core funding of £0.777 per annum to fund the service. It is essential that the service reviews its current payment to carers to ensure there is sufficient incentive to sustain, develop and grow the service. It is also essential that as we move into an Integrated Care Organisation that we continue to demonstrate the financial benefits and sustainability of the service, particularly the significant costs that can be avoided.

6.4 The key concern to implementing a banded payment system is that it could lead established long term placements to be ended if the carer payment is reduced to a level they deem to be unacceptable. It is anticipated that the number of carers whose payment will reduce will be low in terms of potential reduced payment based on the table top exercise.

6.5 There is also the concern that the cost of service to the Council may increase if the individual is placed on a higher band. It is anticipated that the majority of placements will remain on the band which is comparable to the current payment which is band 2 on the scale. The potential cost avoidance however could be significant in comparison to using other methods of provision.

7. PROPOSED CONSULTATION PLAN AND METHOD

7.1 In order to consult with current Service Users, Shared Lives carers and key stakeholders we propose to use a variety of methods which include:

- Focus groups.
- Drop in sessions.
- Letter and questionnaires.
- Telephone contact.
- 1:1 consultation with Shared Lives Team and Managers.
- Big Conversation to establish wider population views.

7.2 The consultation plan and documents including public information (see **Appendix 1**) and questionnaire (see **Appendix 2**) have been developed with support from the Policy, Performance and Communications team to ensure that best practice is followed.

7.3 In order to ensure responses can be gathered from the letters and questionnaires, stamped addressed envelopes will be provided; alternatively, people can contact the service and a worker can offer advice and support.

7.4 If a Service User requires support to complete the questionnaire then a dedicated worker will be able to provide the support. Alternatively service user and their families can contact the scheme via telephone and the questionnaire can be completed remotely.

7.5 A combination of focus groups and drop in sessions will be arranged to run in parallel with Service User and Carer Forums over a range of day / evening sessions. These will allow individuals to speak openly about their concerns with staff and management to inform the final report.

7.6 Communication approaches will be made accessible in terms of people who have sensory or cognitive difficulties. Where appropriate individual meetings will be arranged with advocates, including family members and carers.

7.7 A consultation questionnaire will also be created for referring agencies as part of the process to inform them of the consultation and seek their views, and secure their support.

7.8 The consultation will also be posted on the Big Conversation online to ensure the wider public are made aware of the proposed changes and can contribute to the consultation process. Shared Lives carers and service users and their families will be directed to the dedicated consultation web pages supporting the Shared Lives consultation.

7.9 It is important to consult on these proposals and involve the Shared Lives carers, Service Users and their families in the co-design of the service to ensure that the service offer is

effective in meeting the current and future needs of current and future Shared Lives service users and wider Tameside residents.

7.10 All feedback will be used to inform the final report, recommendations and final Equality Impact Assessment.

8. RISK MANAGEMENT AND PLAN

8.1 There are a number of risks identified as a result of undertaking this review:

Risk	Consequence	Impact	Likelihood	Action to Mitigate Risk
Failure to effectively communicate options / proposed banding to customers and public	This would impact on the validity of the consultation and results, impacting on decision making	High	Low	To ensure that a range of different consultation approaches are used to fully inform consultees and subsequent decision making. To offer support for individuals who require support understanding or answering questions.
To ensure that individuals being consulted with have capacity and fully understand what they are being consulted on.	This would impact on the validity of the consultation and results, impacting on decision making. Impact on response rates.	High	Low	To offer a range of consultation methods including face to face discussions to ensure support is available to respondents.

8.2 To try and mitigate these risks Shared Lives will utilise a range of consultation and engagement methods (see section 7 above) with all stakeholders to ensure they are fully informed and engaged in the decision making process and to ensure that decisions are informed and valid.

9. EQUALITIES

9.1 Part 1 Equality Impact Assessment has been conducted and consideration will be given to a full Equality Impact Assessment following consultation, and as part of the decision making process / report.

10. CONCLUSION

10.1 The Council faces significant budgetary challenges over the foreseeable future which means it must diversify service delivery by looking at new and innovative approaches to deliver services whilst also reducing the cost of provision. This may also include a cost benefit analysis across the health and social care system identifying where efficiencies can be made. An example can be seen in Adult Services respite provision, currently Cumberland Street respite has no available capacity and costs significantly more than Shared Lives provision. Shared Lives could offer a viable alternative to meet demand.

10.2 Shared Lives supports some of the most vulnerable individuals across the borough to maximise their independence through a family based community support network.

Throughout the service offer Shared Lives carers can support service users to maintain independence in the community and as a support to family carers to maintain their roles. As people progress into long term placements Shared Lives carers offer an asset based approach as a less costly alternative to traditional services. The Shared Lives Scheme is currently in a period transformation to expand the provision to a more diverse range of Service Users and relieve pressure on other provisions. Recruitment of skilled carers is pivotal to these aims.

10.3 This consultation aims to discuss a proposed banded payment system for Shared Lives carers, which ensures the payment made to carers is reflective of the levels of need of the service users in their care, and providing a choice to carers of the amount of assistance they want to, or can, provide at a certain cost.

10.4 A banded payment system will also support the attraction of a larger number of prospective carers to meet the varying degrees of need. There is a need to review the fixed payments that are currently offered to carers, and consider a payment mechanism that is more reflective of the complexity of service users that carers currently support, and could support in the future as we expand our services. It will also support us in recruiting more carers to the service.

10.5 Some individuals may be willing to provide accommodation but not much support while others may be willing and indeed want to provide a substantial amount of support on the basis that the level of support and commitment is financially recognised. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role.

10.6 It is important that we fully communicate and consult with Shared Lives carers, service users and their families regarding these proposals and where appropriate offer support to individuals to fully understand the proposal, and the potential impact on them as an individual in the service. This will be done using various approaches including letters, focus groups, drop-in sessions and individual interviews. All individuals who require additional support to provide their feedback and will be offered assistance.

11. RECOMMENDATION

11.1 As stated on the report cover.

APPENDIX 1

Tameside Shared Lives Scheme Information on Banding Proposal

What is Shared Lives?

Shared Lives, is a regulated form of social care delivered by Shared Lives Carers who are approved by a Care Quality Commission (CQC) registered scheme. The CQC is the independent regulator of all health and social care services in England and monitors and checks all care services to make sure they meet fundamental standards of quality and safety.

The aim of Shared Lives is to offer people aged 18 years and older an alternative and highly flexible form of accommodation and support. Individuals who need support, and choose Shared Lives, are matched with compatible Shared Lives Carers who support and include the person in their family and community life.

All Shared Lives Carers are subject to *Disclosure and Barring Service* (DBS) checks and complete an assessment and approval process, and are required to undertake regular mandatory training. They are paid expenses for the care and support provided.

Service Currently Offered by Shared Lives

The services Tameside MBC Shared Lives currently offers are;

- **Long-term** - This service enables people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families.
- **Interim -** A service user can live with a Shared Lives Carer for up to 12 months. These placements focus on promoting skills and independence, with a view to moving towards more independent living. There is the potential for interim placements to become long term placements after 12 months based on assessed needs.
- **Respite -** A service enabling users to take either regular short breaks or one off periods e.g. to allow for convalescence after a hospital stay or for family members to go on holiday or have a break from their caring role.
- **Day Support -** This is a flexible service enabling people to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home**.**
- **Emergencies** - We may also able to provide emergency respite placements, dependent on Carers available and the needs of the service user.

Current Payment Position

Shared Lives currently has a fixed payment to carers for their services. The service users who are referred to the Shared Lives service vary in complexity of needs and levels of support required. These levels of support are currently not reflected in the current fixed payment. This can lead to carers becoming less incentivised to support service users with complex needs. This is a growing area of need within the borough.

Current fixed term payments to Shared Lives carers are as follows;

Long Term Support	£395.65 per week
Respite Support	£44.45 per night
Day Support (per five hours session)	£34.45 per session

Emergencies and interim payments are determined at the time, and are dependent on the potential length of time required and the type of service.

What are the Proposed Changes?

The introduction of a banded payment system for Shared Lives Carers will enable the Shared Lives Scheme to develop and expand in the knowledge that service users have different needs. The use of banded payment systems has been implemented by eight of the eleven Greater Manchester Schemes and is seen as national best practice. Tameside aims to create a fair and transparent banded system to align with the best practice. The proposal is for an introduction of a four band system that would enable the Shared Lives Scheme to pay carers according to the level of need the service users have which they support.

The bands being proposed are:

- Low needs (Band one).
- Medium needs (Band two).
- Complex banding (based on assessment) for exceptional circumstances (Complex band).
-

It is proposed that banding will be introduced for

- long term,
- respite and
- day support provision

These will be used to calculate the interim and emergency payments

A banding toolkit has been produced, based on best practice guidelines from the national Shared Lives Plus scheme, which will support carers. Initial work to investigate the impact of the banding system on carers shows that most carers will continue to be paid the same / current rate of payment. There will, however, be a small number of carers whose payments will increase or decrease as a result of the proposals.

The proposed payments to carers are as follows:

Day Support

The below bands assume that a session is five hours.

Band One	Band Two	Complex Needs
£35.30 per session	£42.35 per session	£63.55 per session

Respite

Band One	Band Two	Complex Needs
£45.56 per night	£80 per night	£110 per night

Long Term and Interim

	Per week	Per Annum
Band One	£300	£15,600
Band Two	£405.54	£21,088.08
Complex Needs	Discretionary based on individual needs.	Discretionary based on individual needs.

For long term placements there will typically be a respite provision of 21 nights built in, which will usually be provided within the scheme. Carers will not be charged for these respite nights, but may choose to purchase additional respite if required.

Interim Placements

Because interim arrangements are dependent on the potential length of time required, and the type of service, it is proposed that the weekly payments are as above, but will be calculated on a case by case basis.

Emergencies

Emergencies will be paid on the long term or respite rate dependent on anticipated length of placement. In placing an emergency, it is expected that carers will receive the high banding rate until the banding assessment is completed. If the person's banding is lowered after assessment, carers will not be expected to refund the difference.

Service Users

It is important to note that the proposed changes to the payments for Shared Lives Carers will not impact the charging of service users.

Service users will continue to be assessed on their eligible needs, and their contributions are based on a financial assessment (based on Charging Guidelines).

APPENDIX 2

SHARED LIVES CONSULTATION QUESTIONS

QUESTIONS

Q1. Please indicate which of the following best describes your main interest in the Shared Lives consultation (Please tick one box only):

□ I am a Shared Lives Carer (Go to Q2)

□ I am a Shared Lives service user (Go to Q3)

□ I am a relative or friend of a Shared Lives service user. (Go to Q3)

□ I am a member of the public (Go to Q5)

□ I work for Tameside Metropolitan Borough Council / CCG (Go to Q5)

□ Other (please specify below) (Go to Q5)

Q2. Which Shared Lives services do you currently provide? (Please tick all that apply)

□ Long Term - Where people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families

□ Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living

□ Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights,

□ Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home

□ Emergencies – respite or interim provision due to emergency circumstances.

(Go to Q4)

Q3. Which of the following services provided by Shared Lives do you, your relative or friend use? (Please tick all that apply)

□ Long Term - Where people to live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families

□ Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living

 Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights,

 Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home

 Emergencies – respite or interim provision due to emergency circumstances.

 Don't Know

Q4. What impact will the proposed changes to the Shared Lives payment system (i.e. change from a fixed payment to a banded system) have on you as a carer / or on you, your relative or friend who uses the Shared Lives service? (Please state in the box below)

Further information on the proposed changes to the payment system for Shared Lives can be found at (*insert webpage URL here)* or with the letter which accompanied this questionnaire if you received a copy by post

(Go to Q6)

Q5. Do you have any comments you would like to make on the proposed changes to the Shared Lives payment system (i.e. change from a fixed payment to a banded system)? (Please state in the box below)

Further information on the proposed changes to the payment system for Shared Lives can be found at (*insert webpage URL here)*

Q6. Do you have any other comments you wish to make about the Shared Lives Service in general? (Please state in the box below)

ABOUT YOU

Q7. Are you…..?

☐ Male ☐ Female

☐ Prefer to self-describe ☐ Prefer not to say

Q8. What is your age? (Please state)

Q9. What is your postcode? (Please state)

Q10. What is your ethnic group? (Please tick one box only)

White

☐ English / Welsh / Scottish / Northern Irish / British

☐ Irish

☐ Gypsy or Irish Traveller

☐ Any other White background (Please specify)

Mixed / Multiple Ethnic Groups

☐ White and Black Caribbean

☐ White and Black African

☐ White and Asian

□ Any other Mixed / Multiple ethnic background (Please specify)

Black / African / Caribbean / Black British

□ African

□ Carribbean

□ Any other Black / African / Caribbean background (Please specify)

Asian / Asian British

□ Indian

□ Pakistani

□ Bangladeshi

□ Chinese

□ Any other Asian background (Please specify)

Other ethnic group

□ Arab

□ Any other ethnic group (Please specify)

Q11. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? Include problems related to old age. (Please tick one box only)

□ Yes, limited a lot

□ Yes, limited a little

□ No

Q12. Do you look after, or give any help or support to family members, friends, neighbours or others because of either, long-term physical or mental ill-health / disability or problems due to old age? (Please tick one box only)

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

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 May 2018

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

Debbie Watson, Interim Assistant Director of Population Health

Subject: **TAMESIDE POPULATION HEALTH INVESTMENT FUND AND BUSINESS CASE (2 OF 3) - PREVENTING AND MANAGING LONG TERM CONDITIONS**

Report Summary: On 20 March 2018 the Strategic Commissioning Board agreed three priority areas for Population Health Investment –

- 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.

The paper outlines the three business cases within the **Preventing and Managing Long Term Conditions** workstream focusing on.

- Tobacco – Making Smoking History in Tameside;
- MacMillan GP in cancer prevention and care;
- Campaign and Social Marketing Programme – Find, Diagnose and Treat.

Recommendations: The Strategic Commissioning Board is asked:

- To agree the proposals set out in the business cases.
- To agree investment outlined in section four of the report:
  2017/18 - £313,401
  2018/19 - £329,751
  2019/20 - £190,000

Financial Implications:

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

ICF Budget	**£'000**
Tameside Council – Population Health Section 75 Strategic Commissioning Board	3,004
Additional Comments The proposed priority areas for investment as outlined in the report will be resourced via the non-recurrent Population Health reserve of £ 3.004 million. It is essential that robust performance monitoring arrangements are implemented to ensure the aims of the investment are realised and the proposed impact is incorporated within the Medium Term Financial Plan of the Strategic Commission	

Legal Implications:

(Authorised by the Borough Solicitor)

The Board should be satisfied that the proposals for investment represent value for money and on balance demonstrate that they will successfully prevent and manage longterm conditions.

How do proposals align with Health & Wellbeing Strategy?	The proposals and strategic direction are consistent and aligned.
How do proposals align with Locality Plan?	The proposals are aligned to the locality plan. The proposals are consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Locality-based services.
How do proposals align with the Commissioning Strategy?	The proposals are aligned to the Commissioning strategy. The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person;' • Target commissioning resources effectively.
Recommendations / views of the Health and Care Advisory Group:	The Health and Care Advisory Group was supportive of the proposals.
Public and Patient Implications:	Public and patient implications have been considered for each of the proposals included in the document.
Quality Implications:	A quality impact assessment has been completed
How do the proposals help to reduce health inequalities?	The proposals will have a positive impact on health inequalities. The proposal seeks to reduce health inequalities, target the resources to where most needed and ensure services are accessible to all.
What are the Equality and Diversity implications?	An Equality Impact Assessment has been completed on this proposal. It is not anticipated that the proposal will have a negative effect on any of the protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	There are no anticipated safeguarding implications. Where safeguarding concerns arise as a result of the actions or inactions any providers and their staff, or concerns are raised by staff members or other professionals or members of the public, the Safeguarding Policy will be followed.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. Any procured service will include minimum requirements for training and qualification of interpreters which includes standards and requirements for information governance, privacy and respect.
Risk Management:	A detailed risk log will be managed as part of the implementation following approval of the proposal.
Access to Information :	The background papers relating to this report can be inspected by contacting Debbie Watson, Interim Assistant Director of Population Health

Telephone: 0161 342 3358

e-mail: : debbie.watson@tameside.gov.uk

1.0 PURPOSE OF REPORT

1.1 On 20 March 2018 the Strategic Commissioning Board agreed three priority areas for Population Health Investment resourced via the non-recurrent Population Health 'ring fenced' reserve of £3.004 million. These were:

Priority 1: Delivering our new approach to Early Help for Children and Families;
Priority 2: Improving Mental Health and Wellbeing in our neighbourhoods; and
Priority 3: Preventing and Managing Long Term Conditions.

1.2 The proposals around Priority 1: the new approach to Early Help for Children and Families were agreed on 20 March allocating £1.2M aimed to ensure a move from reactive service provision, based around responding to accumulated acute needs, towards earlier intervention via targeted interventions, where problems can be addressed before they escalate taking a holistic whole family approach based on early intervention and prevention.

1.3 This paper outlines three business cases within the **Priority 3:** Preventing and Managing Long Term Conditions workstream focusing on.

- Tobacco – Making Smoking History in Tameside;
- MacMillan GP in cancer prevention and care;
- Campaign and Social Marketing Programme – Find, Diagnose and Treat.

1.4 The business case for the Lung Screening programme will be presented separately to a future Strategic Commissioning Board for decision.

2.0 BACKGROUND

2.1 Key messages to ensure maximum health impact include:

- Benefits can be derived from preventative approaches both in terms of improved outcomes for people and communities and reduced demands on public services;
- A high proportion of premature death, illness and health care demand is preventable;
- This burden falls more on the poorest, where prevention should be focussed and should start younger;
- The system together can make a significant contribution to prevention efforts.

2.3 The funding is ring fenced public health grant reserve. The public health grant is provided to enable local authorities to discharge their duty to improve the public's health. Statutory guidance states public health funding will be invested towards:

- Improving the health and wellbeing of local populations;
- Delivering and assuring health protection and health improvement responsibilities delegated from the Secretary of State;
- Reducing health inequalities across the life course, including within hard to reach groups;
- Improving healthy life expectancy; and,
- Ensuring the provision of population healthcare advice.

2.4 A recent review of premature mortality by the Health and Wellbeing Board aligned priorities outlined in the Joint Health and Wellbeing Strategy, agreed that the Board should consider an Action Plan for 2018/19 to strengthen the local drive towards a place-based approach to reducing early deaths, improving healthy life expectancy and delivering sustainable reductions in health inequalities, in order to realise our ambition to bring health experience in Tameside line with regional and national averages.

2.5 The focus is on the continuing importance of early identification of circulatory and respiratory disease and cancers, our 'big killer' to enable effective self-care and treatment to reduce further illness and mortality. The proposed approach endorses the current Locality Plan and RightCare priorities.

3.0 INVESTMENTS

Investment 1: Making Smoking History in Tameside

3.1 Reducing smoking prevalence is a key objective in the Greater Manchester Population Health Plan, the Greater Manchester Tobacco Strategy, the Greater Manchester Cancer Plan and Tameside's Health and Wellbeing Strategy. As smoking is the biggest cause of ill health and early death in the borough, it is central to the vision of the Strategic Commission to improve the population's health.

3.2 The ambition for a Smokefree Tameside is to make faster progress towards becoming a smokefree borough, to meet Greater Manchester ambitions to achieve a smoking prevalence of 13% for adults and 5% for 15 year olds by 2020/21. To achieve these ambitions we need to considerably scale up investment and commitment to tobacco control in Tameside across all partners.

3.3 Tameside has the highest smoking prevalence rate (22.1%) in Greater Manchester, and the second to highest in the North West region. Smoking is the biggest cause of ill health and premature death in the population, and a major contributor to health inequalities. There are about 24,952 households in Tameside with at least one smoker. When net income and smoking expenditure is taken into account, 7,941 or 32% of households with a smoker fall below the poverty line[1]. f these smokers were to quit, 3,088 households in Tameside would be elevated out of poverty.

3.4 In the North West, Tameside ranks 6th highest for smoking attributable mortality, including 5th highest for deaths from lung cancer and 4th highest for smoking attributable deaths from heart disease. Care Together will not realise its ambitions to improve the health of the population, reduce health inequalities and reduce health and social care costs unless tobacco control is invested in as a strategic top priority. It is estimated that smoking costs the Tameside economy £73.4 million, including £10.1 million to the NHS and £7.6 million in social care.

3.5 Smoking in pregnancy rates have been steadily declining over recent years to 15.4% in 2016/17. This decline has been contributed to by the work of a Midwife-led stop smoking service. However, in 2017-18 the rate has increased slightly to 15.9%, indicating that more work needs to be done to support pregnant smokers. The local rate is still significantly higher than the England average of 10.7%. The Greater Manchester tobacco strategy target is to reduce smoking in pregnancy rates to 6% across Greater Manchester by 2021 (now 12.8%). This is therefore a key priority in Tameside's tobacco control plans. Reducing smoking in pregnant women not only contributes to reducing smoking prevalence in the adult population, but also reduces risk for the unborn child and protects the subsequent infant and developing child from second hand smoke and from being at higher risk of becoming a smoker itself.

3.6 The current public health budget funds one part time midwife. Whilst that worker has achieved some important outcomes, further resource is needed to increase engagement with the pregnant women who smoke.

3.7 Whilst it is impossible to assess the current volume of illicit and illegal tobacco sales in Tameside due to its very nature, the Trading Standards team regularly find evidence of illicit

[1] The Poverty measure used is the 'before housing costs' relative measure

and illegal material which is then confiscated. Tackling the supply of such tobacco is a key strand in Tameside's tobacco control plan and is essential in reducing the supply of cheap tobacco to children, young people and adults.

3.8 This proposal has three strands:

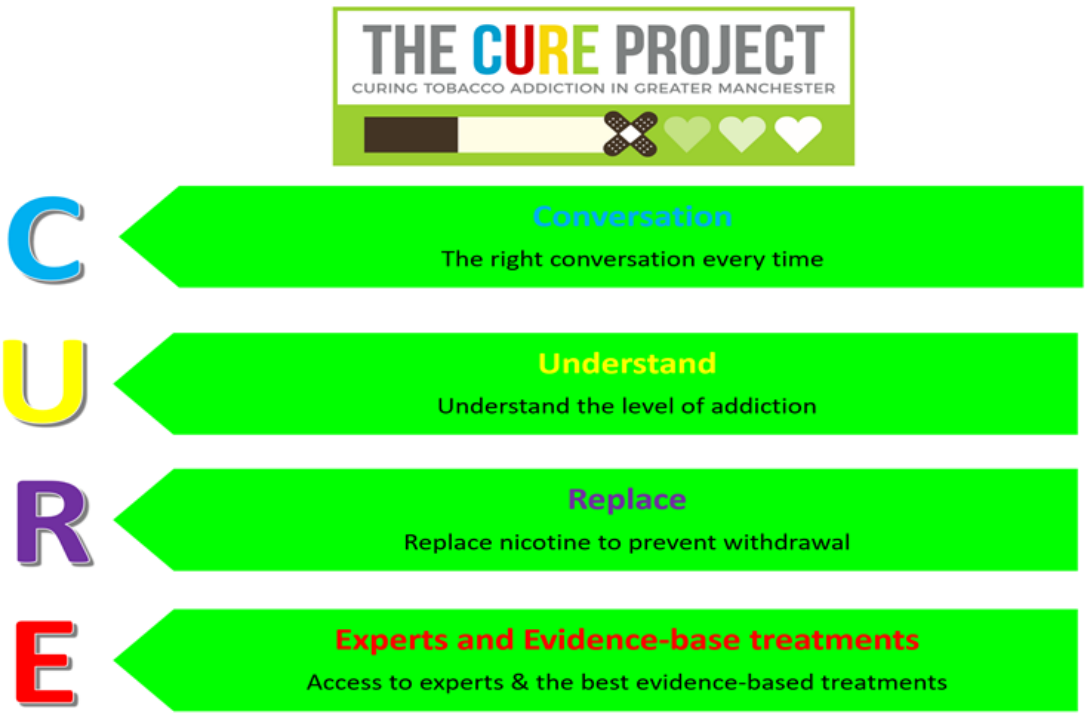
1. Piloting a nurse-led stop smoking/tobacco addiction service in Tameside & Glossop Integrated Care Foundation Trust (CURE pilot);
2. Increasing the capacity in the midwife-led stop smoking service;
3. Providing additional resource to tackling illicit and illegal tobacco.

(1) Developing a nurse-led stop smoking/tobacco addiction service (CURE pilot) in Tameside & Glossop Integrated Care Foundation Trust (ICFT)

3.9 In 2016-17 there were 2,885 incidents of smoking attributable hospital admissions in Tameside, which represents the sixth highest rate in the North West.

3.10 Helping someone to become smoke free is the single most cost effective intervention provided by the NHS and is 1/25th the cost of statins. This proposal outlines additional investment needed to pilot a new tobacco control scheme within Tameside & Glossop Integrated Care Trust which will learn from the CURE programme being developed in Wythenshawe Hospital (University Hospital South Manchester) by Dr Matthew Evison, Director of the Lung Pathway Board for Greater Manchester and a Cancer Consultant in Respiratory Medicine.

FIG 1: The CURE Programme: curing tobacco dependency in the hospitals of Greater Manchester.



3.11 The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. Its aim is to systematically identify all active smokers admitted to secondary care and immediately provide nicotine replacement therapy for the duration of the admission. This is supplemented by a consultation with an expert tobacco addiction team to construct a long term treatment plan after discharge.

3.12 The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment. There is strong evidence that secondary care represents a unique teachable moment when a smoker is admitted to hospital to seed the concept of a quit attempt and achieve successful long term abstinence. Data from Canada has demonstrated that comprehensive secondary care treatment programmes for tobacco addiction deliver immediate and highly significant reductions in admission rates and mortality.

3.13 Objectives of the Tameside project would include:

- Every health care professional is aware of the smoking status of every patient they care for;
- Every health care professional has the competence and confidence to offer help to stop smoking through direct action and referral;
- Every patient has access to the best available treatments and expert support to treat this disease;

3.14 Whilst Tameside figures need to be estimated, the CURE programme is based on the Ottawa model of smoking cessation which saw:

- Increase quit rates by 11%;
- At 30 days post discharge: 50% of patients are less likely to be re-admitted & 30% less likely to attend A&E;
- At 2 years post-discharge: 21% of patients are less likely to be re-admitted and 9% less likely to attend A&E;
- 40% reduction in the risk of death over 2 years.

3.15 A new nurse specialist-led tobacco addiction team would contribute to the local ambition to reducing smoking prevalence by supporting smokers who are accessing hospital services to quit. The team will establish referral systems from each department of the hospital and provide 1-2-1 quit support for all patients except pregnant women. The team would learn from the model of the alcohol addiction nurse practitioners in the Hospital Alcohol Liaison Service (HALS) team and from the Stop Smoking Midwife to establish strong and effective links with all hospital departments, resulting in a full case load of patients receiving stop smoking support whilst they are in and after they have been discharged from hospital. Patients would be referred on to 'Be Well Tameside' for continued support where appropriate.

(2) Increasing the capacity in the midwife-led stop smoking service

3.16 This project aims to expand the successful midwife-led service to further reduce smoking in pregnancy rates by supporting more pregnant women to quit smoking. The project will also prepare for and support the additional workload that will be required from the local delivery of the Greater Manchester tobacco strategy's Baby Clear and incentive scheme.

3.17 An additional full-time stop smoking midwife will provide additional capacity to the existing part-time stop smoking midwife (already funded by public health) to engage more pregnant women who smoke. It would also provide additional capacity to implement the GM tobacco strategy initiatives of Baby Clear and the incentive scheme, and managing the full-time Midwifery Support Worker which will be commissioned by the GM tobacco strategy team.

(3) Scaling up activity to tackle illicit and illegal tobacco

3.18 Sustained action is needed to reduce the supply of and demand for illegal tobacco, which is cheap and unregulated. Its low price undermines high taxation which is key to encouraging cut-downs and quits (the World Bank estimates a 10% price rise leads to c4% less consumption).

3.19 The illegal tobacco trade also makes it easier for children to start and keep on smoking, and is linked to low level and organised crime. As Tameside has high youth smoking rates, it is highly important that illicit and illegal tobacco continues to be tackled and the supply

reduced wherever possible. Smoking prevalence amongst 15 year olds in Tameside is 11.8% which is the second highest rate in the North West, the highest in Greater Manchester[2] and is significantly higher than the national and regional average. Smoking prevalence amongst 15 year old girls is 16.1% and is the fifth highest rate in England.

3.20 Detection dogs are a highly effective method of identifying illicit and illegal tobacco during retail inspections carried out by Trading Standard officers. Due to the speed at which detection dogs can identify tobacco in premises, the rate of inspection that a Trading Standards officer can carry out in one day is at least trebled.

Return on Investment

3.21 Every £1 spent on smoking cessation, saves £10 in future health care costs and health gains according to the NICE tobacco return on investment tool.

3.22 Smoking cessation interventions are considered among the most cost-effective available in the health care sector[3] and are a key component of tobacco control strategies because they offer smokers their best chance of quitting[4]. However, numbers of people contacting the core stop smoking services in Tameside and across the country have steadily declined over recent years. Therefore a more proactive approach to engaging and referring smokers needs to be put in place.

3.23 Nationally it is estimated that 25% of patients in acute hospitals are smokers – a far higher rate than national average. For people accessing secondary care services there are additional advantages of quitting, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, decreased infections and fewer readmissions after surgery.

3.24 Whilst Tameside figures need to be estimated, the CURE programme is based on the Ottawa model of smoking cessation which saw:

- Increase quit rates by 11%
- At 30 days post discharge: 50% of patients are less likely to be re-admitted & 30% less likely to attend A&E
- At 2 years post-discharge: 21% of patients are less likely to be re-admitted and 9% less likely to attend A&E
- 40% reduction in the risk of death over 2 years

3.25 Both the nurse specialist and midwife teams will use a standard 4-week quit measure plus other metrics (such as signing up to smokefree homes) as evidence of success. This will be backed up by the annual publication of smoking prevalence and smoking at time of delivery (SATOD) data by Public Health England in which a declining trend would be expected.

3.26 Public spending on tackling illicit tobacco shows a return on investment of about 10 to one[5] which suggests a sound economic rationale for further investment into this part of the local tobacco control plan. Success will be measured by the increase in weight and sticks of illegal tobacco that is confiscated as a result of inspections made accompanied by a detector dog compared to previous years. A visible increase in detector dog visits is also likely to have the benefit of providing a disincentive to traders to deal in illegal tobacco.

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[2] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132900/pat/6/par/E12000002/ati/102/are/E08000008/iid/91552/age/44/sex/4

[3] http://www.ncsct.co.uk/usr/pub/B7_Cost-effectiveness_pharmacotherapy.pdf

[4] http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf

[5] http://www.gmhsc.org.uk/assets/Tobacco-Free-Greater-Manchester-Strategy.pdf

Investment 2: Macmillan Gp In Cancer Prevention And Care

3.27 Cancer is the leading cause of premature death in Tameside and Glossop. We have a relatively high number of cancers detected late, and consequently reduced survival rates, compared to the England average and other areas across Greater Manchester. One of the challenges we face in Tameside and Glossop relates to early diagnosis of cancer.

3.28 A key role to supporting delivery of the Cancer Agenda is the Macmillan GP as they can help to influence commissioning decisions and improve engagement around cancer. Macmillan provide grants to enable Clinical Commissioning Groups to employ Macmillan GPs, this role is seen as pivotal to the commissioning of Greater Manchester and local cancer services, pathways and new models of care as they are able to provide primary care clinical leadership to:

- influence the development of cancer services establishing relationships with a wide range of stakeholders including local GP commissioning leads, secondary care colleagues, specialist services for cancer and end of life care;
- improve patient experience, patient satisfaction and quality of care for people living with and beyond cancer and people affected by cancer;
- inform and influence the delivery of care for cancer patients, and to influence local GP peers as widely as possible in driving up standards of cancer care in primary care;
- work in partnership with key stakeholders to influence and facilitate change and improve delivery of care (across Health and Social Care, voluntary organisations at all points of care along the pathway) and local cancer services;
- enable a culture of change through communication, motivation, support and education of GP peers and other local stakeholders;
- raise the profile of cancer in primary care and encourage / facilitate uptake of models of good practice;
- ensure national and Greater Manchester strategies delivered within the locality.

3.29 The Macmillan GP has proven to be a vital link:

- facilitating training, education and development within primary care and ensure knowledge exchange sessions between wider stakeholders;
- enhancing the knowledge and skills of primary health care teams in providing care to cancer patients with regard to early diagnosis, pathways of care, symptom control and supportive and end-of-life care to ensure the delivery of optimal care as well as early recognition of needs at all stages of the cancer pathway;
- enhancing knowledge and provision of information on the availability of services to cancer and palliative care patients and routes of access to services within the locality;
- enabling cancer patients to have a greater understanding of their condition, treatment and navigation of the services and support available to them (including self-management);
- supporting the use of and roll-out of National, Greater Manchester and Macmillan programmes;
- representing patient views and opinions and ensure equity of service.

3.30 The CCG was awarded a grant from Macmillan to fund a Macmillan GP for two years with an understanding that, pending evaluation, the CCG had intentions to fund this post beyond this period (this is the usual Practice for grants given by Macmillan). Details of the amount contributed by Macmillan are included in Table 1 below.

3.31 To ensure equity of pay to other clinical posts within the CCG it was agreed in 2014-15 (via the Planning Implementation & Quality Committee, and Governing Body) that the CCG would invest Palliative Care Multi-Professional Education & Training funds (allocated to the locality by the Strategic Clinical Network) to supplement Macmillan funding for two sessions per week (for 49 weeks per year) at £350 per session plus 26% on costs for pension

contributions etc. In additional Macmillan agreed to additional resources to cover training and educational events and travel expenses. This total contribution is shown in table 1 below:

Table 1	Cost per annum
Grant received per annum from Macmillan (2 sessions per week at £202.55 per session plus travel expenses)	£19,850
Contribution from the CCG (from Multi-Professional Education and Training funding)	£23,401
The annual cost of the Macmillan post including pay award to be received in January 2018 (£353.50 per session)	**£43,251**

3.32 A GP (Dr Mary Ann O'Mara) was appointed to this post and commenced on 01 June 2016 following a period of maternity leave. Dr O'Mara is paid by on a fixed 'Contract of Service' with the CCG, part funded by the CCG and part Funded by Macmillan. Macmillan funding is for 24 months on a sessional basis as per the other clinical leads within the CCG. The Macmillan GP reports into Dr A Lea, clinical Lead for the CCG. The CCG will carry out an annual appraisal, ensuring they meet their terms and conditions of employment.

3.33 The key objectives of the role are to:

- support primary care staff to optimise early identification of cancer and patients who may be approaching the last year of their lives;
- collaborate with providers in primary care, secondary care, CCG, public health, the voluntary sector and wider health and care community teams, supporting them to develop quality services;
- provide education to enhance skills in cancer and palliative care across NHS Tameside and Glossop CCG;
- work with the CCG to influence local commissioning decisions around cancer, palliative and end of life care pathways, aligned to national priorities;
- identify and promote good clinical practice and systems.

3.34 **Achievements:** The Macmillan GP is a member of the Tameside & Glossop Cancer Board, and a number of locality groups supporting delivery of the GM Cancer Plan in the locality. Achievements to date include:

- Extensive working with Tameside & Glossop Integrated Care Foundation Trust (ICFT) and other partners around development of referral pathways to improve early diagnosis of cancer.
- Good working relationships established between Primary, Secondary Care and other stakeholders which will enable better communication going forward and enable key work in Significant Event Analysis (SEA) to support delivery of improvements.
- Providing support of the implementation of the Recovery Package to ensure high quality care for patients living with and beyond cancer.
- Providing advice to practices on improving their cancer diagnosis and care, including via the Primary Care Quality Scheme.
- Working with other sectors in the locality around cancer prevention.
- Represent the CCG, ICFT and Primary Care, working with ICFT and other partners on Living With and Beyond Cancer agenda (referral and stratified follow up pathways) and key to developing a locality response and action plan to the Greater Manchester Cancer Plan.
- Exceeded the target of 60% with 75% of GP Practices signed up to Gateway C (the Greater Manchester / Christie School of Oncology online GP education portal) by the end of October 2017 (the next phase will include completion of the online Primary Care education learning tool).

- To identify solutions that reduce local inequalities, ensuring services are appropriate and considerate to the needs of the individual (to ensure none of the protected characteristic groups are disproportionately affected); for example tackling poor uptake of cancer screening for people with Learning Disabilities and ensuring this is addressed in the strategy plus working with Be Well Tameside and Hyde Community Action to increase screening uptake among Black and Minority Ethnic groups.
- Represent the CCG and Primary Care on the Greater Manchester Pathway boards for Acute Oncology and Living With and Beyond Cancer (LW&BC).
- Address specific queries from GPs to improve patient experience and support.
- Helping to establish a voice locally and in the wider Greater Manchester cancer community via the Macmillan GP network but also within Greater Manchester Cancer itself. Particularly around Acute Oncology and LW&B.
- Building up relationships with GPs and becoming established as a contact point for queries around cancer, described by one GP as 'very supportive and proactive' in their cancer audit report which they shared with the GP and therefore moved to a good position to influence.
- Undertaking GP education Target sessions
- Developing and circulating the neighbourhood cancer data packs, which identified areas for improvement within each practice; in August 2017 this data was also used to highlight possible improvement areas (which also supports Right Care data). Information, advice and support provided from the Macmillan GP aimed to reduce practice and neighbourhood variation.
- Successful application for a £1000 grant from Macmillan to deliver an event for GPs on improving cancer diagnosis through Significant Event Analysis – which will follow on from the Knowledge Exchange event (24 January 2018).
- Delivering the three day Macmillan Practice Nurse Cancer course (supported by Macmillan) – which enables PNs to broaden their chronic disease management skills to care for patients living with and beyond cancer. Also to equip PNs to carry out Cancer Care Reviews as part of the roll out of the Recovery Package.
- Key to developing a local Lung cancer screening pilot.
- Key to developing a pilot for Direct Access breast lump referrals within the Stalybridge Neighbourhood.
- Key to reviewing, developing, implementing and embedding an agreed suspected cancer colorectal pathway (including straight-to-test) and also routine STT lower and upper GI pathways.
- Established as a clinical lead in this area and helped to bring together key stakeholders across boundaries to move forwards in developing the locality Palliative care service.
- A series of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) events were held for GPs to coincide with the launch of the 'lilac form' at Tameside ICFT at the end of May. The aim of the sessions was to refresh knowledge of the guidance around DNACPR decision making, and to discuss difficult cases. Over 46 people attended the training which were held at a variety of venues (details available if requested).

3.35 The proposal is to continue to fund the post. Macmillan have stipulated that this role is essential if they approve funding (up to £635,000) for a 2 year pilot (outline pilot, provisionally approved at stage 3) aimed at influencing and improving care and support in primary and community care for People Living With Cancer and People Affected By Cancer (PLWC/PABC). The role is seen as key to clinically leading the development and implementation of this pilot.

3.36 In addition to ongoing membership of the locality's Cancer Board and Cancer Strategy group(s) commissioners have worked alongside the Macmillan GP to develop a work plan for 2017/18 (to June 2018), to include:

- Improving Early Diagnosis of Cancer in Tameside & Glossop (e.g. GP endorsed letters for all Bowel screening invites from the central hub, teaching around NICE guidelines).

- Review cancer risk prediction tools and implement e.g. Q Cancer Prediction tool.
- Be aware of recurrent themes in delayed diagnosis and consequently emergency presentations; barriers to diagnosis and early diagnosis.
- Targeted communications to practices around awareness campaigns to include promotional material and link in with Be Well campaigns.
- Set up a cancer champion in each surgery (clinical and clinical administrative role) to link with Macmillan information points and Greater Manchester cancer champions.
- Support development of practices level data packs with up to date Public Health England data to show variation in screening, 2 week wait (2ww) referral data, emergency presentations (Correlate any additional themes, recommend solutions) and use this to support practices to identify areas for improvement and to reduce local variation.
- Share information as it becomes available to keep practices informed and encourage feedback (e.g. Share Cancer Research UK (CRUK) patient survey results with GPs to get their thoughts on issues around early diagnosis; National Cancer Diagnosis Audit (NCDA) to look at practice level, regional and national learning and Primary Care Cancer (RCGP QI) Toolkit provides a collection of key evidence-based resources about cancer prevention, diagnosis and care relevant for the primary care setting).
- Support Practices to ensure they complete the modules on Gateway C and other e learning events (Cancer Research UK to support).
- Explore the role and implications of the Genetics service provision (breast/bowel initially).
- Provide two way feedback between Primary and Secondary Care (for example on Cancer Care Reviews) to share good practice and improvements made so far (this includes individual cases) and keep them informed of any developments. Develop dedicated section of the website.
- Prospectively review all patients who are diagnosed with cancer via an emergency admission at ICFT and collate themes for learning.
- Encourage GPs to complete SEAs on patients who have had delayed diagnosis and emergency presentation, analyse SEAs and share learning at a Macmillan funded event.
- Support Implementation of the Recovery Package as recommended both nationally and as part of the GM cancer plan.

3.37 It is proposed that the post is managed by the Governing Body GP member responsible for 'Ageing Well' and that a formal process of objectives and appraisals is in place, supported by the appropriate officer(s) in the commissioning directorate and with input from Macmillan.

Investment 3: Campaigns And Social Marketing Programme – Find, Diagnose And Treat

3.38 Social Marketing utilises traditional advertising media to 'sell' a concept or idea to drive social change. Social marketing is the use of commercial marketing techniques to,
"*Increase the acceptability of a social idea, cause or practice amongst a target audience"*
(Kotler, 2005)

3.39 Evidence shows it offers an impactful and cost-effective evidence-based methodology for driving behaviour change around public health issues. Public Health England in partnership with local authorities has led the field across government in taking tools and techniques from independent sector marketing and repurposing them for the public good, designing marketing programmes that have already changed the behaviour of millions of people, to drive health improvement as a means of prevention of illness, and to promote knowledge of symptoms with a view to early detection of disease.

3.40 It is proposed that sustain and develop the current social marketing programmes which allow identification of the 'missing thousands' from current disease registers in primary care, using risk stratification and insight. All programmes will seek to ensure residents:

- are engaged with their own health and wellbeing;
- understand how their lifestyle choices impact on their current and future health outcomes (and, in the case of parents, their children's health outcomes);
- can obtain sound advice about what constitutes a healthy lifestyle, and
- have access to appropriate services, products and tools to support and help them change their behaviour.

3.41 The campaigns will involve the identification of risk factors related to the development of Cardiovascular Disease, COPD and Cancer, including smoking, high blood pressure and physical inactivity. Proposed campaigns are:

1) #Check It! Hypertension campaign

The #Checkit campaign has ran in Tameside for 3 years and the proposed funding would scale up the existing investment. The rationale for the campaign is as follows;

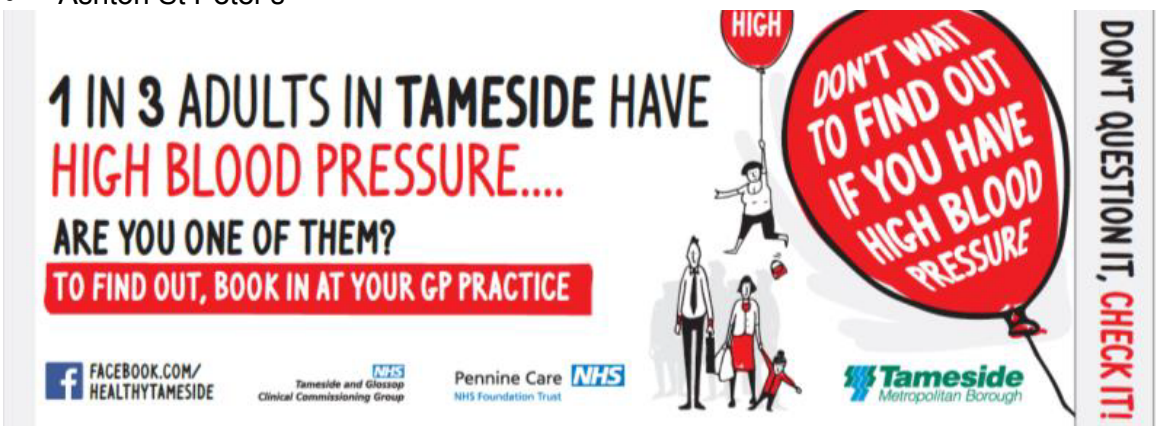
- 29.9% of people are estimated to have high blood pressure in Tameside &Glossop.
- 38,788 were known to their GP (via registers) in March 2017
- We are hoping to find some of the other 22,714 people currently undiagnosed
- We had identified 2887 more people with hypertension in the three years up to March 2017.

The campaign is intended to identify the missing 14% of Tameside residents who have hypertension. This is with the intention of ensuring those at risk receive a diagnosis, are treated and monitored, and their conditions managed. It is also to raise awareness of the steps residents can take to self-monitor and maintain their own blood pressure as a preventative measure.

The campaign is aimed at Tameside residents aged between 40 and 74. In particular those at increased risk of developing hypertension, which includes those who are overweight and/or smoke

The campaign will focus in the areas that are known to have higher prevalence of hypertension. This includes the following wards;

- Denton West
- Hyde Godley
- Longdendale
- Ashton Waterloo
- Ashton St Peter's



2) Love your Lungs Campaign

The aim of this campaign is to raise awareness of the signs and symptoms of Respiratory Disease (COPD) through community awareness events, encouraging early diagnosis and treatment.

The objectives of the campaign are:

- To increase awareness of the signs and symptoms of respiratory disease particularly COPD among the local population.
- To identify people who may have undetected COPD by providing lung function testing in the community.
- To refer people onto their GP for further testing if the test shows a low predicted FEV1% value (<80% for their age, height, ethnicity and gender).
- To uncover undiagnosed COPD patients and increase early diagnosis of COPD.
- To signpost to British Lung Foundation support services including our BLF helpline and local Breathe Easy groups.
- Provide access to local smoking cessation services to help residents access support to change their smoking behaviour.

The *Love Your Lungs* campaign was piloted during the month of November 2017. It included stakeholder engagement, media and digital work and 5 community screening events.

A minimum of 10,000 flyers, 10,000 COPD publications, and 1000 event posters were distributed to stakeholders across Tameside.

Community screening events

- 5 community events were delivered in supermarkets and markets in areas of Tameside with high prevalence on COPD.
- 620 people were screened for COPD by a health care professional using handheld spirometry.
- 125 people were referred onto their GP for further testing due to a low predicted FEV1% value (<80% for their age, height, ethnicity and gender).
- Information packs were given to everyone screened at an event. Information packs included information on COPD, lung health and disease.
- 79% of people found this information useful.

Impact

Awareness of COPD

20% (n=125) of screened participants took part in the campaign evaluation:

- 75% were more aware of COPD as a result of attending an event.
- 79% of people stated they now knew the signs and symptoms of COPD.
- 93% of people said they would now visit their GP if they developed any of the signs and symptoms of COPD.

Diagnosis

- 63% of people referred had visited their GP for further investigation.
- 25% intended to visit their GP.
- 61% of people who visited their GP had been offered further tests.
- 9% of those that visited their GP reported receiving a respiratory condition diagnosis.

Smoking status

- Current smokers made up 18% of the screened population.
- Be Well Tameside smoking advisors were present at all events.
- 16 of current smokers who attended an event were referred to Be Well Tameside at the events

The proposal is to upscale this campaign and to embed FEV1% testing (in particular for smokers) into Be Well, Active Tameside and NHS Health Check programmes.

3) Don't Be the One – Greater Manchester stop smoking campaign
http://www.dontbethe1.tv/
'Don't Be The 1' is a large-scale tobacco behaviour change campaign that launched across Greater Manchester in February and March 2018 by the GM Health and Social Care Partnership (GM H & SCP). It seeks to deliver a hard-hitting message that at least one in two long term smokers will die from their habit, balanced with a positive, empowering call to action that if you quit you can beat those odds.

The campaign focuses on a TV advert, complemented by paid-for digital advertising, social media activity and a website offering information and support. The GM H & SCP is also asking localities to amplify the 'Don't Be The 1' message by promoting the campaign via networks, finding case studies/stories to support content and PR effort and order print and digital materials for distribution through your channels. The proposal is to amplify the campaign.

4) Physical Activity Social Marketing Programme
The evidence base for the preventative effects of physical activity on ill health, disease and premature mortality is exceptionally strong. The biggest gains and the best value for public investment are found in addressing the people who are least active, and mobilising them for 30 minutes per week.

A local social marketing campaign is required to address the challenge of physical inactivity in Tameside. It is pertinent here to outline that physical activity for the purpose of this campaign is not solely sport in leisure centre settings, but covers sport in any setting, as well as active travel (walking, cycling), and physical activity for leisure and social purposes. It is also pertinent to outline that the benefits of physical activity are not solely physical, but are also mental and emotional.

The Physical Activity Campaign will have two aspects of delivery. Phase one will be the creation of a bespoke campaign targeted at specific audiences. It is proposed these are:

- Women and girls under 44 years of age;
- People with a long term condition.

The Population Health Investment will fund:

- The development of a creative brief to develop a bespoke campaign for physical activity in Tameside.
- Determination of a detailed audience profile to feed into the creative process.
- The creation of an appropriate local look and feel through a suite of branded/recognisable audiovisual resources (photography, video on demand etc). This may involve local case studies in Tameside settings/locations.
- Fully integrated strategic comms campaign plan driven by Tameside Active Alliance.

5) Be Clear on Cancer
Be Clear on Cancer campaigns aim to improve early diagnosis of cancer by raising public awareness of signs and/or symptoms of cancer, and to encourage people to see their GP without delay. The programme is led by Public Health England, working in partnership with the Department of Health, NHS England and Cancer Research UK. Be Clear on Cancer has been developed for bowel, lung, breast, blood in urine (as a symptom of bladder and kidney cancer), oesophago-gastric and ovarian cancers. An additional breast cancer campaign specifically for women over 70 years and a cancer symptoms campaign called 'Know 4 sure' have also been developed. The proposal is to upscale and locally target these campaigns.

3.42 These social marketing campaigns do have the potential to increase demand in primary care, in particular the targeted hypertension campaign and the Love Your Lungs which have a clear 'call to action' to see a GP. It is appropriate that people with diagnosed

conditions are supported and have access to the annual review processes and wide range of self-care and social prescribing support where appropriate. In acknowledgement of this, it is proposed that some of the social marketing budget is allocated to support each neighbourhood to build capacity in the appropriate areas. This could be by also funding spirometer training for example, or equipment or increasing neighbourhood capacity to carry out any tests needed for diagnosis. Certain results will then lead to use of existing protocols and pathways, e.g. hypertension guidelines. Clear administrative and clinical pathways will need to be developed. The Strategic Commission's Commissioning Directorate (including Primary Care Commissioners) will work with the Public Health team to develop the detail of the 'diagnose and treat' pathways to ensure the effects of the social marketing programmes are optimised and are translated into demonstrable improvements in terms of recorded prevalence and effective management. This will therefore ensure delivery of improved support and care for the population described in this report, investing as required to deliver effective diagnostic and treatment pathways, to include support from the locality's self-care and social prescribing opportunities.

3.43 **Impact:** Demonstrating evidence of effectiveness is integral to the social marketing programme to assure quality and effectiveness. Each programme has KPIs and will develop a full evaluation within six months, with individual business cases, including SMART communication objectives, aligned to policy, our strategic approach, evidence of effectiveness and a comprehensive evaluation plan with key performance indicator targets. All programmes will follow PHE Marketing evaluation framework to ensure to maximise return on investment for all campaigns.

4.0 VALUE OF THE PROPOSAL

4.1 The Population Health Investment funding is non-recurrent, and a key consideration is the sustainability of the interventions recommended for approval.

4.2 Rigorous evaluation of the outputs and outcomes from the prevention interventions will enable an assessment of the value to the health and social care community of different approaches. The proposals will be evaluated and monitored and reported back to the Strategic Commissioning Board.

4.3 The total value of the proposal to prevent and manage long term conditions is £313,401 in 2018/19, £329,751 in 2019/20 and £190,000 in 20-21. Total non-recurrent investment over three years is £833,152. Details for the three investment programmes are as follows:

Priority 3: **Preventing and managing long term conditions – find, diagnose and treat**			
	Yr 1	**Yr2**	**Yr3**
Tobacco - Making Smoking History	£190,000	£190,000	£190,000
MacMillan GP in cancer prevention and care	£23,401	£43,251	
Social Marketing/ Comms programme – Find, diagnose and treat	£100,000	£96,500	
Total	**£313,401**	**£329,751**	**£190,000**

5.0 DELIVERY / PROCUREMENT APPROACH

5.1 Investments two and three are both within in-house teams and as such there are no procurement issues to address.

5.2 Investments one requires a three year contract variation to be implemented within the Standard NHS contract that the Strategic Commission has with the ICFT.

6.0 RECOMMENDATION

6.1 As set out on the front of the report.

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 May 2018

Officer of the Single Commission Jessica Williams, Interim Director of Commissioning

Subject: **MENTAL HEALTH NEIGHBOURHOOD DEVELOPMENTS BUSINESS CASE**

Report Summary: This business case is prepared to request investment in two neighbourhood mental health developments in line with the Mental Health Investment agreed by the Strategic Commissioning Board in January 2018.

Section 2 outlines the proposed ambitions for 2018/20.

Section 3 details two developments which require additional investment:-

1. Mental Health in the Neighbourhoods: 101 Days for Mental Health Project to co-produce a new model of mental health support
2. Dementia Support in the Neighbourhoods – increasing dementia practitioner capacity

Recommendations: The Strategic Commissioning Board is asked to endorse the proposed ambitions and agree to the two proposals for investment as follows:-

Proposal	**Investment**
101 Days for Mental Health Project	£58,000
Dementia Practitioner capacity	£144,000 recurrently

Financial Implications:

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

ICF Budget	**S 75 £'000**	**Aligned £'000**	**In Collab £'000**	**Total £'000**
CCG	£130k 2018/19 £144k recurrently	-	-	£130k 2018/19 £144k recurrently
Total	**£144k**	**-**	**-**	**£144k**

Section 75 - £'000 **Decision: SCB**	As shown in the table in section 1 of the report there is a budget of £134k for 'dementia in neighbourhoods', with recurrent spend of £275k p.a. from 2019/20 onwards. The business case proposes spend of £130k in 2018/19. This is based on a start date for dementia support of 1st October (i.e. 6 months at £72k), plus

	£58k of non-recurrent funding for the 101 day project, which broadly aligns to the current budget. For 2019/20 and beyond, the £275k budget will fund the recurrent impact of the dementia practitioners from this business case. In addition it is assumed dementia support workers, currently funded from iBCF will be recurrently financed through this budget.

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

Mental Health investment is a high profile area in 2018/19, with increased scrutiny of locality plans at both a GM and national level. The T&G health and social care economy recently made a commitment to increase investment in mental health services (an additional £2.5m in 18/19 budgets) to ensure delivery of the five year forward view and the Mental Health Investment Standard (MHIS).

This business case is funded from the additional investment approved at January SCB and is aligned to the strategic ambition for mental health in Tameside and Glossop.

The paper cites evidence from the Norfolk Admiral Nursing Service and from Telford and Wrekin were significant theoretical savings have been calculated. Because of contractual arrangements with the ICFT, Pennine Care and GP practices it is unlikely that cash releasing savings on this scale can be realised by the strategic commissioner in Tameside & Glossop. But operational efficiencies and released capacity across the system as a result of this investment would contribute towards the wider ambitions of the Care Together programme.

Current budgets are based upon a fully recruited service going live from 1 October. In the event of slippage against this date, consideration should be given to releasing the slippage to contribute towards the economy wide financial gap on a non-recurrent basis

Legal Implications: **(Authorised by the Borough Solicitor)**	The Board should be satisfied that the business case represents value for money and on balance demonstrates that it is capable of fulfilling the aspirations to improve mental health and dementia support in the neighbourhoods.
What is the evidence base for this recommendation?	National Five Year Forward View for Mental Health.
Is this recommendation aligned to NICE guidance or other clinical best practice?	Yes – based on range of NICE Guidance re mental health and requirements to deliver NICE Concordat Care.
How will this impact upon the quality of care received by the patient?	If additional funding for mental health support is committed the quality of care for patients will be improved.

Recommendations of the Health and Care Advisory Group:	The Health and Care Advisory Group recognised the benefit of expanding the dementia expertise within the Neighbourhoods and the benefit of taking time within the 101 Days for Mental Health Project to collaborate and co-produce a new model of mental health provision for people who currently fall between the gap in mental health services.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey.  Telephone: 07792 060411  Email: pat.mckelvey@nhs.net

1. INTRODUCTION

1.1 In January 2018 the Strategic Commissioning Board agreed to:

a) Commit to improving the mental health of the Tameside and Glossop population by agreeing to prioritise increasing investment to improve parity of esteem.
b) Commit to prioritise investment in mental health services from now until 2021 and that this would be done on a phased basis in order to support the following objectives:-
- Affordability;
- Development of robust business cases for each scheme;
- Phased approach to building complex services;
- Recognition of the time lag in recruitment to mental health posts.

1.2 In February SCB agreed to earmark investment, subject to business cases, for Mental Health within the Public Health Development Fund as follows:-

Element	Investment earmarked
Health and Well-being College	£160k for two years
Mental health keyworkers	£300k for three years
Mental Health Skills and Employment Workers	£225k for three years

1.3 The following table is a refreshed version of the table agreed by SCB in January. This summarises all the income streams and the outline financial commitments:-

Source of MH Funding	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Baseline budgets	40,388	41,273	42,204	43,647
GM MH Transformation Funding	219	438	438	0
Care Together Transformation Funding	187	280	280	93
Local Authority Transformation Funding	389	432	0	0
Total Source of Funds:	**41,183**	**42,423**	**42,922**	**43,740**
PH Investment Fund - Health and Wellbeing College	60	80	20	0
PH Investment Fund - Employment Support Workers	44	175	175	131
PH Investment Fund MH Key Workers	25	100	100	75
Self-management Education budget (CCG baseline)	27	27	27	27
Total Source of Funds including Public Health	**41,338**	**42,805**	**43,244**	**43,973**
Application of MH Funding	**2018/19**	**2019/20**	**2020/21**	**2021/22**
Committed MH Expenditure in Baseline Budgets				
Pennine Care FT core contract	23,341	23,805	24,301	25,190
Individualised commissioning	7,350	7,552	7,760	7,973

Prescribing	3,294	3,385	3,478	3,573
Other	4,297	4,383	4,474	4,637
Total Commitments:	**38,282**	**39,125**	**40,012**	**41,374**
Proposed New Mental Health Investment				
Increasing access to MH support for children & young people	308	554	804	1,552
IAPT Plus/Psychological therapies	550	640	740	830
Early Intervention in Psychosis	180	350	450	450
Neighbourhood Developments	208	550	550	571
AMPH, Recovery	211	251	251	251
Mental Health Crisis	478	833	833	1,268
LD Transforming Care	200	200	200	200
Neurodevelopmental Adult	70	170	170	170
Dementia in neighbourhoods	134	275	275	275
Specialist Perinatal Infant MH	0	224	224	224
Health and Well-being College	60	80	80	80
PH Investment Fund MH Key Workers	25	100	100	75
MH Employment Support Workers	25	175	175	175
Total Proposed New MH Investment:	**2,449**	**4,402**	**4,852**	**6,121**
Grand Total of Proposed MH Expenditure/Investment:	**40,731**	**43,527**	**44,864**	**47,495**

2. AMBITIONS FOR 2018/20

2.1 Further work has taken place within the locality, in Greater Manchester and with partner CCGs in the Pennine Care footprint. From this learning a range of ambitions are proposed to be taken forward in 2018/20

2.1 **Increase opportunities for people to stay well in the community**

- Identify options to create One Front Door - integrated entry point for all MH referrals (including self-referral).
- Develop a neighbourhood model that meets the needs of people who fall into a gap in services. Within this explore the potential benefits of keyworker / case manager support - re employment/ young adult/ perinatal infant/ lived experience peer support/ housing/ money matters/ mental health /7 day follow-up worker and identify a range of options for support from mainstream (incl social prescribing) to MH secondary care.
- Build on new developments to promote self-management including the new Step 1 IAPT service - community drop ins, active monitoring and counselling – and the Health and Wellbeing College.
- Build on our existing rich community and voluntary mental health support including physical health (Active Tameside and Be Well), Arts, peer groups.
- Take learning from the Winter Pressures Crisis Drop-in pilot to build sustainable VCS/PCFT MH Drop Ins in both Tameside and Glossop. Within this test the opportunity to support potential impact on earlier step down from Community MH Teams.
- Ensure new investment in the to be developed integrated IAPT Plus service streamlines the pathway into psychological therapies at all levels

- Increase specialist dementia expertise in the community though investing in and integrating dementia practitioners in the Integrated Neighbourhood Teams. Consider options for formalising this through a single integrated dementia team working across the hospital acute wards and the community.

2.2 **Increase opportunities to get help before/during a crisis**

- Identify the opportunities to avert crises through the MH Crisis Drop In's - as described above
- Establish a Safe Haven in urgent care - connected to expansion of RAID and Home Treatment Team to provide extended assessment and short term crisis support
- Identify requirements to deliver a STORM pathway - suicide assessment and intervention pathway
- Increase access to support through CMHT and Home Treatment (as below)

2.3 **Make effective use of secondary care**

- Establish potential to reduce short stay admissions through above
- Establish capacity requirements in Home Treatment Team to increase this option as an alternative to admission
- Establish solutions to reduce Delayed Transfer of Care (DTOC) including formalising DTOC meetings and speeding up funding decisions process
- Identify options to expand community VCS inreach onto the wards to connect patients into community support after discharge early
- Identify best use of resources to effectively support older people with serious mental illness SMI, including a review of older people's day hospital, Home Intervention Team and Age UK Grant
- Complete the tender for a specialist dementia care home to reduce DTOC and improve care closer to home for people with very complex dementia.

3. PROPOSALS

3.1 This paper outlines requests for the Strategic Commissioning Board agreement to progress with two elements:

- Mental Health in the Neighbourhoods: 101 Days for Mental Health Project
- Dementia Support in the Neighbourhoods – increasing dementia practitioner capacity

Mental Health in the Neighbourhoods: 101 Days for Mental Health Project

3.2 A series of workshops were held in November to January 2018 to explore the significant gap in mental health services for people with multi-faceted needs, who fall between secondary care mental health services and the psychological therapy service, Healthy Minds. Through this analysis the project team discovered the Lambeth Living Well model, co-produced through a ground up collaboration between partners in Lambeth and the Innovation Unit.[1]

3.3 The key elements of the Lambeth development is the way commissioners, providers (the local authority, CCG, mental health trust and voluntary sector) and community representatives have redefined system outcomes in collaboration with people with lived experience. Together they created a compelling vision for a new Living Well model of system change and a set of successful service innovations that are helping many more people get help when they need it in primary and community settings. As well as new mechanisms for delivery they also developed new methods of commissioning and contracting.

[1] The Innovation Unit is a social enterprise that brings innovative solutions to the public services https://www.innovationunit.org/

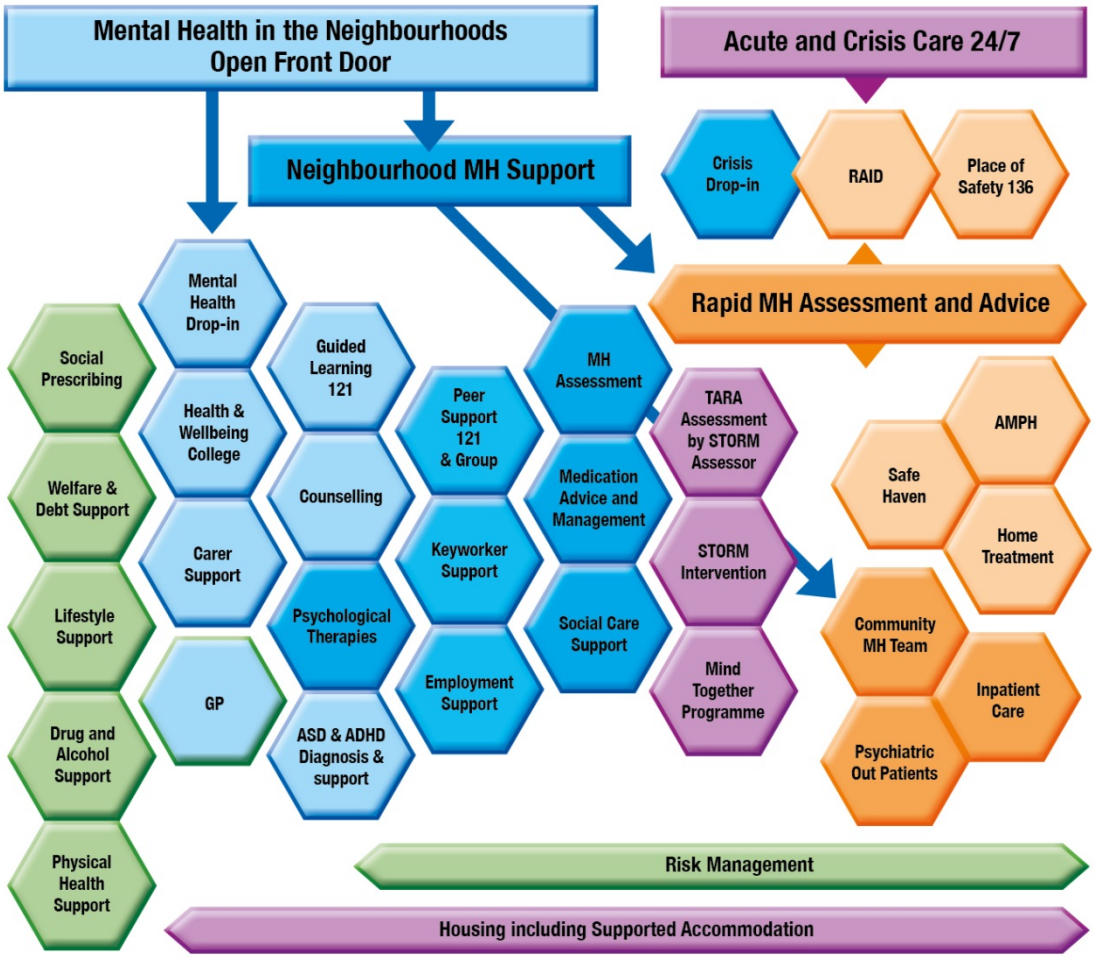
3.4 Lambeth's Living Well model for better mental health comprises of three distinct elements:

- Multi-disciplinary teams that assess need and provide easy access to short, preventative, holistic reablement support delivered by and alliance of providers;
- A network of community and statutory agencies that support the Living Well teams to meet users wider needs (debt, housing, welfare, relationships);
- A collaborative of dynamic, ambitious leaders who own the vision and drive change.

3.5 Data shows a positive impact on:

- Service user experience and satisfaction;
- Access to services;
- Waiting times;
- Referrals to secondary care.

3.6 Initial thinking on how existing and new support could be integrated in the Tameside and Glossop neighbourhoods is outlined below –



3.7 To take this thinking forward it is proposed that we commit local executive leadership, management capacity and bring in an appropriately skilled consultancy partner to establish a 101 day project to co-design model for meeting mental health needs of people who are currently not receiving a service in the neighbourhoods in Tameside and Glossop. To deliver this project the following resources will need to be committed:-

Role	Proposal	Additional capacity
Executive lead	Steven Pleasant/Alan Dow	
Consultancy support	TBC	£49,000

Senior managers	Pat McKelvey, Commissioning Sarah Barnes, PCFT Mark Whitehead, ASC TBC, Action Together	3/7 1/7 1/7 1/7
Project Support	Commissioning team	5/7
Clinical Lead	TBC following expressions of interest	£6,000
Engagement and Communication	TBC Engagement budget	1/7 £3,000
	Total	£58,000

3.8 In addition to the above considerable support over the 101 days will be required from Pennine Care, VCS groups, clinical leads, neighbourhood leads and, most importantly, people with lived experience.

3.9 High level project plan

Element	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Project team assembled													
Consultancy engaged													
Project plan developed and initiated													
Clinical lead engaged													
101 Day period to develop a new model with all stakeholders													
Mapping of existing resource and costing													
Proposal for consideration by SCB													
Contracting													
Go-live with new model													

Dementia Support in the Neighbourhoods – Phase 2

3.10 As part of the Care Together development Tameside and Glossop committed to improving the lives of people living with dementia. In 2016 in Tameside, the rate of emergency admissions, aged 65+ with dementia was 4,839 per 100,000 population, compared to the rate for England of 3,046 per 100,000 population. The current estimated cost of avoidable Dementia related acute admissions is £0.5m per year in Tameside. It is hoped that by increasing specialist dementia support in the community reactive costs associated with the high volume of activity in unscheduled and long term care will be reduced. Therefore, in October 2017 the Strategic Commissioning Board approved a comprehensive business case to increase dementia support in the neighbourhoods.

3.11 The business case proposed to build dementia expertise and support by embedding Dementia Practitioners each of the five Neighbourhood Teams and, in Tameside*, commission a pilot scheme from the Alzheimer's Society to provide a Dementia Support Worker in each neighbourhood through the Adult Social Care Transformation Funding.

**NB Dementia support is already available in Glossopdale through the High Peak Alzheimer's Dementia Support worker and through the Derbyshire Dementia Reablement Service).*

3.12 The proposal links to various Local and National priorities for Dementia Care:

- The Five Year Forward View for Mental Health- Dementia United & Crisis Care;
- Single Commission Strategic plan and Health and Wellbeing Board;
- Single Commission Quality, Innovation, Productivity and Prevention Agenda (QIPP);
- GM Mental Health and wellbeing Strategy- Dementia United & Crisis Care;
- Living Well with Dementia: A National Dementia Strategy 2009;
- Prime Minister's Challenge on Dementia 2020(2015).

3.13 The overall vision is to develop a rich, post diagnostic support offer to support people living with dementia and their carers to make informed choices, be empowered to take control of their lives and maintain their wellbeing and independence for as long as possible.

3.14 The Strategic Commissioning Board agreed to:

1. Establish a pilot with Alzheimer's Society for Dementia Support Workers (DSW) in each Neighbourhood in Tameside –December 2017 - Alzheimer's Society to establish a DSW as an integral member of each Tameside neighbourhood team, each supported by a volunteer. When fully operational the DSWs are expected to support 192 cases of people affected by dementia every month; the DSWs will: - provide post diagnostic support to people and their families and work with dementia practitioners (DPs) to support an allocated caseload, providing emotional support and promoting access to emotional support/mental health pathways; - be a consistent relationship across primary/acute/secondary care and collaborate with local resources and, with DPs, build capacity/capability in primary care, community services and the voluntary and community sector; - liaise with and, through monitoring their role, provide advice to Primary Care annual care plan reviews and support access to advocacy services; - provide a communication conduit for individuals admitted into hospital and ensure continuity of care plans and support discharge planning; - link with Palliative Care Team; - facilitate and support peer to peer support through a rich community offer - support dementia practitioners	**2. Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing PCFT CMHT nurses, Willow Wood Dementia Nurse and ICFT Admiral Nurse capacity:** DPs will: - provide expert training, advice and support to all colleagues regarding dementia assessment, monitoring, support and intervention; - supervise the Dementia Support Workers in their role; - Dementia Nurses will undertake assessments and provide care plans for people with complex dementia; - carry a caseload of patients/and or carers who require additional support; - work with Neighbourhood colleagues to monitor and take preventative action to reduce crisis. Where crisis occurs, provide support to reduce escalation, including preventing avoidable hospital admissions and expediting safe discharges; - work with partners to deliver a rolling training programme in the locality; - support the community and voluntary sector provision of a rich choice of carer and peer support; - promote high quality psychosocial interventions; - Willow Wood Dementia Nurse will also offer support and consultation for dementia end of life across Tameside and Glossop.

Progress to date

3.15 The Dementia Support Worker Pilot is now underway and will be fully operational in June.

3.16 Establish Dementia Practitioners (DPs) in each neighbourhood team by investing in three new roles to add to existing PCFT CMHT nurses, Willow Wood Dementia Nurse and ICFT Admiral Nurse Capacity. It was decided that this development would be taken forward in two phases;

Phase 1	**Phase 2**
Integrating time from existing postholders (currently working in Pennine Care FT, Willow Wood Dementia Nurse and the ICFT Admiral Nursing Team) into each of the Neighbourhood Teams.	Increasing capacity with additional funding/redesigning neighbourhood team skill mix to ensure that sufficient dementia expertise is in place to reduce unscheduled care demand.

3.17 Progress toward the integration of existing dementia practitioners into the neighbourhoods is underway with an emerging vision to create a single management structure of dementia expertise, spanning in-patient and community and the ICFT and Pennine Care FT. A working group is developing an integrated pathway for dementia care and a pilot has commenced in Glossop. One of the challenges has been the capacity of postholders who have existing caseloads therefore it is timely to take forward phase 2 of the proposal to increase capacity by committing investment in additional dementia practitioners.

Phase 2 Cost: Expansion of Dementia Practitioners	**FYE**
Dementia Practitioners	£116,025
Non-pay	£5,802
Overheads	£21,441
Total	**£143,268**

Outcomes & Benefits

3.18 The anticipated outcomes associated are explained in detail the October 2017 Business Case however in summary;

- Improvement in the delivery of dementia care in Tameside and Glossop, which will improve integration, deliver better outcomes for individuals and achieve efficiencies across the local health economy.

- Major outcomes identified as part of the Single Commission's Quality, Innovation, Productivity, and Prevention (QIPP) agenda in particular:
  - better service user and carer experience;
  - reduced demand for acute inpatient provision;
  - reduced demand for specialist mental health inpatient provision;
  - prevention of inappropriate hospital admissions;
  - prevention of admissions to care homes;
  - reduction in inappropriate drug prescribing.

3.19 It is anticipated that as the cost savings from reduced unscheduled admissions will ultimately allow movement of money within the system that ensures the implementation is sustainable in the first instance, and cost saving in the medium and long terms.

- This proposal has the potential to create cost savings to the wider health and social care economy.

- Dementia Practitioner/Admiral Nurse roles have a strong evidence base for efficacy in a range of different settings. An analysis of the caseload over one month (November 2013) in **NHS Telford and Wrekin** showed cost savings of over £17,000 in terms of savings on GP contacts and respite provision (Lee, T, et al, 2014). This evidence has been built upon by the most recent cost benefit analysis of the Norfolk Admiral Nursing

Service which showed savings of over £440,000 over a 10 month period with a team of 3 Admiral Nurse/Dementia Practitioners (Aldridge and Findlay, 2014). These savings included delayed admissions to care homes, a reduction in hospital admissions (both acute and mental health), and a reduction in the referrals to psychological therapies.

4. RECOMMENDATIONS

4.1 As set out at the front of the report

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 May 2018

Officer of the Single Commission Jessica Williams, Interim Director of Commissioning

Subject: **DEVELOPING SELF MANAGEMENT EDUCATION IN TAMESIDE AND GLOSSOP**

Report Summary: This business case proposes that two funding streams are brought together to invest in a new programme for Tameside and Glossop to develop a co-ordinated self management education offer that consists of 7 key elements. The funding streams are:

- £27,000 recurrent funding used in the past to commission Self Management UK (previously Expert Patient Programmes) to deliver self management courses
- £80,000 of Public Health Investment Fund, committed for two years

Recommendations: The e Strategic Commissioning Board recommend to the Council and CCG to support the proposals for investment outlined in this report .

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 Population Health	80	-	-	80
CCG	27	-	-	27
Total	**107**	**0**	**0**	**107**

Section 75 - £'000 **Decision:** **Strategic Commissioning Board**	£80k is currently earmarked in the public health investment fund for this in 18/19 and 19/20. £27k is built into CCG budgets on a recurrent basis in anticipation of this.

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

Mental Health investment is a high profile matter in 2018/19, with increased scrutiny of locality plans at both a GM and national level. The Tameside and Glossop health and social care economy recently made a commitment to increase investment in mental health services (an additional £2.5m in 2018/19 budgets) to ensure delivery of the five year forward view and the Mental Health Investment Standard (MHIS).

This business case is aligned to the strategic ambition for mental health in Tameside and Glossop and is funded within existing budget.

	Consideration needs to be given to future commissioning intentions when the Public Health Investment Fund expires in 2020/21.
Legal Implications: **(Authorised by the Borough Solicitor)**	The Board should be satisfied that the business case represents value for money and on balance demonstrates that it is capable of fulfilling the aspirations to develop a co-ordinated self management education offer.
What is the evidence base for this recommendation?	National Five Year Forward View for Mental Health.
Is this recommendation aligned to NICE guidance or other clinical best practice?	Yes – based on range of NICE Guidance re mental health and requirements to deliver NICE Concordat Care.
How will this impact upon the quality of care received by the patient?	If additional funding for mental health support is committed the quality of care for patients will be improved.
Views of the Health and Care Advisory Group:	The Health and Care Advisory Group recognised the benefit of expanding the self-care offer and recommended that the SCB support the business case on the proviso that robust evaluation is embedded within the service.
Access to Information :	The background papers relating to this report can be inspected by contacting Pat McKelvey.

Telephone: 07792 060411

Email: pat.mckelvey@nhs.net

1. EXECUTIVE SUMMARY

1.1 A co-ordinated vision for self management education that aims to align and develop resources that support individuals to self care, across physical health, mental health and lifestyle change has been developed within Care Together.

1.2 This business case proposes that two funding streams are brought together to invest in a new programme for Tameside and Glossop to develop a co-ordinated self management education offer that consists of 7 key elements as described below. The funding streams are

- £27,000 recurrent funding used in the past to commission Self Management UK (previously Expert Patient Programmes) to deliver self management courses
- £80,000 of Public Health Investment Fund, committed for two years

1.3 These resources combined with the existing Care Together self care transformation programme to support the development of a much more ambitious self management education offer that is co-ordinated, accessible and embedded in both clinical pathways and community opportunities.

1.4 The £107,000 p.a. for two years would be invested specifically into the development of a more ambitious self management education offer that comprises of the following key elements:

- Continuing to invest in the high quality mental health self management education programme delivered by Pennine Care in the Health and Well-being College
- Developing a generic self management course for Tameside & Glossop and equipping local trainers to deliver it.
- Co-ordinating existing SME assets and developing new ones in partnership with local organisations.
- Ensuring people have access to high quality, accessible information about their condition(s) and how to manage it.
- Supporting the development of peer support opportunities, led by local community groups but formally linked to their clinical teams

1.5 Going forward it is hoped to add the following elements provided through developments in the system wide self care transformation programme;

- Bringing together the wide range of existing resources into an online resource to help people self manage, with associated neighbourhood hubs.
- Supporting access to specialised health coaching, specifically for people with long term conditions who have lower activation levels and require more intensive one to one support.
- Embedding self management consistently in clinical pathways ensuring we have a dual role in supporting people's conditions and empowering them to be effective self managers.

2. OUTLINE DESCRIPTION

2.1 The system wide self care transformation programme aims to radically change the relationship between patients, public and the health and care system. People and Tameside and Glossop are living increasingly with multiple long term health conditions that impact considerably on their health, happiness and quality of life.

- 13,040 (5.3%) of the population of Tameside and Glossop, account for £48m (39%) of all acute activity – this doesn't take account of primary care, social care or community services;

- We have a growing population of people with long term conditions and a growing number with multiple co-morbidities;
- On average someone with a long term condition will spend 4 hours a year with a health or care professional, and 8,756 with their families and within their communities – yet the vast majority of health and care resource is focused on the professional interaction;
- Approaches that seek to build people's capacity to manage their health and health condition(s) are key to meeting the needs of the population we have today, as well as addressing some of the economic challenges faced by the health and care system.

2.2 The system wide self-care programme is the over-arching name for a suite of projects that will empower individuals, families and communities to manage their health and health conditions more effectively either independently or in partnership with their health and social care team. It is funded through the transformation fund.

2.3 The building blocks of the approach are as follows;

Enabling the individual, families and carers – (self-management education and peer support) taking into account the knowledge skills and confidence that an individual requires to manage their health and health conditions well. This involves tailoring the education required to meet the level of support the individual needs.

Enabling communities - 'More than medicine approaches' – (Social prescribing, asset based approaches, volunteering, public engagement and participation). Developing and navigating to community resources that enable individuals to manage their health and health conditions well outside of routine healthcare contacts. Creating the conditions for people to live healthy, satisfying and fulfilling lives beyond merely managing a condition.

Enabling the workforce – (person centred care and support planning, workforce development, Patient Activation Measure, partnership approaches) developing the knowledge, skills and competency to foster a new relationship with patients and the public that promotes independence, voice and choice. This involves the provision of training, continuing development opportunities and the provision of the tools to support person centred approaches.

2.4 This business case is presented with particular reference to the element focused on enabling the individuals, families and carers – Self Management Education and Peer Support.

2.5 There are a range of opportunities available across Tameside and Glossop to support individuals to become active self-managers that include topics on physical health, mental health and lifestyle. Currently these opportunities are provided attached either to specific conditions, organisations or services and specific locations. There is much that we can do to develop and expand the current offer and present it as a cohesive collection of opportunities that are easier to navigate by individuals and their supporters including workers and peers.

2.6 It is suggested that there are some practical actions that could be taken to co-ordinate and develop the self-management education resources that are available. This is recommended on the premise that individuals prefer to use and access information and support in different ways;

Continuing to invest in the high quality mental health self management education programme delivered by Pennine Care in the Health and Well-being College

2.7 The Health and Wellbeing College aims to provide something very different to promote good mental health. It moves away from the clinical focus offered by many traditional mental health support services; instead offers 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 students

to recognise their own potential and make the most of your talents and resources, through self-management. All courses are co-produced and co-delivered by people with lived experience.

Developing a generic self-management course for Tameside and Glossop and equipping local trainers to be able to deliver it

2.8 It is proposed to expand the programme offered by the Health and Wellbeing College to include a generic course that would be applicable to anyone, regardless of their condition (whether physical or psychological) and could focus on building confidence, self-esteem and wellbeing. The content should be informed and developed and co-designed with individuals managing conditions and the staff working with them. A network of trained facilitators and peer educators from the VCS and statutory services could be built using a cascade model that can disseminate and deliver courses through their organisations for their service users and members of the community. Facilitators could be supported through a peer support network, sharing ideas, resources and course adaptations for specific groups. A central function to support quality assurance, consistency and the recording of outcomes would need to be agreed and could include a 'panel' of staff and patients/individuals.

2.9 This would have the advantage of incurring no product licence fees attached to national accredited programmes, and no cost or lag attached to waiting for courses for new trainers to be organised.

Co-ordinating existing SME assets and developing new ones in partnership with local organisations to create a comprehensive programme of SME

2.10 There are organisations across the statutory, voluntary and community sector in Tameside and Glossop that offer an existing range of opportunities for people to learn and gain skills to live healthier lives, in the form of courses, workshops and peer support groups. These encompass organisations specialist in specific conditions (such as courses run by the Stroke Association or Macmillan), or those that offer education to improve lifestyle habits (such as Hyde Community Action in collaboration with Be Well) or opportunities to learn a broader range of skills that support people with long term conditions to reduce the stress of living with a life limiting illness or mental health problem (such as the Health & Wellbeing College). There is the opportunity to map, co-ordinate and further develop this offer so it can be described as a virtual 'college' of opportunities that are accessible in communities and led by organisations that are experts in their field and represent often marginalised or vulnerable groups.

2.11 There are opportunities to link in volunteers and peer educators to co-design and deliver learning opportunities in communities where there are gaps, drawing on learning from the Health and Wellbeing College model. Consideration would need to be given to the development of a light touch quality assurance framework that ensures provision is accessible, has clear objectives, an evidence base where appropriate and outcomes are measured (does the activity improve knowledge, skills or confidence?)

Ensuring that people have access to high quality, accessible information relating to their condition and how to manage it

2.12 There are many existing resources covering physical, mental health and lifestyle topics available online that are high quality and free to use and access. These include courses, self-help books and information leaflets. Some online resources are provided by Pennine Acute and the ICFT on physical and mental health conditions. There are a range of national and international resources available and there is also some information available in translation to support contacts with individuals whose first language may not be English.

2.13 However, from a public perspective, quality assured resources can feel difficult to source and distinguish in amongst the plethora of information available on the internet. It would be helpful to collate a 'recommended' list of resources to support individuals who are able to

access information more independently and are able to make use of this universal resource with the reassurance that the content has been assessed and approved by health practitioners, or recommended by peers.

Supporting the development of peer support opportunities led by local community groups but formally linked to clinical teams.

2.14 Linking peer support with self-management education options is particularly important in building sustainability into any programmes. The evidence of the longer term benefits of self-management education is limited and what is available suggests that the benefits gradually fall off or decrease post intervention. Consideration needs to be given to the mechanisms that need to be in place to support ongoing change and any improvements in an individuals' physical, social and mental health and wellbeing. This could be built in through a number of ways:

- Resourcing the development of peer support groups in communities.
- Creating opportunities for individuals to skills share, design sessions together and run their own education sessions.
- Linking with the asset based community development grant funding to build education opportunities in communities
- Creating a virtual network/community where individuals can sign up, share stories, ask questions, create chats and receive updates about activities and opportunities happening in their area.

3. FUTURE DEVELOPMENTS

Bringing together the wide range of existing resources to provide an online resource to help people self manage.

3.1 A central hub where information about all activities and opportunities is available could be developed in order to support navigation and signposting by individuals and the staff working with them. It would need to be accessible for communities and organisations to use. This could be a website – either newly developed or building on any appropriate existing network for Tameside and Glossop that was complemented by information hubs in the neighbourhoods.

3.2 There is a range of literature available that has been developed specifically for people with long term conditions, including the resources available online (Pennine and the ICFT both provide resources online for physical and mental health conditions) and resources in hard copy for people who prefer to access information in hard format. Examples of free to use services include the 'Reading Well scheme for people with long term conditions available in public libraries across the borough. The information centre available in the Hartshead Building on the Tameside Hospital site, and the Macmillan Information Centre, also on the hospital site.

3.3 Information hubs in each of the neighbourhoods, building on the provision in libraries and perhaps civic buildings and community resources could be further developed.

Supporting access specialised health coaching, specifically for people who have lower activation levels and require more intensive one to one support.

3.4 Clinical teams provide elements of health coaching in their contacts with individuals but can be limited by the pressures of limited appointment times and the requirement to complete other tasks during the consultation. A bespoke health coaching service specifically for people with long term conditions who have lower activation levels would allow space for coaching conversations, with a dedicated coach at a frequency agreed with the individual. This would have the benefit of enabling individuals to feel in more control of their health, and to make the most of their contacts with clinical teams. Importantly these opportunities should be created in partnership with clinical teams specialist in condition management.

Embedding self-management education in clinical pathways ensuring we have a dual focus on supporting people's conditions and empowering them to be effective self-managers.

3.5 There are many elements of self-management education that already form the offer of some services in the system. For example, the Diabetes team provide courses and the Pulmonary Rehab service include education in combination with their exercise programmes. Similarly there is provision to support mental health and wellbeing available through organisations such as Healthy Minds and the Health & Wellbeing College. However these opportunities aren't always joined up and SME is not always routine, or incorporated across the system for every condition or available to every patient. There are opportunities to incorporate the provision of SME into service improvement programmes, and the re-design of clinical condition pathways.

4. NATIONAL, STRATEGIC AND LOCAL CONTEXT

4.1 The vision seeks to make a reality of the approaches outlined in Chapter 2 of the NHS' Five Year Forward View and Greater Manchester Health and Social Care Partnership's Population Health Plan 2017-2021. Our approach acknowledges that the population of Tameside and Glossop is changing and with this change comes a need for a greater focus on the ageing population and increased prevalence of chronic diseases as well as a need to shift resources from merely treating ill health to proactively preventing and managing health and wellbeing.

4.2 This proposal meets all the strategic commissioning priorities for improving population health:

- A focus on the ***wider determinants*** of health and wellbeing, in particular giving children the best start in life and helping people to stay in and return to work, thereby improving their own prosperity.
- Early intervention and prevention across the life course to encourage ***healthy lifestyles*** and promote, improve and sustain population health.
- Creating the right care model so that people with ***long term conditions*** are better supported and equipped with the right skills to look after themselves and manage their conditions more effectively, reducing dependency on the health and social care system by promoting independence.
- Supporting positive ***mental health*** in all that we do.

4.3 This proposal aligns to the investment in self care with the aim of promoting good health, promoting independence and reducing dependency

4.4 The system wide self-care programme accounts to the Care Together Programme Management Office and the approach has been ratified at Care Together Programme Board, and through internal governance structures at the ICFT.

4.5 A Self Care Neighbourhoods Group meets monthly and provides independent scrutiny, advice and guidance to the programme involving a range of organisation and operational service representatives. This group involves amongst others GP Clinical Neighbourhood Directors; Neighbourhood Managers; VCS leads, and wider health and social care partners.

4.6 The Health and Well-being College has been recognised as a key element within the Mental Health in the Neighbourhood Developments.

5. OUTCOMES AND BENEFITS

5.1 Primary beneficiaries are 13,500 individuals identified through risk stratification as living with chronic health conditions across Tameside & Glossop and people with both common mental health disorders and serious mental illness.

5.2 Anticipated outcomes:

- Patients will increase their knowledge, skills and confidence to manage their own health and therefore become more effective self managers.
- Staff will feel better able to support patients to self manage and have easier access to information about self management education opportunities.

5.3 The offer is both specific and universal in nature therefore having a broad reach and supporting population health. For example, creating a site for co-ordinating self management education opportunities and ensuring quality, accessible information about health and health conditions could equally support prevention in the wider population, and families and carers of primary beneficiaries.

5.4 Developing a cohesive offer of Self Management Education that is accessible and easy to navigate gives patients and the public opportunities to develop the knowledge, skills and confidence to become active self managers in control of their health and health conditions.

5.5 Clinical guidelines suggest that self management education is embedded in clinical pathways. For example, in Diabetes education courses/group interventions are routinely offered as part of their core offer. This proposal intends to build opportunities across all pathways and within communities, in recognition that people spend the majority of time managing their condition(s) independently on their own with little contact with health professionals.

5.6 The outcomes will align with the roll out of the Patient Activation Measure across Tameside and Glossop which has gathered a wealth of evidence to demonstrate the benefits of tailoring self management education and supporting self management on impacting health service usage, i.e higher activated patients use health services less and transact more appropriately. http://www.insigniahealth.com/research/archive/

5.7 A range of benefits are anticipated for patients:

- Improvements in knowledge, skills and confidence will be measured by the Patient Activation Measure – a licensed tool which has been made accessible for Tameside & Glossop through an agreement with NHS England and is available for roll out from the end of January 2018.
- Benefits for staff can be measured through CS-PAM (a version of PAM that measures the level of knowledge, skills and confidence clinicians have to support self management in their patients).
- Qualitative evidence will be derived through patient stories, and staff feedback.
- Quantitative evidence will also be made available through the evaluation of courses and the culmination of outputs/products developed as a result of the programme to provide choice for patients and public.
- No dis-benefits are anticipated, as it is intended to replace the current courses delivered by Self Management UK with a locally developed course, delivered through a network of local trained facilitator.

5.8 Monitoring of this programme will be incorporated into the current monitoring arrangements in the provider contract

6. EVIDENCE BASE

6.1 There is strong evidence that self-management support helps to increase people's knowledge about their condition, when to self-care and how to appropriately use health services. Most research suggests that self-management support can improve: people's satisfaction, coping skills, confidence to manage their condition (self-efficacy), perceptions of social support and health literacy. Evidence is drawn from a study of 779 systematic reviews by National Voices (Supporting self-management: Summarising evidence from systematic reviews (1998-2013) National Voices).

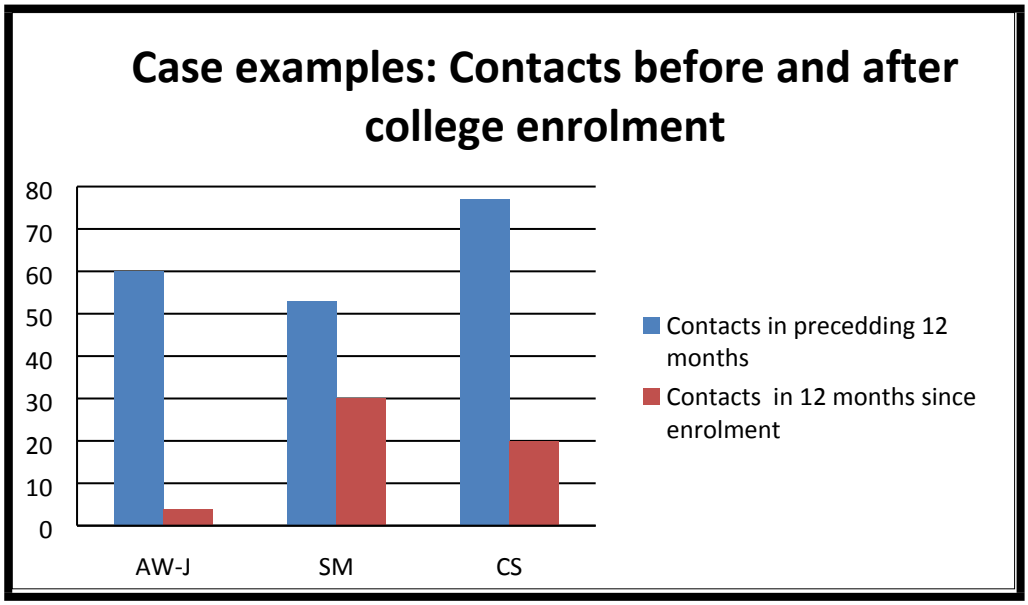
6.2 **Health and Well-being College -** The College moves away from the clinical focus offered by many traditional mental health support services; instead offering an educational approach designed to empower people to take control of their own health and wellbeing, while learning new skills, making friends 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.

6.3 **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).

6.4 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) * 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

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



6.6 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

6.7 **Self-Management UK –** Self-Management UK has been providing self-management education courses for a number of years. The patient-reported outcomes show a positive impact in all domains.

6.8 Change measured through the Health Education Impact Questionnaire:-

Domain	Score Range	Average Score At Base Line	Average Score At Follow Up	Proportion of Participants with a substantial improvement at follow-up
Health directed behaviour	1-4	2.72	3.08	15 of 42 = 35.71%
Positive and Active Engagement in Life	1-4	2.83	3.11	13 of 44 = 29.55%
Emotional Well-being	1-4	2.64	2.37	11 of 44 = 25.00%
Self-Monitoring and Insight	1-4	3.03	3.27	10 of 40 = 25.00%
Constructive Attitudes and Approaches	1-4	2.73	3.04	14 of 44 = 31.82%
Skill and Technique Acquisition	1-4	2.67	3.04	10 of 39 = 25.64%
Social Integration and Support	1-4	2.84	2.96	11 of 42 = 26.19%
Health Service Navigation	1-4	2.86	3.02	11 of 42 = 26.19%

*Emotional Well-being is a reverse scale so a reduction in score is expected.

6.9 Historically low numbers attended the courses resulting in high costs per patient however a recent drive through the neighbourhoods has resulted in much greater take up and retention through the three weeks of the course.

6.10 It is considered that the £27,000 investment will have a greater impact if aligned with the Health and Wellbeing College to ensure a more comprehensive, cohesive collection of approaches to self-management education, offering more opportunities and choices for people.

7. RESOURCE REQUIREMENTS

7.1 It is proposed to bring together two funding schemes to create a viable budget with which to meet the objectives outlined in 1.2 above:

Funding	**Year 1**	**Year 2**
Public Health Investment Fund	£80,000	£80,000
Section75 (CCG budget)	£27,000	£27,000
total	**£107,000**	**£107,000**
Grand total		**£214,000**

7.2 It is proposed to work with Pennine Care and other partners to establish a new Health and Well-being College for Tameside and Glossop, taking on the wider remit.

8. TIMESCALES AND IMPLEMENTATION

8.1 Implementation of this proposal will commence from July 2018 preceded by a continuing planning phase in May and June 2018.

9. PERFORMANCE MONITORING, EVALUATION AND EXIT STRATEGY

9.1 A robust performance and outcomes framework will be developed to capture the impact of the programme. This will include, for example:

(1) How much has been done?
- Reach – number and demographics of people accessing self-management support

(2) How well has it been done?
- Retention on courses
- Number of peer volunteers
- Number of co-produced and co-delivered education activities
- Students will complete evaluation forms at the end of each course
- All students will have access to co-review sessions at the end of each term

(3) Is anyone better off?
- Students will complete WEMWBS and PAM at the beginning of each term and again at the end of each term (to measure changes in self-assessed wellbeing and activation (self-management) levels
- Students will be followed up 3 and six months following completion of the course

10. RECOMMENDATIONS

10.1 As set out on the front of the report.

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	23 May 2018
Officer of Single Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP**

Report Summary:

Tameside & Glossop Strategic Commission have led the development of a locality strategy for Intermediate Care.

In August 2017, the Strategic Commissioning Board agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options were the subject of public consultation over a 12 week period from 23 August to 15 November 2017.

Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, an interim report was presented in December 2017 to inform SCB of the consultation progress and process, initial themes and the next steps to ensure a final report to the SCB January meeting.

A report containing the full detail of the consultation analysis, and an Equality Impact Assessment which responded to issues arising during the consultation and explored mitigations, was presented to the SCB in January 2018. On the basis of this report, the SCB approved Option 2, resulting in the centralisation of the intermediate care beds into the Stamford Unit, adjacent to Tameside Hospital and part of Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

An interim report was presented to the February meeting of the SCB, including a letter from the Clinical Chair and Chief Executive of the CCG, which set out expectations with regard to assurance on the progress of mitigations required before implementing the new model and moving the bed based care from Shire Hill to the Stamford Unit.

Commissioners have been working with ICFT and other partners in the locality to ensure the mitigations are being delivered and to develop the implementation plan set out in this report.

Recommendations:

The Strategic Commissioning Board is requested to:

- Note progress against mitigations outlined in the conclusions to the report at Section 6
- To approve the move to implementation of the agreed model of Intermediate Care
- To request the Quality and Performance meeting to undertake a review of the delivery of Intermediate Care and report findings to the Strategic Commissioning Board in January 2019.

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	8,032	0	0	8,032
Total	**8,032**	**0**	**0**	**8,032**

Section 75 - £'000 Strategic Commissioning Board	Proposed recurrent budget of £8,032k, plus up to an additional £250k to support the purchase of up to 8 beds at any one time on an individual basis for residents of Glossop. £1,983k of non-recurrent transformation funding from GMHSCP is available to fund transition to the new arrangements.

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

A financial review of this business case is supportive of the implementation of option 2 (as the preferred option presented in the public consultation). £23.2m of transformation funding has been awarded by GM Health and Social Care Partnership to support transformation of health and social care in Tameside and Glossop and £1.983m of this non recurrent money has been earmarked for funding the transition to the new intermediate care arrangements. It is important to recognise that receipt of this funding is subject to the attainment of stretching quality and financial targets which are stringently monitored by the GM Health and Social Care Partnership.

Implementation of this proposal is anticipated to deliver a net recurrent saving to the Tameside and Glossop Locality of at least £436k per annum which will contribute towards the overall economy gap whilst providing a quality and clinically safe service.

However, it is critical that notice is served timely on Shire Hill and a prompt transfer to the new service arrangements aligned to coincide with the term of notice. Failure to do so will result in additional estates costs of circa £50k per month beyond the term of notice and additional staffing/cost pressures and quality risk from having to use agency staffing whilst existing staff finish their notice periods and are redeployed in other areas.

Legal Implications: **(Authorised by the Borough Solicitor)**	It is noted that in order to achieve a seamless and cost efficient transition to the new service arrangements the timelines with current contracts/arrangements and notice of termination by the Integrated Care Foundation Trust of the lease in relation to Shire Hill owned by NHS Property Services Ltd should be synchronised. Management of staffing will be key to the safety of patients and service users are not compromised in any way, as again this is an area with the potential for costly complaints and claims. In order to demonstrate quality standards current and future NICE guidance should be followed, built into contracts and reflected in contractual documentation particularly since there is currently a consultation exercise requiring consideration. Likewise the National Audit of Intermediate Care 2018 expects compliance with statutory and mandatory requirements for Clinical Audit and so contractual and monitoring arrangements, processes and procedures will need to reflect the same if the service is to demonstrate excellence, that it is fit for purpose and provides value for money in the four categories of crisis response, home based rehabilitation, bed based intermediate care and re-ablement.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The intermediate care proposals are in line with the locality plan and the Care Together model of care
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme
Recommendations / views of the Health and Care Advisory Group:	The HCAG (in previous form as PRG) discussed and provided comments on the proposed options for Intermediate Care which were incorporated in the consultation documents and process.
Public and Patient Implications:	This report details the implementation of the new model of Intermediate Care following on from the public consultation and engagement with communities in Tameside & Glossop. Details of the consultation have been presented to SCB along with a full Equality Impact Assessment, and it was this detail which informed the decision taken in January 2018.
Quality Implications:	A Quality Impact Assessment was completed to accompany the report presented in January 2018. Tameside & Glossop ICFT will be required to participate, along with commissioner colleagues, in the annual National Audit of Intermediate Care. The results of this Audit will be presented to the SCB to provide ongoing assurance. The Director of Quality & Safeguarding chairs the Quality & Performance meetings held between the Strategic Commission and T&G ICFT which monitors process and enables commissioners to request specific quality reviews where there are areas of interest. Through these meetings the commissioners will ensure the continued delivery of home based intermediate

care to all 5 neighbourhoods in the locality, in line with the National Audit of Intermediate Care 2018 (NAIC) expectations and the NICE quality standards referred to in section 4. The Interim Director of Commissioning recommends that a specific quality review be enacted in 2018-19 to review delivery of the new model for Intermediate Care.

As described in the body of the report, safe staffing of intermediate tier services will also be monitored through quality and performance contract meetings to ensure a focus on quality and safety during and after transition.

How do the proposals help to reduce health inequalities?

The proposal will ensure the delivery of intermediate care services which to meet individuals' needs across the locality and addresses health inequalities.

What are the Equality and Diversity implications?

A full Equality Impact Assessment (EIA) was developed to support the report presented to the SCB in January 2018 and can be viewed here:

http://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board

What are the safeguarding implications?

The commissioned model will include all required elements of safeguarding legislation, as the provider will be Tameside & Glossop Integrated Care NHS Foundation Trust. The GM Safeguarding Standards are included in the ICFT contract.

What are the Information Governance implications? Has a privacy impact assessment been conducted?

As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements between the parties sending or receiving the data. The commissioner will seek assurance from all parties involved in the delivery of intermediate care that appropriate arrangements are in place. The locality's Information Governance Working Group will sense check data flows and IG requirements relating to this project.

Risk Management:

This transformation programme will be managed via the Care Together Programme Management Office. The risks will be reported and monitored via this process.

Access to Information :

APPENDIX	
1	Letter to Chief Executive of Tameside & Glossop ICFT
2	National Audit of Intermediate Care – Service Category Definitions
3	Intermediate Care referral process and patient information
4	Intermediate Care Model for Tameside & Glossop - ICFT
5	Additional services and integration of existing services within Glossop
6	National Audit of Intermediate Care 2018 – Audit Proposal

The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Commissioning:

Telephone: 07979 713019 e-mail: alison.lewin@nhs.net

1 INTRODUCTION

1.1 Tameside & Glossop Strategic Commission have led the development of a locality strategy for Intermediate Care.

1.2 In August 2017, the Strategic Commissioning Board (SCB) agreed to consult on 3 options for the delivery of bed based Intermediate Care. Two of the options, one of which was proposed as the preferred option, involved the relocation of intermediate care beds from the Shire Hill site. The 3 options were the subject of public consultation over a 12 week period from 23rd August to 15th November 2017.

1.3 Due to the richness of evidence arising from the public consultation and in particular from the Glossop neighbourhood, an interim report was presented in December 2017 to inform SCB of the consultation progress and process, initial themes and the next steps to ensure a final report to the SCB January meeting.

2 STRATEGIC COMMISSIONING BOARD DECISION

2.1 A report containing the full detail of the consultation analysis, and an Equality Impact Assessment which responded to issues arising during the consultation and explored mitigations, was presented to the SCB in January 2018. On the basis of this report, the SCB approved Option 2, which will result in the future commissioning of the intermediate care beds for Tameside and Glossop into the Stamford Unit, adjacent to Tameside Hospital and part of Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).

2.2 The SCB approved Option 2 with the following mitigations:

- The Glossop Integrated Neighbourhood team are asked to examine further opportunities to deliver enhanced rehabilitation and recuperation at home

- In light of some Glossop patients possibly requiring intermediate bed based care as close to home as possible to maximise their recovery, the Strategic Commission will engage with local care providers to explore the potential for up to 8 beds for purchase on an individual basis for residents of Glossop, subject to these reaching the commissioner's required standards for quality

- The Strategic Commission will commission the maximum appropriate health and social service provision from Glossop Primary Care Centre (GPCC)

- To review annually the Intermediate Care home based offer and bed requirement across Tameside and Glossop to ensure future demand is continually assessed and planning for future local provision is adapted accordingly.

2.3 An interim report was presented to the February meeting of the SCB, including a letter from the Clinical Chair and Chief Executive of the CCG, which set out expectations with regard to assurance on the progress of mitigations required before implementing the new model and moving the bed based care from Shire Hill to the Stamford Unit. This letter is attached at **Appendix 1**, and includes the following:

- The development of a clear, documented process which the ICFT will follow to identify patients requiring support from an intermediate care bed in the Glossop neighbourhood. This will need to include how patients are identified, what information they receive with regard to their choice of inpatient intermediate care offer, how it will be agreed that their period of 'discharge to assess' in the Stamford Unit will conclude and the move to Intermediate Care take place and how this will be organised in conjunction with the

patient, their carers, their GP, Glossop Integrated Neighbourhood team including Derbyshire County Council

- A view that the ICFT will wish to lead the commissioning of these Intermediate Care beds in Glossop and will be able to do so within the financial envelope already provided for Intermediate Care, as included in the January SCB report (see finance section below). The commissioners will support the quality assurance process of the beds identified as appropriate;

- Strategic Commissioners will require assurance through our Contract, Quality and Performance meetings regarding delivery of the 4 elements of intermediate care throughout Tameside and Glossop, as set out in the National Audit of Intermediate Care (**Appendix 2**) and the basis for our new model of Intermediate Care.

- In regards to Glossop specifically, commissioners believe it will be important to communicate effectively and assure the local population on the delivery of Glossop Integrated Neighbourhood services as set out in the paper considered by the Strategic Commissioning Board and seek to agree with the ICFT how this can be done optimally.

- Commissioners have long accepted that the Glossop Primary Care Centre is under-utilised in terms of capacity and range of services offered and would like to work with the ICFT to facilitate the development and/or transfer of additional health services to the Glossop Primary Care Centre with the ambition of an 80% occupancy rate (a good standard usage for public sector buildings) and increased service provision.

2.4 The Commissioners have been working with the ICFT and other partners in the locality to develop the implementation plan set out in this report, ensuring the conditions included in the attached letter (listed above) are addressed.

3 IMPLEMENTING THE NEW OFFER

3.1 The report to January SCB stated that details of proposed actions, timelines and milestones for the implementation would be presented to SCB to confirm support to proceed. This section of the report outlines how the conditions set out above and in the letter to the Chief Executive of the ICFT will be met.

Project Management

3.2 In order to ensure that all actions and mitigations outlined in the letter to the Chief Executive of February 2018 are met, the ICFT has established a dedicated Intermediate Care project group which is led by the Chief Nurse and Director of Human Resources and reports into the Trust Executive Management Group. The group's objectives are:

- To provide governance and oversight of the staff consultation exercise for the intermediate care staff based at Shire Hill
- To develop a project plan (with critical actions) for the relocation of bed based intermediate care services from Shire Hill to the Stamford Unit
- To monitor and manage the risks and issues identified during the development of the Shire Hill relocation plans and during the implementation period
- To further refine the detailed clinical delivery model for the flexible community bed base service in the Stamford Unit, including the provision of bed-based intermediate care
- To agree the staffing structure to deliver the clinical model
- To oversee the compilation of the standard operating policy for the flexible community bed base in Stamford Unit (including identification and referral processes) and revision of all supporting policies, procedures and patient documentation.

- To oversee the communication plans associated with the relocation of bed based intermediate care services from Shire Hill
- To ensure robust and safe plans are in place for the relocation of staff and patients from Shire Hill.
- To ensure plans are in place for the safe removal of all intermediate care Trust records and surplus equipment from Shire Hill following the relocation of intermediate care.

3.3 Senior leads have been identified and sub-groups established to progress these key actions prior to the relocation of services. These leads report progress into the Intermediate Care workstream at a weekly meeting.

3.4 The Commissioner expectation is that this group will ensure there are clear criteria and referral mechanisms for patients to opt to receive bed-based care from the Glossop neighbourhood based option for bed-based intermediate care, as described in the section below.

Process for identification and referral of patients in intermediate care in Glossop

3.5 A key principle of the intermediate care model is that wherever it is possible a person should have their care requirements met within their own place of residence and that the system will be responsive to meeting this need in a timely manner. The ICFT has implemented the "Home First" service model, which responds to meet an urgent/crisis health and/or social care need for patients.

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

3.7 The ICFT has a well-established and documented process for referring patients into intermediate care services from acute care to facilitate discharge and a referral document for step up from community to avoid an admission. This includes patient information on choice of inpatient intermediate care offer through the ticket home initiative for patients being discharged into intermediate care services from the acute setting or stepping up from the community. This documentation supports discussions with patients, carers and social care services on discharge planning and choice of services (2 documents are attached at **Appendix 3**).

3.8 The plan for the relocation of bed based intermediate care from Shire Hill is to transfer the existing clinical model and staffing to Stamford Unit onto one 32 bedded floor. This was in response to the preferences indicated by the staff during consultation to relocate as a complete unit and to allow them to become familiarised with the unit and other services being provided from the flexible community bed base and understand the patient requirements. Therefore the documents attached are based on the current inpatient bed based provision.

3.9 The ICFT has established a project group to develop a revised clinical model for the whole unit and agree policies and procedures for the new state. This will include the process for identifying and referring patients into the specific Glossop bed based intermediate care.

3.10 For patients stepping up into intermediate care services (home and bed-based) the referral can come from a range of individuals from GPs, neighbourhood team, community service to the patient or carer. This is facilitated by the Integrated Urgent Care Team (IUCT) who are the team responsible for delivering the home first service model for both crisis response and home based intermediate care services

Commissioning of Intermediate Care Beds in Glossop

3.11 The development of the process to commission and provide additional bed based intermediate care provision in Glossop for patients needing to be close to their familes/carers to deliver their optimum outcome is ongoing and being led by the ICFT Glossop Neighbourhood team with involvement from primary care, commissioning, social care, Derbyshire County Council and patient representation.

3.12 The offer would be based on the principals of bed based intermediate care with additional nursing and therapy input delivered by community services within the IUCT and intermediate tier of the ICFT and be supported and supplemented by the staff and resources in the neighbourhood team including Derbyshire Social care services.

3.13 The use of telehealth solutions would be possible, to introduce individuals to the technology, its benefits and so that they are familiar with how to use it on discharge.

3.14 Families can more easily be enabled to be part of the "team" and therefore part of the solution rather than the recipient of a plan and an individual's ability to initiate activities and manage independently can be tested, prior to returning home.

3.15 The ICFT will continue to develop the plan for these beds with the commissioners and neighbourhood team.

Delivery of all levels of Intermediate Care

3.16 The National Audit of Intermediate Care uses 4 categories for intermediate care: crisis response, home based rehabilitation, bed based intermediate care and re-ablement. This section of the report outlines the NAIC definitions (outlined in full in the document attached at **Appendix 2)** and the ICFT's statements regarding delivery of intermediate care across all 4 categories.

3.17 Crisis Response:

Setting	Aim
Community based services provided to service users in their own home / care home	Assessment and short term interventions to avoid hospital admission

3.18 (NICE definition) - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

3.19 The urgent element of the Intermediate Care model for Tameside and Glossop provided through the Integrated Urgent Care Team (IUCT). IUCT is a joint service provided by the ICFT and TMBC, which is made up of health and social care services for Tameside patients and healthcare services for Glossop patients (with interface with Derbyshire County Council social care services). IUCT provide the urgent response to the crisis health and/or social care need for patients. The IUCT ensures patients are supported through the most appropriate pathway into and out of acute hospital or care services with "home" always being the goal.

3.20 Home Based Rehabilitation:

Setting	Aim
Community based services provided to service users in their own home / care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness,

	timely discharge from hospital and maximising independent living

3.21 (NICE definition) - Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

3.22 A range of services come together to provide home based intermediate care services for Tameside and Glossop, these include IUCT, community and specialist intermediate care services (and new services being implemented as part of the Integrated Neighbourhoods). These are provided in the community setting to deliver the home based intermediate care offer to patients in their place of residence (whether that is at home or in a care home). Under the Home First model, the IUCT team aim to support patients to receive home based Intermediate care whenever possible and appropriate to the person's rehabilitation goals.

3.23 Following the crisis response IUCT provides on-going nursing and therapy care for up to six weeks until individuals are suitably rehabilitated for the community therapy and district nursing teams to take over ongoing care or the person no longer needs these services. For social care, IUCT provide crisis response wrap around support for up to 72 hours, at which time, if the individual has not regained independence they would be referred to Reablement intermediate care). Reablement can be in place for an individual anything between a couple of days and 6 weeks to meet their rehabilitation needs. Following this period of care a social worker will review the support package and if longer term support is required, the social worker will commission a package of care and the neighbourhood teams would then take over the ongoing care coordination.

3.24 Alongside this the intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services. These services are detailed in **Appendix 4** and include District Nursing, therapy services such as Speech and Language therapy and Community Neuro-Rehabilitation and community IV therapy services.

3.25 Bed Based Intermediate Care:

Setting	Aim
Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, Independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital

3.26 (NICE definition) Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

3.27 In line with the outcome of the consultation, bed based intermediate care for the population of Tameside & Glossop will be delivered from the Stamford Unit on the Tameside Hospital

site. In addition, there will be an offer developed for the Glossop neighbourhood, as outlined in detail in sections 3.11 – 3.15 of this report.

3.28 Re-ablement:

Setting	Aim
Community based services provided to service users in their own home / care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised

3.29 (NICE definition) Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

3.30 Reablement services are provided in Tameside and Glossop by Tameside Metropolitan Borough Council (TMBC) Adult Social Care, and for Glossop, by Derbyshire County Council.

Glossop Integrated Neighbourhood Services

3.31 The report presented to the SCB in January 2018 included details of services available to the Glossop neighbourhood. The document which was shared as an appendix to the January report has been updated and is attached to this report at **Appendix 5**.

3.32 The offer to the population of the Glossop neighbourhood has been developed and enhanced over recent months, with some services in the neighbourhood commencing since the presentation of the report to the SCB in January, and plans in place to develop more during 2018-19. These include:

- Neighbourhood Pharmacists have been recruited by the ICFT and are providing care in all neighbourhoods, including Glossop
- A 7-day primary care access service, delivered by Orbit (GP Federation) with Go To Doc, is available in Glossop Primary Care Centre. The promotion of the service has increased to ensure it is used to its optimum
- Extensive Care service – a new weekly Extensive care clinic in Glossop PCC commenced in April. A second clinic will be explored subject to demand being established
- Community IV Therapy operates in people's homes in Glossop
- The Digital Health service is providing access to hospital clinicians for Glossop Care homes and the Glossop Community Paramedic. Glossop Care homes are signed up and have the required equipment
- In addition to the existing mental health services, Glossop residents with common mental health problems will be supported by the expansion in psychological therapies, where a new provider will be joining Pennine Care Healthy Minds service to create a new psychological therapy (IAPT Plus) service to enable more people to receive support from a wider choice of therapies. This new service will be operational in Autumn 2018
- The ICFT have confirmed that they have made provision for the Physiotherapy, OT, Therapy Outpatients and Pulmonary Rehab to be delivered from the Glossop Primary Care Centre for Glossop residents
- The Glossop Neighbourhood team operate a Glossop Multi-Disciplinary Team meeting from GPCC

3.33 Through the Intermediate Care programme work stream, a full public and staff communication plan is being developed to ensure that staff and our local population are fully engaged in relocation plans. This will be finalised and enacted once the relocation date is confirmed. This will include:

- Patient information and a communication plan for patients and carers who are resident in Shire Hill in the lead up to the relocation which will include individualised patient information and discussions with patients on discharge and rehabilitation planning.

- Public and stakeholder communication materials which will include, visual communication materials to be distributed to community estate, use of existing stakeholder communication channels (such as GP newsletters, target meetings, neighbourhood forums), communication information to be presented at existing neighbourhood led patient and public forums and use of social media platforms.

- Staff updates for all staff across the ICFT including Shire Hill, Stamford Unit, and Community and Neighbourhood team. As well as dedicated staff updates on the relocation, the ICFT will use existing methods to communicate with the wider ICFT staff group including the weekly catch up with Karen newsletter, the executive led open house forum and the dedicated staff social media channels.

- Finally, the ICFT will arrange a staff celebratory event to recognise the contribution of Shire Hill and the dedication of the teams.

Glossop Primary Care Centre Utilisation

3.34 The Strategic Commissioning Board requested assurance on progress towards an 80% occupancy rate and increased service provision from Glossop Primary Care Centre.

3.35 The Strategic Estates Group have reviewed the situation, and have indicated that with moves – planned and delivered – utilisation is already at around 80%.

Staffing Implications

3.36 The staff members directly affected by the proposals for bed-based intermediate care were briefed throughout the consultation process by the senior management team of the ICFT, and were involved in the public meetings held during the consultation period. Their views were incorporated in the consultation feedback included in the January SCB report.

3.37 The ICFT as the employing organisation of staff directly involved in the delivery of the existing bed based intermediate care services, have ensured the required staff engagement and consultation processes have been undertaken following confirmation of the Strategic Commissioning Board's decision.

3.38 The consultation process for the relocation of staff commenced in February 2018. All staff based at Shire Hill have been offered a 1:1 meeting and offered the opportunity to relocate to the Stamford Unit, or to be considered for redeployment opportunities within the Community setting, if travel to the acute site would be difficult. The one to one meetings have been successful, with most staff either confirming their transfer to the Stamford Unit and others being actively considered for redeployment opportunities. A number of staff have been successful in obtaining redeployment opportunities within the organisation in community services, although they will remain at Shire Hill until transfer, to ensure safe staffing levels.

3.39 A recruitment event has been held to recruit to vacant posts and the Trust believes that there is sufficient staffing transferring to the Stamford Unit or commencing in post to ensure that the intermediate care beds can be safely staffed. Currently there are enough staff to support the existing Intermediate care beds at Shire Hill. However, a number of staff from Shire Hill have accepted posts outside of the organisation and are currently working their agreed notice period, therefore there is a risk that staffing at Shire Hill could be reliant on agency staff if the relocation of the Intermediate care beds is not progressed at pace. In addition, other areas within Community may experience operational pressures if staff are not soon released to their redeployed roles.

3.40 Safe staffing of intermediate tier services will be monitored through quality and performance contract meetings between the Strategic Commission and T&G ICFT to ensure a focus on quality and safety during and after transition.

Financial Implications

3.41 The January SCB report included a proposal for a recurrent budget of £8,032k, plus up to an additional £250k to support the purchase of up to 8 beds at any one time on an appropriate individual basis for residents of Glossop. The report also stated that £1,983k of non-recurrent transformation funding from GMHSCP is available to fund transition to the new arrangements. With the additional (up to) £250k to support the beds in Glossop, this still represents a financial efficiency to the locality.

Estates Implications

3.42 The report to SCB in January 2018 stated that the decision of the Strategic Commissioning Board would be communicated to the ICFT who would then take any necessary action with regard to their estate and current contracts / arrangements.

3.43 Shire Hill is owned by NHS Property Services (NHSPS), a limited company owned by the Department of Health. If a decision is made to transfer services out of Shire Hill and dispose of the site, notice will need to be served to NHSPS. Current rental payments would stop at the end of the notice period.

3.44 At the end of this period the NHSPS would control the site and it will be for them to determine the future of the estate. Any capital receipts which result from a hypothetical sale of the site would accrue to NHSPS. As the asset is not owned within the local economy, there would be no financial benefit to either the ICFT or the strategic commissioner.

Service Improvements and Outcome Measures

3.45 In the January report to the SCB it was confirmed that the Strategic Commission would ensure that the outcome of the consultation would result in the development of clear outcome measures in the contract with the ICFT, to enable the monitoring of the quality of intermediate care services in Tameside and Glossop. These will be included in the contract held between ICFT and the Strategic Commission.

3.46 NICE issued new guidance in September 2017 on **NG74: *Intermediate care including re-ablement*** and are currently consulting on the development of Quality Standards. Commissioners will ensure this guidance is reflected in the contractual documentation supporting the delivery of Intermediate Care in Tameside & Glossop.[1]

3.47 A Quality Impact Assessment of the bed based intermediate care proposals was produced to support the January SCB report.

4 NATIONAL AUDIT OF INTERMEDIATE CARE (NAIC) 2018

4.1 The NAIC measures intermediate care (IC) service provision and performance against standards derived from government guidance and from evidence based best practice. The audit provides national comparative data for bed and home based intermediate care and re-ablement services provided by a range of health and social care providers including acute trusts, community service providers and Local Authorities. The specification for this audit is attached at **Appendix 6**.

[1] https://www.nice.org.uk/guidance/ng74 ; https://www.nice.org.uk/guidance/GID-QS10059/documents/draft-quality-standard

4.2 The objectives of the audit, set out in the specification, are:

- To assess performance at the national level against key performance indicators and quality standards and provide benchmarked comparisons at the local level to facilitate service improvement.
- To assess the service user experience of intermediate care through the Patient Reported Experience Measures (PREM) for bed, home and re-ablement services, highlighting areas of improvement that are important to service users.
- To collect standardised outcome measures for intermediate care and to use the outcomes data to understand the key features of high performing services.
- To provide evidence of the whole system impact of intermediate care to assist commissioners in making the case for intermediate care investment.
- To inform future policy development within the Department of Health (DH), NHS England, the Welsh Government and the Northern Ireland Public Health Agency.
- To continue to share good practice in intermediate care services by encouraging networking amongst participants and developing case studies.

4.3 It is the commissioner expectation that the commissioner (Tameside & Glossop CCG) and provider organisations (ICFT, Tameside Metropolitan Borough Council and Derbyshire County Council) will participate in the 2018 National Audit of Intermediate Care to support the ongoing review and analysis of the Intermediate Care system in Tameside & Glossop.

5 EQUALITY IMPACT ASSESSMENT

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

5.2 The Equality Act 2010[2] makes certain types of discrimination unlawful on the grounds of:

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

These are called 'protected characteristics'.

5.3 The Strategic Commission have an additional 4 locally determined protected characteristic groups:

- Carers
- Mental health
- Military veterans
- Breastfeeding

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

5.4 A full Equality Impact Assessment (EIA) was produced to support the report presented to the SCB in January 2018, and was used to inform the decision taken. The EIA was produced to ensure a response to issues raised within the consultation, providing a full evaluation of the impact of the proposed model, and exploring the required mitigations. These mitigations form the basis of the implementation plan outlined in this latest report.

6 CONCLUSIONS

6.1 The interim report presented to the February meeting of the SCB included a letter from the Clinical Chair and Chief Executive of the CCG, which set out expectations with regard to assurance on the progress of mitigations required before implementing the new model and moving the bed based care from Shire Hill to the Stamford Unit. The ICFT's response to this letter is included in detail in this report. This conclusion outlines the Interim Director of Commissioning's review of the ICFT response.

6.2 **Process for identification and referral of patients in intermediate care in Glossop:** The response in Section 3.2 – 3.10 address in detail how patients are currently assessed for Intermediate care and how this can be enhanced in the future. The Project Management team clearly have objectives of how Glossop patients in particular, will be offered choice as appropriate.

The Interim Director of Commissioning is satisfied that processes are in place to identify patients, offer choice and fulfil the expectation of Commissioners. There are clear processes to monitor adherence to the principles agreed in the Intermediate care decision of January 2018.

6.3 **Commissioning of Intermediate Care Beds in Glossop:** The commissioning of intermediate care beds in Glossop will be purchased on an individual basis to meet an individual's needs. The commissioning of these beds will be subject to ensuring that the provision meets expected standards for providing intermediate tier services. That such provision meets CQC standards and can be assured is of sufficient quality, safety and has sufficient staffing available to provide high quality intermediate care. The clinical oversight and treatment of individuals using beds in Glossop will remain with Tameside &Glossop Integrated Care Foundation Trust and will be subject to ICFT governance processes.

The Interim Director of Commissioning is satisfied that there is a plan to develop a commissioning process to support the additional bed based intermediate care provision in Glossop should this be appropriate. However, this work can happen in parallel with the implementation but assurances will need to be gained that this is in place prior to the actual relocation of beds.

The Interim Director of Commissioning is working with the Strategic Commission's Director of Quality and the ICFT Director of Nursing to ensure the process is robust and agreed.

6.4 **Delivery of all levels of Intermediate Care:** The evidence provided by the ICFT is strong in relation to the delivery of bed based intermediate care and re-ablement. The IUCT model is cited as delivering the crisis response and home based intermediate care. The ICFT's commitment to participating in the National Audit of Intermediate Care 2018 will enable commissioners to review and evaluate the delivery of crisis response and home based intermediate care.

The Interim Director of Commissioning is satisfied that the ICFT is offering service provision at all levels of Intermediate Care. This however will need to be kept under review and assurance gained via the National Audit.

The Director of Quality & Safeguarding chairs the Quality & Performance meetings held between the Strategic Commission and ICFT which monitors process and enables commissioners to request specific quality reviews where there are areas of interest. Through these meetings, commissioners will ensure the continued delivery of home based intermediate care to all 5 neighbourhoods in the locality, in line with the National Audit of Intermediate Care 2018 (NAIC) expectations and the NICE quality standards referred to in section 4.

As described in the body of the report, safe staffing of intermediate tier services will also be monitored through quality and performance contract meetings to ensure a focus on quality and safety during and after transition. In addition, the Interim Director of Commissioning recommends that a specific quality review be enacted in 2018-19 to review delivery of the new model for Intermediate Care.

6.5 **Glossop Integrated Neighbourhood Services:** There is strong evidence to show a high level of integrated working in the Glossop neighbourhood and progress towards delivery of the commissioned model for Integrated Neighbourhoods. The evidence provided by the ICFT, included in this report and the reports presented to SCB in December and January, provide details to support this. Further work is being undertaken across the locality to determine how the effectiveness of the Integrated Neighbourhood model will be reviewed and evidenced.

The Interim Director of Commissioning is satisfied that the ICFT has met this SCB recommendation as described in the letter to the ICFT on February 2018 and attached at Appendix 1.

6.6 **Glossop Primary Care Centre Utilisation:** There is strong evidence that the use of the Glossop Primary Care Centre is improving, and that the work of the Strategic Estates Group will ensure this continues to be the case.

The Interim Director of Commissioning is satisfied that the ICFT has met this SCB recommendation as described in the letter to the ICFT on February 2018 and attached at Appendix 1.

7 RECOMMENDATIONS

7.1 As set out on the front of the report.

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Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Headquarters
Dukinfield Town Hall
King Street
Dukinfield
SK16 4LA

Tel: 0161 342 5500
www.tamesideandglossopccg.org

8 February 2018

Karen James
Chief Executive
Tameside and Glossop Integrated Care NHS Foundation Trust
Fountain St
Ashton-under-Lyne
OL6 9RW

Dear Karen

Re: Intermediate Care in Tameside & Glossop

The Tameside & Glossop Strategic Commissioning Board considered the report on bed based intermediate care on 30th January 2017 and following considerable discussion, supported the recommendation to approve Option 2 for those patients where it is not possible to deliver rehabilitation and recuperation at home. This will result in the centralisation of the Tameside and Glossop Intermediate Care beds into the Stamford Unit.

The recommendation was approved subject to the implementation of the following mitigations:

- During the public consultation, views were heard from Glossopdale residents that they could be disadvantaged by the implementation of Option 2 due to not having families and friends close by to support their care and recuperation. In order to mitigate this, we will work with you and the Glossop Integrated Neighbourhood team to maximise their ability to support enhanced rehabilitation and recuperation at home as well as to continue to examine further opportunities to increase this provision in the future;

- As the Strategic Commissioner, we will seek advice from you regarding additional health and social service provision we could commission from the Glossop Primary Care Centre and support this increase as rapidly as possible;

- We recognised the value of receiving intermediate bed based care as close to home as possible and therefore we have agreed to engage with local care providers and Derbyshire County Council to explore the potential for up to 8 beds for purchase on an individual basis for residents of Glossop subject to these beds reaching our required standards for quality;

- We also recognised that the demands for Intermediate Care home based offer and therefore the bed requirement across Tameside and Glossop is likely to change over time and so we agreed to review the numbers of beds required on an annual basis. We will obviously work with you to ensure future demand is continually assessed and planning for future local provision is adapted accordingly;

- The concern regarding the future of the Shire Hill hospital site was also heard by the Strategic Commission. We will be leading initial development work with partners and in particular High Peak Borough Council, Derbyshire Country Council, Greater Manchester Health and Social Care Partnership as well as the residents of Glossop to support the Shire Hill site remaining within the health and social care estate and providing supported accommodation in future.

It would be helpful if we could discuss in the near future the next steps as our expectation is that the relocation of intermediate care beds from Shire Hill to the Stamford Unit should not take place until we collectively have assurance on the progress of these mitigations. Specifically, we would like to discuss;

- The development of a clear, documented process which the ICFT will follow to identify patients requiring support from an intermediate care bed in the Glossop neighbourhood. This will need to include how patients are identified, what information they receive with regard to their choice of inpatient intermediate care offer, how it will be agreed that their period of 'discharge to assess' in the Stamford Unit will conclude and the move to Intermediate Care take place and how this will be organised in conjunction with the patient, their carers, their GP, Glossop Integrated Neighbourhood team including Derbyshire County Council;

- We envisage that you will wish to lead the commissioning of these Intermediate Care beds in Glossop and will be able to do so within the financial envelope already provided for Intermediate Care. We will support the quality assurance process of the beds identified as appropriate;

- As Strategic Commissioners, we will require assurance through our Contract, Quality and Performance meetings regarding delivery of the 4 elements of intermediate care throughout Tameside and Glossop, as set out in the National Audit of Intermediate Care (appendix 3 to the national report) and attached to this letter as Appendix A. As you will appreciate, this was the basis for our whole new model of Intermediate Care.

- In regards to Glossop specifically, we believe it will be important to communicate effectively and assure the local population on the delivery of Glossop Integrated Neighbourhood services as set out in the paper considered by the Strategic Commissioning Board (Appendix 5 in the report – attached again here as Appendix B) and would like to agree with you how we can do this optimally.

- Finally, we have long accepted that the Glossop Primary Care Centre is under-utilised in terms of capacity and range of services offered. We would like to work with you to facilitate the development and/or transfer of additional health services to the Glossop Primary Care Centre with the ambition of an 80% occupancy rate and increased service provision.

We believe the decision taken on 30th January was the right one in terms of improving clinical outcomes for all residents of Tameside and Glossop, we recognise the impact on the Glossopdale community including staff working and living in the local area. By working together and in partnership, we look forward to achieving afore mentioned mitigations and subsequently, safely ensuring the effective relocation of bed based Intermediate Care.

Headquarters: NHS Tameside and Glossop Clinical Commissioning Group, Dukinfield Town Hall, King Street, Dukinfield, SK16 4LA.
Tel: 0161 342 5500 www.tamesideandglossopccg.org

Yours sincerely

Alan Dow
Clinical Chair

Steven Pleasant MBE
Accountable Officer / Chief Executive

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Appendix 3. Service category definitions

The following table was supplied to audit participants to enable them to categorise services in the audit.

IC Function	Setting	Aim	Period	Workforce	Includes	Excludes
Crisis response	Community based services provided to service users in their own home / care home	Assessment and short-term interventions to avoid hospital admission	Services with an expected, standard response time of less than four hours. Interventions for the majority of service users will typically be short (less than 48 hours) but may last up to a week (if longer interventions are provided the service should be included under home based IC)	MDT but predominantly health professionals	Intermediate care assessment teams, rapid response and crisis resolution	Mental health crisis resolution services, community matrons/ active case management teams
Home based	Community based services provided to service users in their own home / care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care rehabilitation	Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care

IC Function	Setting	Aim	Period	Workforce	Includes	Excludes
Bed based	Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care bed based services	Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/ rehabilitation, mental health rehabilitation beds
Re-ablement	Community based services provided to service users in their own home/care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for on going homecare support can be appropriately minimised	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly social care professionals	Home care re-ablement services	Social care services providing long term care packages

Community Step Up Referral

Community Enhanced Intermediate Care Service
REFERRAL FORM

All sections must be completed

Patient Details			
AFFIX PATIENT STICKER **or** record name, address, DOB and NHS No.		Patients Telephone No.	
		Is home the final discharge destination after a period of intermediate care? YES NO	
Ward	Ward Tel No.	Long term discharge plan:	
Religion	Marital Status	Ethnicity	Preferred Language
Interpreter Required		YES NO	
NEXT OF KIN DETAILS		**MAIN CARER (If different from NOK)**	
Full Name	Relationship to patient	Full Name	Relationship to patient
Address (including postcode)		Address (including postcode)	
Contact Tel/Mob Number(s)		Contact Tel/Mob Number(s)	
GP DETAILS			
AFFIX GP STICKER HERE **or** Record GP's details (including postcode)		Date last seen by GP	
GP Tel No.			
Qualified OT/Physio Professional:			
REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

PATIENT DETAILS	
Condition change – why IMC is required?	
Past medical history (include dates)	
WOUNDS PRESSURE ULCERS YES NO LOCATION GRADE	Equipment needed e.g. mattress/dressings Oxygen concentrator required? YES NO
Waterlow score	Weight (approx.)
Continence management	Night time needs
Physio Update	Social Worker Update
	Social Worker Name: Social Worker Tel No:

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

CURRENT MENTAL STATE. MUST complete abbreviated mini mental test. This does not necessarily exclude patients but will support patient safety			
1. What is your age?	2. What time is it to the nearest hour?	3. Give patient the address: 42 West Street to remember ask at end of test.	4. What year is it?
5. Name of hospital	6. Recognise 2 people e.g. Doctor or Nurse	7. D.O.B	8. Dates of world war (1939 – 1945)
9. Name of Prime Minister?	10. Count backwards from 20 to 1	11. Ask the patient to repeat the address in Q3	Total Score **/10**

BEHAVIOUR		
Any signs of confusion?	YES NO	
Able to follow instructions?	YES NO	
Does the patient wander?	YES NO	
Does the patient have insight?	YES NO	
Is the patient motivated?	YES NO	
Does the patient have any challenging behaviour?	YES NO	If yes, please describe what and how is this managed?
Is the mental health team involved?	YES NO	
Is/has the patient been on DoL's	YES NO	
Any other supporting information?	YES NO	

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

Function	Previous	Current
MOBILITY Include equipment used		
STAIRS		
TRANSFERS: • BED • CHAIR • TOILET		
WASHING & DRESSING		
EATING/DRINKING		
MEAL PREPARATION		
SHOPPING/CLEANING/LAUNDRY		
CARE PACKAGE (please include any changes to care package and who will be arranging this)		

REHAB / RECOUP GOALS

REFERRERS DETAILS

NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

MEDICATION LIST		
Name	**Dose**	**Time of day**

REFERRERS DETAILS			
NAME	SIGNATURE	DESIGNATION	DATE

Patient Name…….. DOB…… NHS No……..

Consent for transfer to Intermediate Care

Please sign below to confirm that you agree to completion and consideration of referral for Intermediate Care.

Patients Signature ……..

Print Name ……...

Date ……

NOK Signature ……..

Print Name …….

Date ……

Note: If NOK is unable to sign – please state if discussed with them.

……..

The Bureau

THE BUREAU

Glossop's Voluntary and Community Network
Helping you get on the right track

- Do you want to find out about local services?
- Do you have a long-term health condition?
- Are you feeling anxious or lonely?
- Do you have money or housing worries?

Come and talk to The Bureau!

Having the right support through life's ups and downs can really help. Our community navigators offer a listening ear and practical assistance to get you on the right track. We can connect you to a range of local services that can offer you the support you need.

Some examples include

- Help to manage health conditions
- Help with Shopping
- Social activities
- Transport
- Home Maintenance
- Hobbies and interests
- Employment support

What are you waiting for, Get in touch!
For Glossop contact The Bureau:

Telephone: 01457 865722
E-mail: sophie@the-bureau.org.uk
Web: www.the-bureau.org.uk

The Bureau
High Street East
Glossop
SK13 2BJ

TG1210

Ticket Home

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

TAMESIDE AND GLOSSOP INTEGRATED CARE
NHS FOUNDATION TRUST

FIRST CLASS
TICKET HOME

NAME

WARD

CONSULTANT:

WHY I AM HERE:

EXPECTED DATE OF DISCHARGE:

ACTUAL DATE OF DISCHARGE:

DISCHARGE DESTINATION:

ESTIMATED TIME OF ARRIVAL:

FIRST CLASS
TICKET HOME

FLIGHT : 95678A
FROM : HOSPITAL
SEAT : 31L
TO : HOME
GATE : O2
SEAT : 31L
TIME : 10 : 30

No: 1234567890000000000

Please note that if your condition changes, your Expected Date of Discharge may change.

Admission

My Checklist

- Clothes
- Shoes
- Nightwear / Dressing gown
- Toiletries (toothbrush etc)
- Aids that I use (walking stick, hearing aid, glasses etc)
- Tablets or medicines that I take
- Contact details for my next of kin

Any other thoughts or questions...

Remember: "You come to hospital for acute treatment, you go home to get better."

healthwatch Tameside

Healthwatch Tameside

Healthwatch Tameside is your local consumer champion for health and care.

At the heart of our work is influencing local health and care services. We want to help the people who provide the services, to understand what local people think about those services.

We need to hear from you if you have a story to tell about health or care services you (or a relative) have used in the last 12 months. You can tell us about positive experiences as well as raise concerns.

We provide an information (signposting) service to help you to make informed choices about the services you can access.

We also help people to understand how the NHS complaints process works, if something has gone wrong.

Any information we are given will remain anonymous.

We are careful to share ideas in a way which will not identify any individuals.

If you want to speak to someone about your experiences please contact:

To contact Healthwatch Tameside call: **0161 667 2526**
E-mail : info@healthwatchtameside.co.uk

Or go to the website: www.healthwatchtameside.co.uk

Useful Contacts

Ward Telephone Number:

.....

Once you have left the hospital, if you feel you require further support please contact the Integrated Urgent Care Team on 0161 342 4299

Action Together

When you are discharged from hospital, you may be leaving with a condition or illness and you may want some advice or support about this.

Action Together can put you in touch with charities and support groups who can help you with your particular issue.

Or you may want to be more involved with your local community, join a club, meet up and have a brew with some likeminded people, or get more active.

Action Together can put you in touch with local charities, faith organisations, sports clubs, projects and groups who can provide opportunities to meet people, learn new skills and have fun!

If you are interested in finding out what is happening in your area, please contact us on **0161 339 2345** or e-mail info@actiontogether.org.uk

www.actiontogether.org.uk

During my stay

Things to think about...

How am I feeling?

Am I clear about what is happening next?

Am I worried about anything?

When am I going home?

Have I got dressed and am I moving around?

Medical Notes

What did my doctor say / questions for my doctor [for you to fill in]

Days my Consultant visits the ward:

What is needed to get home? Clinical criteria for discharge:

What did my therapy team say / questions for my therapy team
[for you to fill in]

What did my social team say / questions for my social team
[for you to fill in]

Equipment:

If you require equipment, you will either be given equipment to take home with you (e.g. a walking stick) or equipment may need to be delivered and fitted when you have been discharged. You will be shown how to use your equipment. If your equipment is on loan to you whilst you regain your independence, you will be informed how to return it.

Medications:

If you brought medications into hospital with you, these will be returned to you when you are ready to go home, unless you no longer need them. On discharge you may be given more or less medication and the Pharmacist or Nurse on the ward will explain this to you, including any instructions you need to follow before you leave. Any further prescriptions need to be obtained from your GP.

If you are receiving nutritional support, you will be given a 7 day supply and further supplies will be delivered to your home.

Discharge Summary:

This is a letter giving details of your hospital treatment and discharge medications. A copy will be sent to your GP and you will also be given a copy. Please keep this to show anybody involved in your care.

On the day of discharge

You are expected to arrange your own transport home to arrive by 10am. If you need any support arranging this, please ask your nurse.

If your transport cannot arrive by 10am, you may be asked to wait in the day room or discharge lounge.

If you need contact numbers of local taxi firms, please ask your nurse or case manager.

Daily Diary

What is going to happen for me today?

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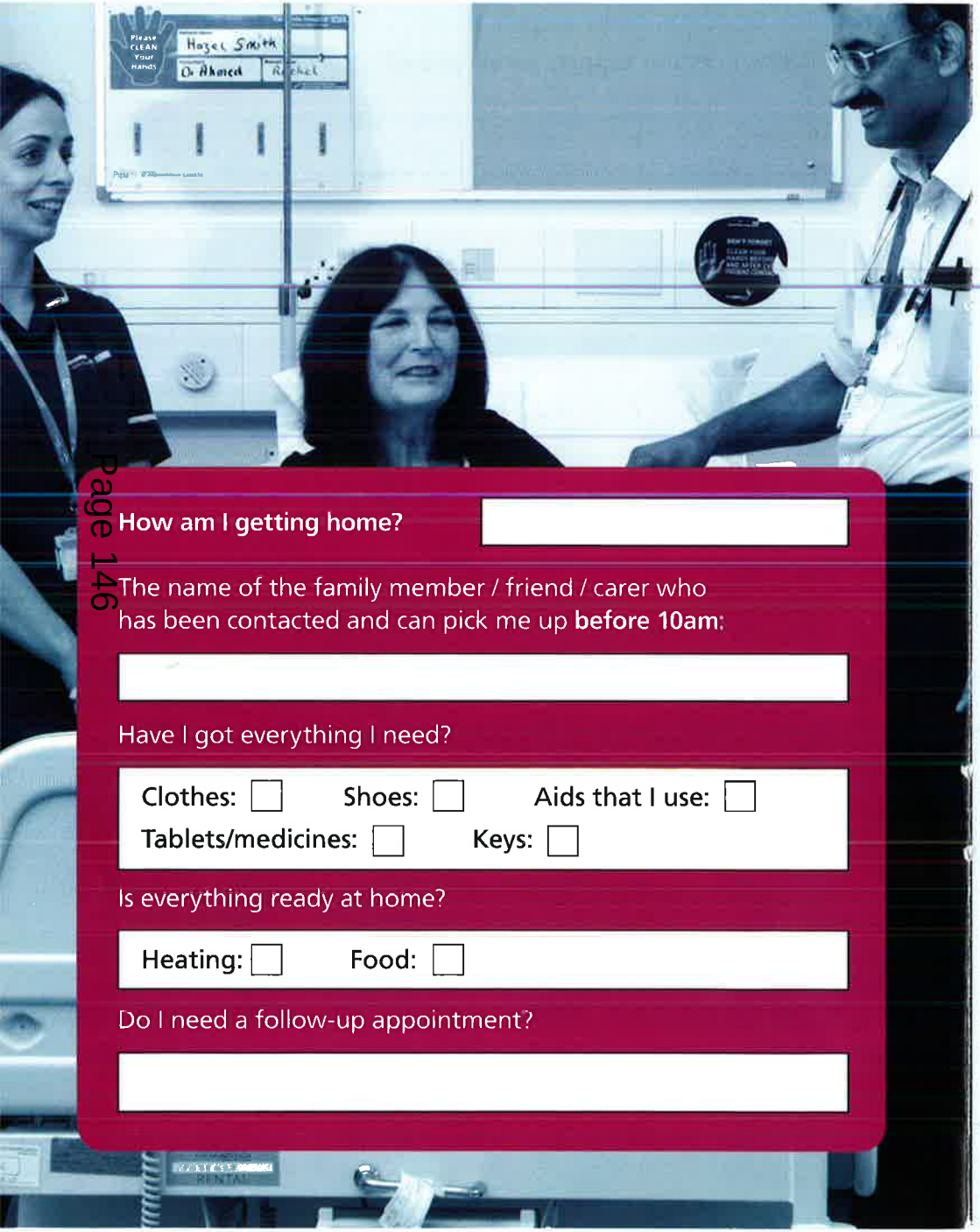
Preparing to leave & Next steps



How am I getting home?

The name of the family member / friend / carer who has been contacted and can pick me up **before 10am**:

Have I got everything I need?

Clothes: ☐ Shoes: ☐ Aids that I use: ☐
Tablets/medicines: ☐ Keys: ☐

Is everything ready at home?

Heating: ☐ Food: ☐

Do I need a follow-up appointment?

Where am I being discharged to?

Who will be involved in my care?

- District nurses ☐
- Physiotherapists ☐
- Occupational therapists ☐
- Social care team ☐
- Voluntary sector ☐

Do I understand my medication?

Do I have everything I need?

Intermediate Care Model for Tameside and Glossop

Vision for New Model of Care for Tameside and Glossop

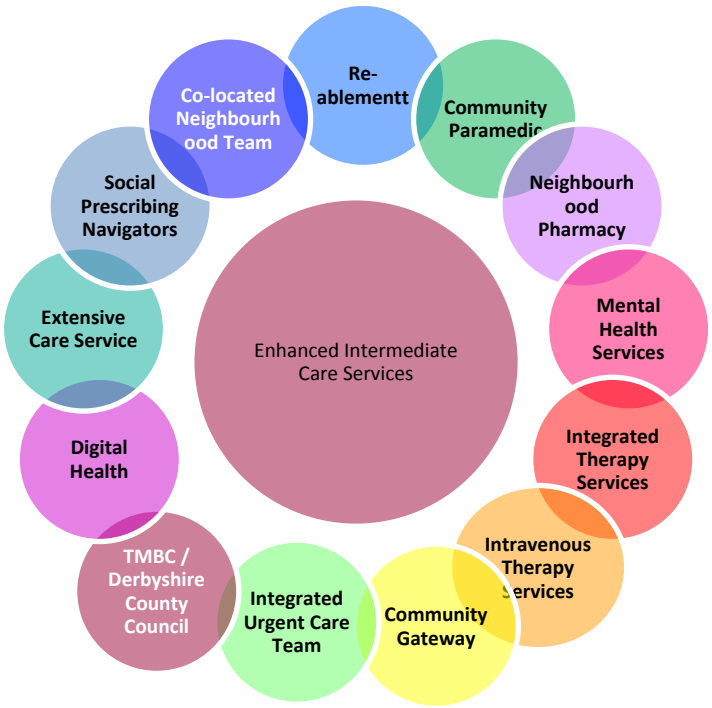
Tameside and Glossop health and care system has recognised that it needs to develop new models of health and social care to meet the changing needs of is population, including an aging population with more complex and long term health and care needs and the need to provide high quality and effective care closer to the patients' home.

The two key aspects of the new model of care is the creation of Integrated Neighbourhood teams in 5 localities and Urgent Integrated Care. The Integrated Neighbourhoods will bring together health and social care delivery and dramatically improve the coordination of care through individual care plans and the sharing of expertise. They will proactively identify those people with the most significant ongoing health and care support needs. The urgent integrated care will have responsibility for looking after local people who are in social crisis, or who are seriously unwell.

Vision for Enhanced Intermediate Care

The aim of the intermediate care model is to provide fully integrated services which support the rehabilitation and recuperation of patients, to enable them to continue living at home in all but most challenging cases. With a requirement for;

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) by an integrated team providing both health and social care input based on individual need.



- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

Proposed Intermediate Care Model

There are four nationally defined categories of intermediate care;

Crisis Response:
(NICE definition) - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home Based Rehabilitation:
(NICE definition) - Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Bed Based Intermediate Care:
(NICE definition) Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Re-ablement:
(NICE definition) Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

Below is a description of how services will be provided at each of these interfaces to make up the intermediate care offer to Glossop residents.

Crisis Response

The urgent element of the Intermediate Care model for Tameside and Glossop is through the Integrated Urgent Care Team (IUCT) which is made up of health and social care services for Tameside patients and healthcare services for Glossop patients (with interface with Derbyshire County Council social care services). IUCT will provide the urgent response to the crisis health and/or social care need for patients. The IUCT service to ensure patients are supported through the most appropriate pathway into and out of acute hospital or care services with “home” always being the goal.

Integrated Urgent Care Team (IUCT)
Integrated Urgent Care Team (IUCT) made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some

difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. The Team can provide care calls for upto 72 hours until longer term care can be put in place. Ongoing support will then be provided working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible. IUCT is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs.

Home/ Community Based Services

IUCT, community and specialist intermediate care services are in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting to deliver the home based intermediate care offer to patients in their place of residence (whether that is at home or in a care home).

The intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services. The intermediate tier services which will provide services for the intermediate care offer include;

Community Integrated Urgent Care Team (IUCT)

The Integrated Urgent Care Team (IUCT) also provide the short term community based social care services and/or placements (for Tameside population) for a period of upto 6 week which sit alongside the intermediate tier health care services to provide a full home based intermediate care service.

Extensivist Care Services

A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will be staffed by specialist Extensivist GPs with clinics being provided from the Glossop primary care centre, who will work with a cohort of high risk patients identified through risk stratification.

Intravenous Therapy (IV) Service

7 day Community IV therapy service to provide IV therapy in the home setting to allow early discharge from hospital or avoid a hospital stay for IV therapy.

Digital Health

Digital Health Service is a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice to avoid unnecessary ED attendances for our elderly population. This service has commenced in Willow Bank and Pendlebury Court care homes in Glossop and will be in place in Oakford Manor by the end of August.

Community Therapy services

These community based services provide assessment and treatment in a number of settings, including Glossop Primary Care Centre, nursing and residential homes, clinics and group sessions. These services include;

Community Physiotherapy/Occupational Therapy - The Team provide a service to patient who require physiotherapy assessment/treatment in their own homes this would include residential and nursing homes. The Occupational Therapy (OT's) is provided by internal referral only from the physiotherapists in the Team. The Team also provide assessment and provision of mobility aids for patients to maintain independence. The Team also takes the lead in provision of case management and therapeutic intervention for patients with MND. Another element to the service is management of respiratory disorders encouraging self –management and coping strategies.

Speech and Language Team (SALT) - The SALT provide services to the Community this would include residential and nursing homes. Assessment, diagnosis and management of swallowing impairment and advice on the management of these conditions. The team work on communication impairment and provide alternative strategies for patient to communicate, the team also work on voice control and management of conditions such as stammering. The team have close working links with Community Dietetics, Community Physiotherapy and Occupational Therapy and the Community Neuro Rehabilitation Team.

Community Dietetics - The Community Dietetics team see patients for a range of conditions where diet and nutrition is part of the long term treatment e.g. Neurological, Oncology, GI conditions, Chronic Obstructive Pulmonary Disease, Diabetes and Home Enteral Tube Feeding the service is provided in a number of ways these being; Home visits, Clinics, Nursing and Residential Homes. The Team also work closely with GP's and provide advice on the appropriate prescribing of Nutritional Supplements.

Community Neuro Rehabilitation Team CNRT - The CNRT assess and treat patients who have an acquired neurological diagnosis from patient who have a registered Tameside & Glossop GP. The team is a multi-disciplinary, holistic, goal led service consisting of; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Specialist Rehabilitation Nurse's, Parkinson's Specialist Nurse, Psychology, Technical Instructors and Team support staff. The Early Supported Discharge Team (ESDT) which is part of the CNRT support patients to live independently as possible in their home after a period of hospitalisation following a Stroke.

Community Podiatry - The podiatry service provides assessment, diagnosis, treatment and advice to improve tissue viability, mobility, to reduce pain and promote foot health. The key roles of the podiatry team are to work as a multi-disciplinary clinical teams e.g. specialist diabetes teams, vascular and diabetes clinics, physiotherapy musculo-skeletal teams and District Nursing teams. The team provide assessment, diagnosis and treatment of foot health problems, provision of preventative interventions and foot health education, provide Screening of diabetes patients within their GP practice and are involved in providing training to carers, health care and social care professionals.

Glossop neighbourhood also has a dedicated community paramedic who is part of the integrated community team and supports Glossop GP's, care homes and the community teams providing first response and specialist paramedic advice, assessment and treatment for patients in Glossop who might otherwise need emergency admission to hospital, including intermediate care patients.

Neighbourhood Pharmacy

The neighbourhood pharmacy service will be one of the key services within the integrated neighbourhood model of care. Pharmacists will work as part of the neighbourhood team to help identify patients at risk and intervene to reduce the need for patients to need to access hospital based services. The neighbourhood pharmacy service will support patients to self-manage their well-being and long term conditions through optimises medicines, as well as improving communication between GPs and other health care professionals.

Single Point of Contact

It is important that people have a single point of contact for all their care needs as we begin to provide an holistic approach to care. Patients will have one telephone number to contact health and social care professionals across the range of services. The SPOC will be based in one place, co-locating health and social care staff, and will operate 7 days a week. The SPOC will provide a 7 day phone line to help and guide people and professionals.

What home based Integrated Intermediate Care looks like for Patients?

When Mrs Smith slipped and fell in her own home she pulled her alarm cord. The community response team visited Mrs Smith and contacted the digital health centre through their 4G tablet device. The digital health nurses could see Mrs Smith to assess her and were able to rule out any obvious serious injury, the team provided advice and guidance and made a referral to the community Integrated Urgent Care Team to help Mrs Smith to mobilise following her fall. A Nurse from IUCT team assessed Mrs Smith and as a trusted assessor provided some equipment to help Mrs Smith's mobilise around her house and asked for one of the team's carers to visit in the evening to assist Mrs Smith to make her evening meals. The teams Physio provided Mrs Smith with some exercises she could do to increase the movement in her leg. After two days of support from the IUCT service Mrs Smith was able to manage independently in her own home but said that she would miss the company of the team. The IUCT team provided contact numbers for Action Together to provide Mrs Smith with the details of community voluntary services that she can get involved with.

Integrated Neighbourhoods

Tameside and Glossop Integrated Care Trust has established five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector. In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate

care needs. The team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required.

Mental Health Service

We are working to improve and integrate mental health services to better support the needs of individuals. This is being done by aligning all available resources within the locality including existing and new resources as part of our Care Together programme.

Social Prescribing Navigators

A social prescribing service within the neighbourhood teams who provide links to non-medical services to support individuals in self-care and wellbeing.

Community Social Care

Social care services are provided by Tameside Metropolitan Borough Council for Tameside and Derbyshire County Council for Glossop. These assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care.

Bed Based Intermediate Care

A **flexible** community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment; rehabilitation; completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care and facilitate timely discharge to assess for those people not able to be assessed at home but do not require Acute care.

When home is not the default position for the provision of care for an individual, the flexible community beds base will offer:

- Step down from acute care for patients who are awaiting assessment for ongoing care services (including complex assessments) or have an non-medical ongoing care/rehabilitation need before they are able to return to their place of residence
- Step up from community to avoid acute admission or long term care placement
- Intermediate Care Services (step up or step down)

The ICFT is the provider of all intermediate care beds for Tameside and Glossop. Following the implementation of the home based intermediate care model which ensures delivery of robust intermediate care services in the home setting, the Trust proposes that all the community beds should be located in the 96 bedded Stamford Unit facility in order to utilise the resource flexibly to meet the needs of the patients across the health economy and fully deliver the service model for intermediate care beds (with some additional provision in Glossop to meet the needs of the population).

What Bed based Intermediate Care looks like for Patients?

Mr Jones was admitted to Tameside and Glossop's flexible community bed base following a recent illness which required acute treatment in hospital. Mr Jones having COPD and diabetes had been admitted to hospital 3 times in the last year. At the IMC unit Mr Jones was assessed by the physiotherapist and provided with a list of 'goals' to be achieved during his stay and how long it was expected that this would take. After only 5 days at the unit Mr Jones had met his goals so a 'Home First' discharge to assess was arranged so that Mr Jones could continue his rehabilitation in his own home as soon as possible. Mr Jones was assessed by a physiotherapist and a social worker who were able to wrap around care and support until Mr Jones regained his confidence and independence. The IUCT team noted that Mr Jones has two long term conditions and has recently been admitted and discharged from hospital so made a referral to the Extensivist service so that Mr Jones could benefit from some enhanced medical intervention before his long term care needs could be fully met within his integrated neighbourhood.

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Tameside & Glossop Integrated Care NHS Foundation Trust

Additional services and integration of existing services within Glossop

Glossopdale has a Community Specialist Paramedic, now permanently funded following a positive evaluation of the test scheme. As well as providing a blue light response in Glossop, the post holder supports and liaises with other parts of the neighbourhood team, to prevent people having to be conveyed to Tameside General Hospital unnecessarily.

Glossop has an established model of working together across agencies, to get the best outcomes for its population. A weekly meeting of health, adult social care and The Bureau, enables a team approach to supporting our most vulnerable residents. The aim of this is to prevent people going into crisis by pre-empting change and being proactive in the management of the situation. Many more people in the neighbourhood have agreed to allow us to work in this way and they are benefitting from a joined up approach which they are at the centre of.

There is a fantastic Community and Voluntary offer in the Glossopdale area, delivered in many forms by 'The Bureau'. There is more capacity than ever before, to enable people to access advice and support that are based on more than medicine, which links people to the community and encourages self-care and peer support. The Bureau is part of the neighbourhood team at all levels from the strategic management team, the neighbourhood operational group and the weekly MDTs clinic location.

Glossop was the first neighbourhood to introduce a new social prescribing service (supported by the Bureau) which provides people with non-medical service options to improve their health and well being.

Home-based intermediate Services

Home-based intermediate tier services, offer intensive packages of care to people in their own homes (including residential and nursing homes) by an integrated team providing both health and social care input based on individual need.

In the Home

In addition to the home first model there are also community and specialist intermediate tier services in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting and form part of the out of hospital intermediate care offer to patients in their place of residence (whether that is at home or in a care home).

The intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services.

The intermediate tier services are described in detail in appendix one and include:

- Extensivist Care Services,
- Digital Health,
- Community therapy services
- Community IV Therapy Service
- Glossop community paramedic service.

Tameside and Glossop Integrated Care Trust has established a Glossop Integrated Neighbourhood Team, which is an integrated team comprising Primary care (including GP

services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector.

These Neighbourhood Teams to deliver high quality and connected core health and care services, tailored to the neighbourhood population in order to best meet the specific needs of the population and to improve outcomes. In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs. The team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required.

These Integrated neighbourhood and Specialist services will be provided from community clinic locations including the Glossop Primary Care centre, GP practises, care homes, community beds or in patients own homes. These services will be fully integrated and will enable more Glossop patients to be safely provided with intermediate care in their own homes or at community clinic locations instead of needing to have an inpatient stay in a community bed, based on clinical assessment.

With respect to home based Intermediate Care the Glossop health and care system is taking part in the NESTA 100 day challenge which is aiming to improve the way in which the neighbourhood supports people, who have been given the news that they have a life limiting condition. The focus is early support and relationship building, to promote living life and reducing anxiety.

Clinic Services

Other services that have been introduced and will be provided to Glossop residents from clinic locations in Glossop are;

- Neighbourhood Pharmacists
- Minor illness scheme
- 7 day primary care access via GTD
- Extensive Care service – a new weekly Extensive care clinic commences from April, which will be run in Glossop PCC. A second clinic is being explored once demand has been established and if accommodation can be found in Glossop (couldn't get in PCC)
- Community IV Therapy operates in people's homes in Glossop
- The Digital health service is providing access to Hospital clinicians for Glossop care homes and the Glossop community Paramedic Glossop Care homes are signed up and have the required equipment
- A new mental health service 'Improving Access to Psychological Therapies' (IAPT) is currently being procured and will be provided in Glossop locations for the Glossop population. This service is still in procurement but will be provided from GP surgeries in Glossop
- Physiotherapy and OT clinics will be delivered in the Glossop Primary Care centre for Glossop residents. Therapy services (OT and Physio) Outpatients and Pulmonary Rehab will move to GPCC in April.

The GP practices in Glossop have purchased the patient information system, EMIS remote which enable sharing of knowledge, skills and potentially GP capacity across the neighbourhood

Attached at Appendix 1 is a document which outlines how the Intermediate Care offer will operate for the population of the Glossop neighbourhood.

Intermediate Care Model for Glossop

Vision for New Model of Care for Tameside and Glossop

Tameside and Glossop health and care system has recognised that it needs to develop new models of health and social care to meet the changing needs of is population, including an aging population with more complex and long term health and care needs and the need to provide high quality and effective care closer to the patients' home.

The two key aspects of the new model of care is the creation of Integrated Neighbourhood teams in 5 localities and Urgent Integrated Care. The Integrated Neighbourhoods will bring together health and social care delivery and dramatically improve the coordination of care through individual care plans and the sharing of expertise. They will proactively identify those people with the most significant ongoing health and care support needs. The urgent integrated care will have responsibility for looking after local people who are in social crisis, or who are seriously unwell.

Vision for Enhanced Intermediate Care

The aim of the intermediate care model is to provide fully integrated services which support the rehabilitation and recuperation of patients, to enable them to continue living at home in all but most challenging cases. With a requirement for;

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) by an integrated team providing both health and social care input based on individual need.

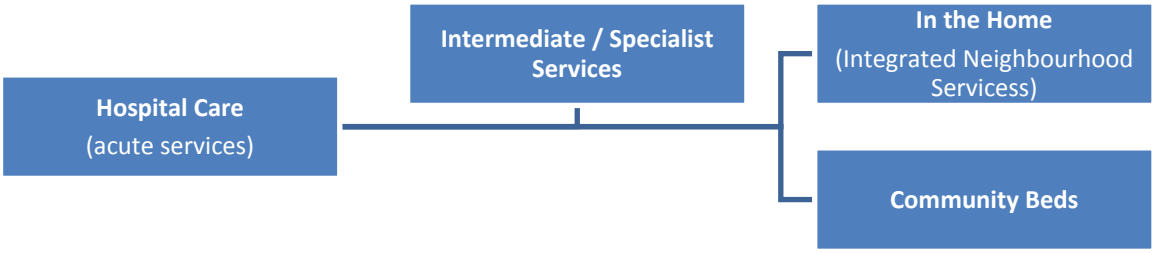
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

What Intermediate Care looks like now for Patients?

When Mrs Smith slipped and fell in her own home she pulled her alarm cord. The community response team visited Mrs Smith and called 999 as she had pain in her leg and was struggling to stand. The paramedics took Mrs Smith to Tameside Emergency Department where an x-ray was and showed that there was no fracture. Mrs Smith was admitted to the medical assessment unit and then to a medical ward to have assessments undertaken by the Occupational Therapist, Physiotherapist and Social Worker. Following 10 days in hospital Mrs Smith was dependent on the nursing and caring staff to support her and it was recommended that she be discharged to an Intermediate Care Unit. In IMC further assessments were undertaken by the OT, Physio and Social Worker and Mrs Smith received rehab to improve her mobility and promote independence following her fall. After 4 weeks in the unit Mrs Smith was assessed to return home by the social worker and the OT. The social worker arranged for carers to visit her 4 times a day to provide personal care and preparation of her meals.

Proposed Intermediate Care Model for Glossop

There are four interfaces where intermediate care services are provided to patients;



Below is a description of how services will be provided at each of these interfaces to make up the intermediate care offer to Glossop residents.

Hospital Care

The urgent element of the Intermediate Care model are the Acute care, hospital based services which are in place to respond to the urgent/crisis health and/or social care need for patients. The acute care is supported by the Home First and IUCT service to ensure patients are supported through the most appropriate pathway out of the acute hospital with "home" always being the goal.

Home First

One of the key principles of the model is that wherever it is possible for a person to have their care requirements met within their own place of residence and that the system will be responsive to meeting this need in a timely manner. Tameside and Glossop Integrated Care Trust has implemented the "Home First" service model, which responds to meet an urgent/crisis health and/or social care need for patients. The Home First offer will ensure that individuals are supported through the most appropriate pathway with "home" always being the default position. However, it is recognised that not all individuals intermediate care can be managed safely in their own home and there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the

individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place. The Community bed base will provide this additional support and is the bedded component of the intermediate care Model.

Integrated Urgent Care Team (IUCT)

Integrated Urgent Care Team (IUCT) made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. The Team can provide care calls for upto 72 hours until longer term care can be put in place. Ongoing support will then be provided working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible. IUCT is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs.

Intermediate / Specialist Community Based Services

In addition to the home first model there are also community and specialist intermediate tier services in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting and form part of the out of hospital intermediate care offer to patients in their place of residence (whether that is at home or in a care home).

The intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services.

The intermediate tier services which will provide services for the intermediate care offer include;

Extensivist Care Services

A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will be staffed by specialist Extensivist GPs with clinics being provided from the Glossop primary care centre, who will work with a cohort of high risk patients identified through risk stratification.

Intravenous Therapy (IV) Service

7 day Community IV therapy service to provide IV therapy in the home setting to allow early discharge from hospital or avoid a hospital stay for IV therapy.

Digital Health

Digital Health Service is a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice to avoid unnecessary ED attendances for our elderly population.

Integrated Therapy Services

Community Therapy services

These community based services provide assessment and treatment in a number of settings, including Glossop Primary Care Centre, nursing and residential homes, clinics and group sessions. These services include;

Community Physiotherapy/Occupational Therapy - The Team provide a service to patient who require physiotherapy assessment/treatment in their own homes this would include residential and nursing homes. The Occupational Therapy (OT's) is provided by internal referral only from the physiotherapists in the Team. The Team also provide assessment and provision of mobility aids for patients to maintain independence. The Team also takes the lead in provision of case management and therapeutic intervention for patients with MND. Another element to the service is management of respiratory disorders encouraging self –management and coping strategies.

Speech and Language Team (SALT) - The SALT provide services to the Community this would include residential and nursing homes. Assessment, diagnosis and management of swallowing impairment and advice on the management of these conditions. The team work on communication impairment and provide alternative strategies for patient to communicate, the team also work on voice control and management of conditions such as stammering. The team have close working links with Community Dietetics, Community Physiotherapy and Occupational Therapy and the Community Neuro Rehabilitation Team.

Community Dietetics - The Community Dietetics team see patients for a range of conditions where diet and nutrition is part of the long term treatment e.g. Neurological, Oncology, GI conditions, Chronic Obstructive Pulmonary Disease, Diabetes and Home Enteral Tube Feeding the service is provided in a number of ways these being; Home visits, Clinics, Nursing and Residential Homes. The Team also work closely with GP's and provide advice on the appropriate prescribing of Nutritional Supplements.

Community Neuro Rehabilitation Team CNRT - The CNRT assess and treat patients who have an acquired neurological diagnosis from patient who have a registered Tameside & Glossop GP. The team is a multi-disciplinary, holistic, goal led service consisting of; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Specialist Rehabilitation Nurse's, Parkinson's Specialist Nurse, Psychology, Technical Instructors and Team support staff. The Early Supported Discharge Team (ESDT) which is part of the CNRT support patients to live independently as possible in their home after a period of hospitalisation following a Stroke.

Community Podiatry - The podiatry service provides assessment, diagnosis, treatment and advice to improve tissue viability, mobility, to reduce pain and promote foot health. The key roles of the podiatry team are to work as a multi-disciplinary clinical teams e.g. specialist diabetes teams, vascular and diabetes clinics, physiotherapy musculo-skeletal teams and District Nursing teams. The team provide assessment, diagnosis and treatment of foot health problems, provision of preventative interventions and foot health education, provide Screening of diabetes patients within their GP practice and are involved in providing training to carers, health care and social care professionals.

Glossop Community Paramedic

Glossop neighbourhood is the only neighbourhood within Tameside and Glossop that has a dedicated community paramedic who is part of the integrated community team and supports Glossop GP's, care homes and the community teams providing first response and specialist paramedic advice, assessment and treatment for patients in Glossop who might otherwise need emergency admission to hospital, including intermediate care patients.

Neighbourhood Pharmacy

The neighbourhood pharmacy service will be one of the key services within the integrated neighbourhood model of care. Pharmacists will work as part of the neighbourhood team to help identify patients at risk and intervene to reduce the need for patients to need to access hospital based services. The neighbourhood pharmacy service will support patients to self-manage their well-being and long term conditions through optimises medicines, as well as improving communication between GPs and other health care professionals.

Single Point of Contact

It is important that people have a single point of contact for all their care needs as we begin to provide a holistic approach to care. Patients will have one telephone number to contact health and social care professionals across the range of services. The SPOC will be based in one place, co-locating health and social care staff, and will operate 7 days a week. The SPOC will provide a 7 day phone line to help and guide people and professionals.

What out of Hospital Integrated Intermediate Care could look like for Patients?

When Mrs Smith slipped and fell in her own home she pulled her alarm cord. The community response team visited Mrs Smith and contacted the digital health centre through their 4G tablet device. The digital health nurses could see Mrs Smith to assess her and were able to rule out any obvious serious injury, the team provided advice and guidance and made a referral to the community Integrated Urgent Care Team to help Mrs Smith to mobilise following her fall. A Nurse from IUCT team assessed Mrs Smith and as a trusted assessor provided some equipment to help Mrs Smith's mobilise around her house and asked for one of the team's carers to visit in the evening to assist Mrs Smith to make her evening meals. The teams Physio provided Mrs Smith with some exercises she could do to increase the movement in her leg. After two days of support from the IUCT service Mrs Smith was able to manage independently in her own home but said that she would miss the company of the team. The IUCT team provided contact numbers for Action Together to provide Mrs Smith with the details of community voluntary services that she can get involved with.

Community Beds

A **flexible** community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment; rehabilitation; completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care and facilitate timely discharge to assess for those people not able to be assessed at home but do not require Acute care.

When home is not the default position for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments)
- Step up capacity to avoid acute admission
- Intermediate Care Services

The ICFT is the provider of all intermediate care beds for Tameside and Glossop in two locations, Stamford Unit and Shire Hill. Following the implementation of home first model which ensures delivery of robust intermediate care services in the home setting, this model proposes that all the community beds should be located in the Stamford Unit facility in order to utilise the resource flexibly to meet the needs of the patients across the health economy and fully deliver the service model for intermediate care beds.

What Community Bed Intermediate Care could look like for Patients?

Mr Jones was admitted to Tameside and Glossop's flexible community bed base following a recent illness which required acute treatment in hospital. Mr Jones having COPD and diabetes had been admitted to hospital 3 times in the last year. At the IMC unit Mr Jones was assessed by the physiotherapist and provided with a list of 'goals' to be achieved during his stay and how long it was expected that this would take. After only 5 days at the unit Mr Jones had met his goals so a 'Home First' discharge to assess was arranged so that Mr Jones could continue his rehabilitation in his own home as soon as possible. Mr Jones was assessed by a physiotherapist and a social worker who were able to wrap around care and support until Mr Jones regained his confidence and independence. The IUCT team noted that Mr Jones has two long term conditions and has recently been admitted and discharged from hospital so made a referral to the Extensivist service so that Mr Jones could benefit from some enhanced medical intervention before his long term care needs could be fully met within his integrated neighbourhood.

Integrated Neighbourhood services

Tameside and Glossop Integrated Care Trust has established five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector, one of which is for the Glossop neighbourhood.

The vision of these Neighbourhood Teams to deliver high quality and connected core health and care services, tailored to the neighbourhood population in order to best meet the specific needs of the population and to improve outcomes.

In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs. The team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required.

Mental Health Service

We are working to improve and integrate mental health services to better support the needs of individuals. This is being done by aligning all available resources within the locality including existing and new resources as part of our Care Together programme.

One of the key priority's is to increase mental health capacity within the Integrated Neighbourhoods through:

a) increasing access to emotional and mental health well-being workers by offering easy accessible drop-ins in GP surgeries and other community locations and a broadened mental health offer with a wider range of interventions;

b) developing a new model, integrated with the Neighbourhood Teams, to meet the needs of people with complex needs;

c) increasing dementia support in the Neighbourhoods by integrating Dementia Practitioners and Admiral nurses in the Neighbourhood Teams, as well as working with a Dementia Support Worker from the Alzheimer's Society; and

d) establishing a self-management education college to support people to develop the knowledge and skills to manage their own health.

Social Prescribing Navigators

A social prescribing service within the neighbourhood teams who provide links to non-medical services to support individuals in self care and well being.

Community Social Care

Social care services are provided by Derbyshire County Council these assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care.

National Audit of Intermediate Care 2018

Proposal for the National Audit of Intermediate Care 2018

Benchmarking Network

Royal College of Speech & Language Therapists

directors of adass adult social services

Chartered Physiotherapists working with older people

Royal College of Nursing

BGS British Geriatrics Society Improving healthcare for older people

the patients association

Royal College of Occupational Therapists Specialist Section Older People

Llywodraeth Cynulliad Cymru Welsh Assembly Government

HSC Health and Social Care

Contents Page

1. Background to the National Audit of Intermediate Care (NAIC)

The audit is a partnership project between the NHS Benchmarking Network, NHS England, the Welsh Government, the Public Health Agency and Health & Social Care Board in Northern Ireland, the British Geriatrics Society, the Association of Directors of Adult Social Services, AGILE - Chartered Physiotherapists working with older people, the Royal College of Occupational Therapists - Specialist Section Older People, the Royal College of Physicians (London), the Royal College of Nursing, The Patients Association, the Royal College of Speech and Language Therapists and the Royal College of General Practitioners (RCGP).

The audit is now well established, having run for five years, and when it last ran in 2017, record coverage was reached in **England** with 99 CCGs, 55 Local Authorities, 118 providers, 461 services taking part, and NAIC 2017 included over 17,500 service user responses.

In **Wales**, 6 University Health Boards (UHBs) submitted strategic level information and 7 UHBs submitted operational level information. 94 intermediate care services were registered in total, and 1,674 service users contributed to NAIC 2017.

Northern Ireland participated for the first time in NAIC 2017 and provided data for 5 Local Commissioning Groups and 5 Health and Social Care Trusts. The 5 Health and Social Care Trusts registered 62 different intermediate care services between them, and 2,185 service user contributions were received.

The NAIC focuses on services which support, usually frail, elderly people, at times of transition when stepping down from hospital or preventing them being admitted to secondary or long term care. These services are a crucial part of the solution to managing increasing demand in the health and social care system. The audit shines a light on intermediate care and provides a stocktake of current service provision. The unique combination of organisational data and outcomes data collected in the audit enables you to address the following questions:

- Are we achieving good outcomes for service users?
- Do we have the correct balance of provision across the four service categories?
- What is the whole system contribution of our intermediate care services?
- How cost effective and efficient are our services?

The audit allows commissioners / funders and providers to consider both the national answers to these questions but also, importantly, how their local health and social care economy is performing on these key issues. Audit participants can access their local results via an online toolkit.

NHS England, the Welsh Government and the Northern Ireland Public Health Agency and Health & Social Care Board are supporting the audit and strongly encourage commissioners / funders and providers of intermediate care to take part in NAIC 2018. NHS England will be providing a letter of support which will be accessible via the NAIC webpages.

HQIP has announced that the National Audit of Intermediate Care has been included on the 2018/19 Quality Accounts list. It is mandatory for NHS Trusts in England to produce a quality account every year which details the Provider's participation in clinical audits. The following link has the background and legislation regarding the HQIP quality accounts and the Statutory and mandatory requirements for Clinical Audit.

NICE have used the NAIC service category definitions in the development of their guidelines NG 74 Intermediate Care including re-ablement and in the new draft Quality Standards, which are currently being consulted upon.

The NAIC Summary Report 2017 is available to download here.

2. Funding

The 2018 audit will be supported by NHS England, the Welsh Government and the Northern Ireland Public Health Agency and Health & Social Care Board. The audit is therefore free of charge for all commissioners / funders and providers of intermediate care services in England, Wales and Northern Ireland.

3. NAIC 2018 aims and objectives

3.1 Purpose

The audit measures intermediate care (IC) service provision and performance against standards derived from government guidance and from evidence based best practice. The audit provides national comparative data for bed and home based intermediate care and re-ablement services provided by a range of health and social care providers including acute trusts, community service providers and Local Authorities. NICE issued new guidance in September 2017 on *Intermediate care including re-ablement* and are currently consulting on the development of Quality Standards.

The audit takes a whole system view of the effectiveness of intermediate care services and the contribution made to demand management across health and social care systems in the three UK countries.

3.2 Definition of intermediate care

For the purposes of the audit, the following definition of IC has been developed with the help of the Plain English Campaign: -

What is intermediate care?

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

Crystal Mark 21029 Clarity approved by Plain English Campaign

What are the aims of intermediate care?

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

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

Where is intermediate care delivered?

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

How is intermediate care delivered?

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

As in previous iterations of the audit, four service categories for intermediate care will be used in 2018; crisis response, bed based IC, home based IC and re-ablement. The definitions are unchanged for 2018. Appendix 1 contains the Service Category Definitions which will be supplied to each audit participant to enable them to categorise IC services for the purposes of the audit.

The Department of Health (DH) introduced reference costs for intermediate care in 2013/14. The DH previously, and now NHS Improvement, has referenced extensively the definitions used for the NAIC in *Combined costs collection: reference costs collection guidance 2016-17:*

https://improvement.nhs.uk/uploads/documents/Reference_costs_collection_guidance_201617.pdf

For the Trusts providing intermediate care services in England, this should mean that they are applying the same principles for the reference costs as for NAIC, for the health funded elements of intermediate care.

3.3 Objectives

The objectives of the NAIC 2018 are:

1. To assess performance at the national level against key performance indicators and quality standards and provide benchmarked comparisons at the local level to facilitate service improvement.
2. To assess the service user experience of intermediate care through the Patient Reported Experience Measures (PREM) for bed, home and re-ablement services, highlighting areas of improvement that are important to service users.
3. To collect standardised outcome measures for intermediate care and to use the outcomes data to understand the key features of high performing services.
4. To provide evidence of the whole system impact of intermediate care to assist commissioners in making the case for intermediate care investment.
5. To inform future policy development within the Department of Health (DH), NHS England, the Welsh Government and the Northern Ireland Public Health Agency.
6. To continue to share good practice in intermediate care services by encouraging networking amongst participants and developing case studies.

4. NAIC 2018 methodology

In this section the proposed scope, approach to data collection, analysis and reporting are considered.

4.1 Scope

The audit will include crisis response, bed based IC, home based IC and re-ablement services provided by a range of health and social care providers including acute hospitals, community service providers and Local Authorities. These services are provided in a range of health and social care settings including service users' own homes, hospitals, community hospitals and residential care homes. All eligible commissioners and providers across the NHS and social care in England, Wales and Northern Ireland will be invited to participate in the audit.

As in previous years, the 2018 audit will have both organisational and service user level components. The organisational level is a necessary element because this is an audit of a service rather than a condition. An understanding of the organisational and service framework within which patient care is being provided is key to reaching conclusions on how patient outcomes can be optimised.

4.2 Proposed structure and scope of the organisational level audit

As in previous years, the 2018 organisational level audit will have sections for commissioners (strategic level) and providers (operational level). This structure enables a "whole health economy" perspective to be taken by commissioners / funders, in addition to allowing comparisons to be made between services. The data sharing arrangements for each country agreed with the national bodies funding the audit, are explained in section 4.8.

Commissioner (strategic) quality standards for IC services

The quality standards were originally developed from DH guidance and other evidence based best practice and cover governance, strategy, participation, pathways and performance management. The NAIC quality standards utilised in previous years remain the same for NAIC 2018.

Commissioner (strategic) organisational level audit

The commissioner organisational level survey will be completed for each health and social care economy. In England, where many services are jointly commissioned by the CCG and Local Authority, they are asked to produce a joint submission for their health economy. In Wales, University Health Boards will be requested to provide a commissioner / strategic level submission for each area. In Northern Ireland, the Local Commissioning Groups will be requested to provide a commissioner submission for each area.

The commissioner organisational audit covers:

- Scope of intermediate care services commissioned
- Commissioning arrangements
- Access criteria
- Funding and costs
- Activity

The NICE guidance has extensively referenced the NAIC and the quality standards have already been covered on different aspects of the audit.

Provider (operational) organisational level audit

Providers are asked to identify separate IC services provided in their locality and categorise them as either crisis response services, bed based IC, home based IC or re-ablement services (based upon an agreed set of definitions, see Appendix 1). Different questionnaires are provided for these service categories reflecting the different currencies used in these services (for example, bed days, community service "contacts", re-ablement "contact hours" etc.). Feedback has suggested that most providers could describe the variety of the IC services provided using this structure. Guidance will be provided on how services which are very integrated, for example across bed and home provision, should complete the audit.

The provider audit covers:

- Service models
- Activity
- Finance
- Workforce

The provider questions will remain largely unchanged from previous years allowing year on year comparisons to be made.

4.3 Proposed scope of the service user level audit

From 2012 to 2017, standardised outcome measures were collected for bed based IC services via a service user questionnaire completed by clinicians. The bed based service user questionnaire included a detachable Patient Reported Experience Measure (PREM) for completion by service users. In 2014, this approach was extended to home based IC services with standardised outcome measures developed and collected using a service user questionnaire suitably revised for use in home based services, again with a detachable PREM. For re-ablement in 2014, a PREM was available for completion by service users. For 2015, the Steering Group extended the use of the home based service user questionnaire (with PREM) to re-ablement services.

Service User Questionnaire

In previous audits, providers of bed based IC services were asked to complete the service user questionnaire for 50 consecutive patients referred to the service. The standardised outcome measure chosen by the Steering Group for bed based services was the Modified Barthel Index. In 2017, 4,874 service user questionnaires were completed in England, 206 in Wales and 655 in Northern Ireland enabling conclusions, collated at both national and local level, to be reached on areas such as the demographic of the patient cohort nationally, waiting times, length of stay and patient pathways through the system. In 2018, bed based services will again be asked to complete 50 forms for consecutive service users.

In previous years, providers of home based IC services were asked to complete the service user questionnaire for 100 consecutive service users referred to the service. 5,934 forms were returned in 2017 in England, 495 in Wales and 335 in Northern Ireland. The home based services form included two standardised outcome measures; the Sunderland Community Re-ablement Scheme and two domains from the Therapy Outcome Measure (Participation and Wellbeing). The same questionnaire was used for re-ablement services in 2017, who were also asked to complete the forms for 100 consecutive service users; 1,408 were returned from England, 489 from Wales and 544 from Northern Ireland. The NAIC Steering Group have recommended that for NAIC 2018, 80 service users questionnaires are completed.

PREM

In 2013, PREM forms were developed with the assistance of the Academic Unit of Elderly Care and Rehabilitation, Bradford Teaching Hospitals/University of Leeds and the Patients Association. Two slightly different versions were produced for bed and for home/re-ablement services. The forms included 15 questions, plus an open text question asking for suggestions for improvement. Every year, the PREM questions have been reviewed and validated, to ensure they are measuring the same construct. The PREM questions for 2018 will remain the same as in 2017.

For all three services, the PREM will be a detachable form at the back of the service user questionnaire to be handed to the service user with a pre-paid envelope on discharge.

There will be no service user questionnaire/PREM for crisis response because of the short-term nature of these services.

The scope and content of both the organisational level audit and the service user audit has not changed materially from NAIC 2017.

Good practice case studies

The inclusion of the PREM and outcome measures, alongside existing efficiency metrics, will enable high performing IC services to be identified from the audit results. Discussions will be held with these services to enable more detailed case studies to be developed. The services will also be invited to present on their service models at the national conference to be held on 15th November 2018.

4.4 Approach to data collection

Registration

Provider and Commissioner registration for NAIC 2018 will be made available through downloading a copy of the NAIC registration form from the NAIC website here. There are different registration forms for Providers and Commissioners. At this stage, providers will be asked to identify the intermediate care services to be included in the audit, against each of the four service categories. A telephone and email helpline will be available to assist providers with this identification and classification task.

Both Commissioner and Provider registration forms should be returned to nhsbn.naicsupport@nhs.net to confirm the registration. Provider registration forms should be returned no later than 20th April 2018. Services registered after this date may not be able to take part in the Service User Audit element of NAIC.

If your organisation took part in 2017, the Project Lead (both Commissioners and Providers) will have received a pre-populated version of the registration template, to check the registration details remain correct for NAIC 2018. Contact nhsbn.naicsupport@nhs.net if you require copy of your organisation's template.

Organisational level audit

As in previous years, the organisational level audit for 2018 will be completed via a web based data entry tool via a secure interface (see Section 4.5 data protection below). Project and service leads completing the audit will be provided with individual login details. A downloadable data specification will be available on the website to assist participants with collating the data ready for input. The helpline will be available to assist users with data definitions and with completing the online data entry tool.

Service user audit

1. At the start of data collection each intermediate care Service Lead (identified at the registration stage of the audit) will receive a pack containing the following: -
    - A booklet containing instructions on how to administer the Service User Questionnaires and PREMs for Project Leads.
    - Copies of the Service User Questionnaire and PREM (50 for bed based services and in the range of 80 for home based services and re-ablement services; to be confirmed by the NAIC Steering Group).
    - Freepost envelopes for handing out to the patient / carer to return the PREM.
    - Instructions on how to return the completed Service User Questionnaires.
    - A parcel to return the completed Service User Questionnaires.
2. The first 6 pages of the Service User Questionnaire should be completed by a member of the intermediate care service with the patient. The first half of the booklet should be completed when the patient is admitted into the service and the remainder of the booklet should be completed when the patient is discharged from the service.

3. The PREM, which is the final page of the Service User Questionnaire booklet, should be handed to the patient with a freepost envelope on discharge from the service (in most cases the PREM will be handed to the patient when the final section of the Service User Questionnaire is completed). Services should encourage the patient (and/or carer) to complete and return the PREM.
4. The completed Service User Questionnaires should be collated within the service and returned to the Project Lead for onward posting back as per the instructions in the pack.
5. The completed PREM forms will be posted back directly by the patient / carer using the free-post envelopes provided, ensuring the independence of the survey.

A telephone helpline and user support email service will be in place throughout the project to support participant enquires in all aspects of the project work. The NAIC support e-mail is nhsbn.naicsupport@nhs.net or telephone 0161 266 1967.

4.5 Data protection

Given that the audit will include sample data collection from patient/service user records the study will comply with the information governance standards for the NHS and social care. No patient / service user identifying information will be collected. A Data Privacy Impact Assessment will be completed and will be available on the NAIC webpages.

Data is transferred via a website, and stored in an SQL database, hosted within the NHS secure network.

4.6 Analysis and validation

Analysis is supported by an SQL database and is undertaken using bespoke software tools. The tools can be used to compare results with previous iterations of the NAIC.

Validation controls are implemented on several levels within the data collection tool. Information buttons containing data definitions to ensure the consistency of data supplied are available throughout the tool. System validation is implemented to protect the integrity of the information being recorded (e.g. allowable ranges, expected magnitude, appropriate decimal places and text formatting). Integrity checks were also incorporated into the underlying database structure, for example, the use of uniqueness constraints to prevent the creation of duplicate records.

Following the first phase of the analysis, outlying positions will be validated with participants, with the opportunity to review draft outputs and amendments made where necessary before finalisation of the project outputs.

4.7 Audit outputs and reporting

Summary reports for NAIC 2018 will be produced separately for England, Wales and Northern Ireland giving an overview of the results of the organisational level and service user level audits. These summary reports will include an introduction to the national audit, methodology and participants, key findings from the audits including compliance with agreed quality standards, progress in developing outcome measures, key discussion points and references. The summary report for England will be publicly available.

Bespoke dashboard reports will be made available to all participants. These will contain summary metrics in dashboard style to give an at-a-glance finding for the commissioner / funder, provider or service.

Participants will also have access to an online benchmarking analysis tool that will allow them to view their own performance in detail on the audit metrics against national comparators. Peer group profiling by country will be available within the tool.

The outputs of the audit will be meaningful to the wide range of audiences who have a stake in the success of intermediate care services including service users, providers, clinicians, policy makers, government agencies and commissioners**.**

4.8 Use of data

The data sharing arrangements are different for England, Wales and Northern Ireland. In summary, these are outlined below: -

England

- High level national report for England – anonymised data, report available publicly
- All England data available to NHS England on named basis (only commissioner data to be shared further e.g. through RightCare)
- Commissioner positions available on named basis to other CCGs and CCGs' own providers (if participating)
- Provider positions on selection of key metrics available to the Provider's own commissioners only (if participating)

Wales

- High level national report for Wales – available to the Welsh Government and Welsh participants only; all Welsh positions identified
- All Welsh commissioners and provider data identifiable to Welsh participants only

Northern Ireland

- High level national report for Northern Ireland – available to the Public Health Agency and Health & Social Care Board in Northern Ireland and Northern Ireland participants only; all Northern Irish positions identified
- All Northern Irish commissioners and provider data identifiable to Northern Ireland participants only

4.9 Engagement with participants

Summary information will be e-mailed to the Boards of all CCGs, NHS Trusts, Health and Wellbeing Boards and Local Authorities in England, University Health Boards in Wales and Local Authorities in Wales to raise awareness of the project. It will also be e-mailed to Health and Social Care Trusts and Local Commissioning Groups in Northern Ireland.

A communications plan has been agreed with the NAIC Steering Group to ensure regular communication with audit participants throughout the process.

The NAIC Steering Group has worked with a wider reference group of audit participants on several issues related to the scope, content and process for NAIC 2018. Regular updates on the audit development and next steps will be posted on the NAIC website.

A national event to discuss the findings of NAIC 2018 will be held on the 15th November 2018 at The ICC in Birmingham. The event is free to audit participants.

5. Outline project plan NAIC 2018

Action	When
Registration for NAIC 2018 commences	w/c 12th March 2018
Northern Ireland – pre-engagement event	April 2018
Service user audit data collection commences	June 2018
Organisational level data collection opens	8th May 2018
Organisational level data collection closes	27th July 2018
Service user audit data collection completes	31st August 2018
Data validation with participants	September 2018
Data analysis – organisational level data and service user audit data	August – October 2018
NAIC UK Conference	15th November 2018
NAIC Wales Feedback Conference	December 2018
NAIC Northern Ireland Feedback Conference	February 2019
Summary reports published, bespoke reports for participating organisations published and online benchmarking toolkit issued	December 2018 – February 2019

* Please be aware that these dates are subject to change throughout the process.

6. Standards and guidelines

Guidance for IC services in England was set out by the DH in the *National Service Framework for Older People* in 2001 (2). Further guidance, entitled *Intermediate Care - Halfway Home* was published by DH in 2009.

The *National Service Framework for Older People* set out some key guiding principles for the provision of IC services:

- Person-centred care
- Whole system working
- Timely access to specialist care, and
- Promoting a healthy and active life.

Halfway Home updates the original guidance and sets out the definitions, service models, responsibilities for provision, charges and planning. The guidance recommends that health and local government organisations, with a shared vision, should undertake strategic planning for intermediate care jointly. The guidance recommends a core multidisciplinary intermediate care team, which is led by a senior clinician, ideally with one overall manager, and closely linked to re-ablement services in social

care. The key target groups for Intermediate care, people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care, remain the priority.

The specific points included in the DH guidance regarding, for example, access criteria, the preference for a single point of access and multidisciplinary team working are used in the national audit to develop quality standards for service provision. However, the guidance in relation to patient outcome measures is limited.

In Wales, the key guidance for the Intermediate Care Fund can be found at https://www.google.co.uk/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=wales%20intermediate%20care%20guidance

In Northern Ireland, the relevant guidance for intermediate care can be found at https://www.health-ni.gov.uk/publications/intermediate-care-guidance

7. Project partners

The partners who have come together to develop and deliver the National Audit of Intermediate Care are:

The **NHS Benchmarking Network** is the in-house benchmarking service of the NHS promoting service improvement through benchmarking and sharing good practice. The NHS Benchmarking Network provides project management, data collection, analysis, reporting and events management to the NAIC.

NHS England leads the National Health Service in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care. NHS England commissions health care services in England for GPs, pharmacists and dentists, and support local Clinical Commissioning Groups, who plan and pay for local health services. A key strategy for the NHS in England can be found in the Five Year Forward View.

The Welsh Government provides the publicly funded National Health Service of Wales providing healthcare to some 3 million people who live in the country. The NHS has a key principle which is that good healthcare should be available to all, regardless of wealth. NHS Wales provides services ranging from smoking cessation, antenatal screening, and routine treatments for coughs and colds to open heart surgery, accident and emergency treatment and end-of-life care. Setting health policy for the NHS in Wales and the funding for health services is the responsibility of the Welsh Government.

The **Northern Ireland Public Health Agency** (PHA) was established in April 2009 as part of the reforms to Health and Social Care (HSC) in Northern Ireland. They are the major regional organisation for health protection and health and social wellbeing improvement. Their role also commits them to addressing the causes and associated inequalities of preventable ill-health and lack of wellbeing. They are a multi-disciplinary, multi-professional body with a strong regional and local presence. In fulfilling their mandate to protect public health, improve public health and social wellbeing, and reduce inequalities in health and social wellbeing, the PHA works within an operational framework of three areas: Public Health, Nursing and Allied Health Professionals, and Operations.

The **British Geriatrics Society** (BGS) is a professional association of doctors practising geriatric medicine, old age psychiatrists, general practitioners, nurses, therapists, scientists and others with a particular interest in the medical care of older people and in promoting better health in old age. The society, working closely with other specialist medical societies and age-related charities, uses the expertise of its members to inform and influence the development of health care policy in the UK and to ensure the design,

commissioning and delivery of age appropriate health services. The society shares examples of best practice to ensure that older people are treated with dignity and respect and that wherever possible, older people live healthy, independent lives.

The **Association of Directors of Adult Social Services** (ADASS) represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for the commissioning and provision of housing, leisure, library, culture, arts and community services within their Councils.

The **Royal College of Occupational Therapists Specialist Section for Older People** (RCOTSS-OP) is passionate about older peoples' independence, well-being and choice. RCOTSS-OP provides professional and clinical information on all aspects of occupational therapy practice related to older people. Through Clinical Forums, the RCOTSS-OP aims to encourage evidence based practice and provide guidance on occupational therapy intervention in the areas of: acute and emergency care, intermediate care, dementia, falls, mental health and care homes.

The core mission of the **Royal College of Physicians** is to promote and maintain the highest standards of clinical care. One of the ways it does this is through engaging Fellows and Members in all parts of the UK in national clinical audit across a range of conditions and services, in hospitals and in community settings. The College's clinical audit work has a particular focus on the needs of frail elderly people and those with chronic conditions and improvements are delivered through partnerships with other professional bodies, patient groups and voluntary sector organisations.

The **Royal College of Nursing (RCN)** is the voice of nursing across the UK and is the largest professional union of nursing staff in the world. The RCN promotes the interest of nurses and patients on a wide range of issues and helps shape healthcare policy by working closely with the UK Government and other national and international institutions, trade unions, professional bodies and voluntary organisations.

AGILE is a Professional Network of the Chartered Society of Physiotherapy and membership is open to therapists working with older people - whether qualified physiotherapists, assistants, students or associate members of an allied profession. Within AGILE our mission is to deliver the highest possible physiotherapy practice with older people. The aims of AGILE are to promote high standards in physiotherapy with older people through education, research and efficient service delivery, to provide a supportive environment for its members by facilitating the exchange of ideas and information and to encourage, support and co-ordinate relevant activities regionally and nationally.

The Patients Association is a national health and social care campaigning charity which has been in existence for 51 years. Our motto is ‘Listening to Patients, Speaking up for Change’. We strive to ensure that patients’ views and experiences are heard. Themes from our national Helpline, large scale surveys and casework influence our campaigns. We also work with NHS organisations to facilitate service improvement through our national project work and staff training. We advocate for better access to accurate and independent information for patients and the public; equal access to high quality health and social care; and the right for patients to be involved in all aspects of decision making regarding their care and treatment.

The **Royal College of Speech and Language Therapists** (RCSLT) promotes the art and science of speech and language therapy – the care for individuals with communication, swallowing, eating and drinking difficulties. The RCSLT is the professional body for speech and language therapists in the UK; providing leadership and setting professional standards. The College facilitates and promotes research into the field of speech and language therapy, promote better education and training of speech and language

therapists and provide information for members and the public about speech and language therapy. Speech and language therapist work with patients of all ages including children with developmental speech and language impairments and the elderly with acquired difficulties requiring rehabilitation.

The **Royal College of General Practitioners** (RCGP) is the professional membership body for family doctors in the UK and overseas. They are committed to improving patient care, clinical standards and GP training.

8. Project governance

A Steering Group with formal terms of reference oversees the National Audit of Intermediate Care. The NAIC Steering Group membership includes representatives from the stakeholder groups listed in Section 7. The Steering Group will meet approximately monthly.

The current NAIC Steering Group membership is as follows:

1. Chair: Dr Duncan R Forsyth Consultant Geriatrician, Addenbrooke's Hospital Cambridge University Hospitals NHS FT Representing: **British Geriatrics Society**	11. Adrian Crook Assistant Director, Health and Adult's Social Care, Integration and Provider Services, Bolton Metropolitan Borough Council Representing: **Association of Directors of Adult Social Services**
2. Cynthia Murphy Chair, Royal College of Occupational Therapists, Specialist Section – Older People Representing: **Royal College of Occupational Therapists**	12. Dawne Garrett Professional Lead – Older People and Dementia Care Representing: **Royal College of Nursing**
3. Vicky Paynter Physiotherapist – Intermediate Care, Bristol Community Health / AGILE National Executive Committee member Representing: **AGILE, Chartered Physiotherapists working with Older People**	13. Dr Fiona Kearney Consultant Geriatrician Nottingham University Hospitals NHS Foundation Trust Representing: **British Geriatrics Society**
4. Claire Holditch Project Director for the National Audit of Intermediate Care Representing: **NHS Benchmarking Network**	14. Professor Martin Vernon National Clinical Director for Older People and Integrated Person-Centred Care Representing: **NHS England**
5. Debbie Hibbert Project Manager for the National Audit of Intermediate Care Representing: **NHS Benchmarking Network**	15. Dr Dawn Moody Associate National Clinical Director for Older People and Integrated Person-Centred care Representing: **NHS England**
6. Joanne Crewe Director of Quality and Governance / Executive Nurse NHS Harrogate and Rural District CCG Representing: **Commissioner organisations**	16. Kathryn Evans Community Nurse Lead / Acting Head of Planning Delivery Programme Lead – Hospital to Home National Directorate of NHS Operations and Delivery Representing: **NHS England**
7. Vacant position Representing: **Royal College of Speech and Language Therapists**	17. Tom Luckraft Assistant Head of Planning Delivery

	Hospital to Home Team - National Directorate of NHS Operations and Delivery Representing: **NHS England**
8. Rachel Power CEO Representing: **The Patients Association**	18. Tracey Williams Assistant Director for The National Unscheduled Care Programme National Collaborative Commissioning Representing: **Welsh Government**
9. Vacant position Representing: **Commissioner organisations**	19. Shane Breen AHP Consultant Representing: **Northern Ireland Public Health Agency and Health & Social Care Board**
10. Lizanne Harland Head of Contracts NHS Gloucestershire Clinical Commissioning Group Representing: **Commissioner organisations**	

9. Further information

9.1 Further information

For further information about the audit please contact the NAIC Support Team on nhsbn.naicsupport@nhs.net or call on 0161 266 1967 or visit the NAIC 2018 webpages at https://www.nhsbenchmarking.nhs.uk/naic

APPENDIX 1- Service category definitions

IC function	Setting	Aim	Period	Workforce	Includes	Excludes
Crisis response	Community based services provided to service users in their own home/care home	Assessment and short term interventions to avoid hospital admission	Services with an expected, standard response time of less than four hours. Interventions for the majority of service users will typically be short (less than 48 hours) but may last up to a week (if longer interventions are provided the service should be included under home based IC)	MDT but predominantly health professionals	Intermediate care assessment teams, rapid response and crisis resolution	Mental health crisis resolution services, community matrons/active case management teams
Home based rehabilitation	Community based services provided to service users in their own home / care home	Intermediate care assessment and interventions supporting admission avoidance, faster recovery from illness, timely discharge from hospital and maximising independent living	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care rehabilitation	Single condition rehabilitation (e.g. stroke), early supported discharge, general district nursing services, mental health rehabilitation/ intermediate care
Bed based	Service is provided within an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, Independent sector facility, Local Authority facility or other bed based setting	Prevention of unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly health professionals and carers (in care homes)	Intermediate care bed based services	Single condition rehabilitation (e.g. stroke) units, general community hospital beds not designated as intermediate care/rehabilitation, mental health rehabilitation beds
Re-ablement	Community based services provided to service users in their own home / care home	Helping people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised	Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)	MDT but predominantly social care professionals	Home care re-ablement services	Social care services providing long term care packages

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 23 May 2018

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

Subject: **INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP**

Report Summary:

In 2017/18 Tameside & Glossop Strategic Commission led the development of a locality vision for an enhanced offer of urgent care. Following a public consultation the Strategic Commissioning Board (SCB) agreed the model for an Integrated Urgent Care Service comprising:

- The Urgent Treatment Centre
- The Primary Care Access Service

The level of integration between the Urgent Treatment Centre, A&E streaming, A&E and diagnostic provision, along with strategic way forward for Tameside and Glossop Integrated Care NHS Foundation Trust, means that the Urgent Treatment Centre element will be commissioned within the Integrated Care Foundation Trust (ICFT) contract.

This report sets out the National and Local Requirements of the Tameside and Glossop Urgent Treatment Centre.

Recommendations:

The Strategic Commissioning Board is recommended to confirm the intention to commission an Urgent Treatment Centre that delivers the Standards and Outcomes stated in this report and recommend the same to CCG.

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	9,882	0	1,018	10,900
Total	**9,882**	**0**	**1,018**	**10,900**
Section 75 - £'000 Strategic Commissioning Board			Current cost of A&E at the ICFT is £9,882k which is included in the S75 pooled budget	
CCG – In Collaboration - £'000 CCG Governing Body			GP walk In Centre currently costs £1,018k p.a. and is funded from	

	delegated co-commissioning budgets which are in collaboration for the ICF.

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

Recurrent savings of £118k p.a. are expected from the implementation of the Urgent Treatment Centre. This is based on efficiencies created from bringing together GP Walk in Centre and A&E.

Realisation of these savings are dependent on completing a programme of capital works to reconfigure the ICFT estate. This is subject to a separate capital business case.

We currently have non recurrent funding in budgets to fund GP Streaming until July 2018. This service will cease once the Urgent Treatment Centre is operational, but is required until the new service goes live. Any slippage beyond July will create a pressure of around £50k per month in CCG budgets.

Legal Implications: **(Authorised by the Borough Solicitor)**	The Board should be satisfied that the proposals represent value for money and on balance demonstrate that they will successfully implement an Urgent Treatment Centre that delivers the stated standards and outcomes.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	The Urgent Treatment Centre standards and outcomes are in line with the locality plan and the Care Together model of care
How do proposals align with the Commissioning Strategy?	The Care Together programme is focused on the transformation of the health and social care economy to improve healthy life expectancy, reduce health inequalities and deliver financial sustainability. This work is a critical part of the programme
Recommendations / views of the Health and Care Advisory Group:	The Health and Care Advisory Group considered the standards and suggested local standards relating to use of Neighbourhood services, discharge back to GPs, Adult safeguarding and Advanced Care Plans. These have been incorporated into this document.
Public and Patient Implications:	This standards and outcomes in this report reflect the national standards and feedback from the 12 week period of public consultation and engagement with communities in Tameside & Glossop.
Quality Implications:	A Quality Impact Assessment has been completed and is attached to this report.
How do the proposals help to reduce health inequalities?	The Urgent Treatment Centre will contribute to the delivery of urgent care services to meet individuals' needs across the locality and address health inequalities.
What are the Equality and Diversity implications?	A full Equality Impact Assessment (EIA) was completed and attached as an appendix to the March SCB paper.

What are the safeguarding implications?	The provider of the Urgent Treatment Centre will be Tameside & Glossop Integrated Care NHS Foundation Trust and the GM Safeguarding Standards are included in the ICFT contract.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	As part of the implementation of this model of care, a data flow mapping exercise will be undertaken to understand what information will be transferred and to where; from that it will be possible to identify the requirements for robust data sharing agreements and protocols between the parties sending or receiving the data. The commissioner will seek assurance from all parties involved in the delivery of urgent care that appropriate arrangements are in place. The locality's Information Governance Working Group will sense check the data flows and Information Governance requirements relating to this project.
Risk Management:	This transformation programme will be managed via the Care Together Programme Management Office. The risks will be reported and monitored via this process.
Access to Information :	March 2018 Strategic Commissioning Board Report – obtainable at http://tameside.moderngov.co.uk/documents/g1511/Public%20reports%20pack%2020th-Mar-2018%2014.00%20Strategic%20Commissioning%20Board.pdf?T=10 **Appendix 1** – Quality Impact Assessment The background papers relating to this report can be inspected by contacting Elaine Richardson, Head of Delivery and Assurance: Telephone: 078554569931 e-mail: elaine.richardson@nhs.net

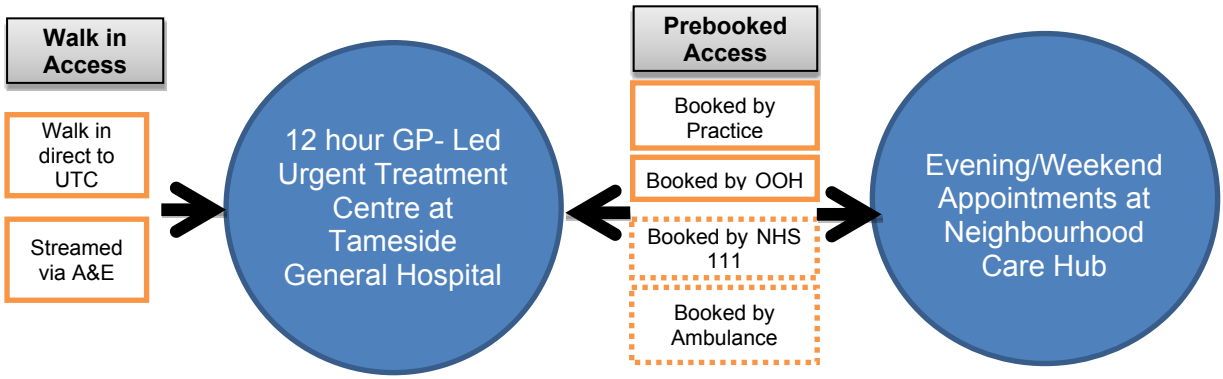
1 INTRODUCTION

1.1 The Tameside and Glossop vision for urgent care is that people who develop an urgent care need will be assessed by the most appropriate person on the same day within primary care and either a treatment plan agreed within the service or a safe transfer made to the care of another neighbourhood based service. This will also ensure that people who have an emergency need can access the expertise they need quickly through A&E.

1.2 Tameside & Glossop Strategic Commission have led the development of a locality vision for an enhanced offer of urgent care i.e. support for conditions that need prompt medical help to avoid them deteriorating but are not life threatening. This included a twelve week public consultation that informed the final model for an Integrated Urgent Care Service.

1.3 In March 2018, the Strategic Commissioning Board approved the final model for future provision of urgent care which included the relocation of walk-in access from Ashton Primary Care Centre to hospital site.

1.4 The Integrated Urgent Care Service model means people with an urgent care need will be able to access support in their neighbourhood or through an Urgent Treatment Centre based at the hospital site in Ashton. People will get 24/7 phone access to support through their practice or NHS 111 which provides appropriate advice or an appointment with the right professional on the same day either at their practice, one of the five Neighbourhood Care Hubs or the Urgent Treatment Centre. People who are not registered with a local GP or who prefer not to make an appointment can walk-in at the Urgent Treatment Centre.



1.5 The availability of appointments and access agreed is shown below.

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

1.6 The Integrated Urgent Care Service comprises the following two component parts that will work together and with General Medical Practices, to ensure people can access same day care when necessary.

- The Urgent Treatment Centre
- The Primary Care Access Service

1.7 The level of integration between the Urgent Treatment Centre, A&E streaming, A&E and diagnostic provision, along with strategic way forward for Tameside and Glossop Integrated Care NHS Foundation Trust, means that the Urgent Treatment Centre element will be commissioned within the Integrated Care Foundation Trust (ICFT) contract.

1.8 This document specifies the Standards and Outcomes required which will be used to commission the Urgent Treatment Centre from the ICFT.

2 NATIONAL CONTEXT

2.1 The expectation that Localities will have an Urgent Treatment Centre was set out the, 'NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW – March 2017'.[1]

Roll-out of standardised new 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services. They offer patients who do not need hospital accident and emergency care, treatment by clinicians with access to diagnostic facilities that will usually include an X-ray machine. We anticipate around 150 designated UTCs, offering appointments that are bookable through 111 as well as GP referral, will be treating patients by Spring 2018.

2.2 This was then followed by the 'Urgent Treatment Centres – Principles and Standards - July 2017'[2] which further clarified the national expectations.

Urgent treatment centres (UTCs) are community and primary care facilities providing access to urgent care for a local population. They encompass current Walk-in Centres, Minor Injuries Units, GP-led Health Centres and all other similar facilities, including the majority of those currently designated as "Type 3 and Type 4 A&E Departments". Urgent treatment centres will usually be led by general practitioners, and are ideally co-located with primary care facilities, including GP extended hours / GP Access Hubs or Integrated Urgent Care Clinical Assessment Services (formerly known as "GP out of hours" services).

By December 2019 patients and the public will:

a. Be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray.

b. Have a consistent route to access urgent appointments offered within 4hrs and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained.

c. Increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate.

d. Know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS111, local GPs, hospital A&E services and other local providers.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

[2] https://www.england.nhs.uk/publication/urgent-treatment-centres-principles-and-standards/

3 LOCAL AIMS AND OUTCOMES

3.1 As agreed by Strategic Commissioning Board in March 2018. the Tameside and Glossop Urgent Treatment Centre will be located on the site same site as A&E in Ashton to enable direct and prompt access to urgent diagnostics or other hospital services, This single walk-in access point will reduce duplication and remove the need for the individual attending to differentiate between an urgent and emergency need as the triage point on the hospital site will ensure the patient is treated by the most appropriate professional.

3.2 The aims of the Urgent Treatment Centre are:

- To treat people with an urgent care need within primary care reducing attendance at A&E thus ensuring people who have an accident or need emergency acute health care can be treated quickly in A&E.

- To, along with the Primary Care Access Service and General Medical practices, create a culture of booking appointments across Tameside and Glossop to support effective demand management and efficient patient flow.

3.3 The key outcomes of the Integrated Urgent Care Service are:

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

4 STANDARDS FOR TAMESIDE AND GLOSSOP URGENT TREATMENT CENTRE

4.1 The standards below are derived from the national minimum standards (N) and include the additional local requirements identified through the development of the Integrated Urgent Care Service or stated as key mitigations following the consultation process.

Urgent Treatment Centre	N	Urgent treatment centres should be open for at least 12 hours a day seven days a week, including bank holidays, to maximise their ability to receive streamed patients who would otherwise attend an A&E department. Typically this will be an 8-8 service, but commissioners will wish to tailor to local requirements based on locally determined demand.
	L	Operational at least 09:00 to 21:00 as specified in the public consultation to align with the Primary Care Access Service. Subject to review after 6 months to ensure capacity meets demand.
2	N	Urgent treatment centres should provide both pre-booked same day and “walk-in” appointments, however patients and the public should be actively encouraged to use the telephone or internet to contact NHS 111 first whenever an urgent care need arises, with access via NHS 111 becoming the default option over time, as walk-in attendances diminish.
	L	Direct Booking must be available through GP practices, NHS 111 or the Primary Care Access Service.
3	N	Urgent treatment centres, and NHS 111, should support patients to self-care and use community pharmacy whenever it is appropriate to do so. Urgent treatment centres should promote and record the numbers of patients offered self-care management and patient education.
	L	Patients should be linked to Neighbourhood based support for self-care and social prescribing to reduce the risk of the same need arising in the future.

		Patients whose needs could have been met by other Neighbourhood based services (including minor ailments, minor eye conditions services and other services with self-referral mechanisms) should be encouraged to utilise these in the future.
4	N	The urgent treatment centre should ensure that there is an effective and consistent approach to primary prioritisation of “walk-in” and pre-booked appointments, and the allocation of pre-booked routine and same day appointment slots.
	L	A minimum of 3600 minutes of bookable appointments across the multidisciplinary team should be available each week. 90% of which should be after 18:30 weekdays or at any time weekends and bank holidays. The timings of appointments should be flexible and aligned with demand. Subject to review after 6 months.
5	N	For patients who require an appointment in the urgent treatment centre this should be booked by a single phone call to NHS 111; locally patients should be encouraged to use NHS 111 as the primary route to access an appointment at an urgent treatment centre.
	L	Direct Booking must be available through GP practices, NHS 111 or the Primary Care Access Service.
6	N	Patients who “walk-in” to an urgent treatment centre should be clinically assessed within 15 minutes of arrival, but should only be prioritised for treatment, over pre-booked appointments, where this is clinically necessary.
	L	No additional requirement.
7	N	Following clinical assessment, patients will be given an appointment slot, which will not be more than two hours after the time of arrival.
	L	No additional requirement.
8	N	Patients who have a pre-booked appointment made by NHS 111 should be seen and treated within 30 minutes of their appointment time.
	L	All prebooked appointments should be able to access the Urgent Treatment Centre directly without additional triage and be seen and treated within 30 minutes of their appointment time.
9	N	Protocols should be in place to manage critically ill and injured adults and children who arrive at an urgent treatment centre unexpectedly. These will usually rely on support from the ambulance service for transport to the correct facility. A full resuscitation trolley and drugs, to include those items which the Resuscitation Council (UK) recommends as being immediately available in its guidance '*Quality standards for cardiopulmonary resuscitation practice and training', should be immediately available.* At least one member of staff trained in adult and paediatric resuscitation present in the urgent treatment centre at all times. This should all be part of an approach of ‘design for the usual, and plan for the unusual’.
	L	Effective procedures will be in place with A&E to manage the above.
10	N	An appropriately trained multidisciplinary clinical workforce will be deployed whenever the urgent treatment centre is open. The urgent treatment centre will usually be a GP-led service, which is under the clinical leadership of a GP. There will be an option for bookable appointments with a GP or other members of the multi-disciplinary team. Where the centre is co-located with an emergency department there may be justification for joint clinical leadership from an ED consultant.
	L	The service will be solely or jointly led by a GP.
		The multidisciplinary teams should ensure people are supported by the most appropriate person fully utilising the skills of the wider Primary Care teams.
11	N	The scope of practice in urgent treatment centres must include minor illness and injury in adults and children of any age, including wound closure, removal of superficial foreign bodies and the management of minor head

		and eye injuries.
	L	The integrated nature will enable people to receive a range of physical and mental health support promptly both on the hospital site and within neighbourhoods.
12	N	All urgent treatment centres should have access to investigations including swabs, pregnancy tests and urine dipstick and culture. Near patient blood testing, such as glucose, haemoglobin, d-dimer and electrolytes should be available. Electrocardiograms (ECG) should be available, and in some urgent treatment centres near-patient troponin testing could also be considered
	L	No additional requirement.
13	N	Bedside diagnostics and plain x-ray facilities, particularly of the chest and limbs, are desirable and considerably increase the assessment capability of an urgent treatment centre, particularly where not co-located with A&E. Where facilities are not available on site, clear access protocols should be in place.
	L	Effective procedures will be in place with diagnostic services and A&E to manage the above.
14	N	All urgent treatment centres should be able to issue prescriptions, including repeat prescriptions and e-prescriptions (e-prescribing should be in place in all sites by June 2019).
	L	The urgent treatment centre should issue patients with prescriptions and sick notes as appropriate to avoid the need for representation at the practice for the same episode of care.
		The urgent treatment centre should ensure patients know where prescriptions can be dispensed. When medication is time critical and pharmacy access is limited consideration should be given to supplying medication.
15	N	All urgent treatment centres should be able to provide emergency contraception, where requested.
	L	No additional requirement.
16	N	All urgent treatment centres must have direct access to local mental health advice and services, such as through the on-site provision of ‘core’ liaison mental health services where services are co-located with acute trusts or links to community-based crisis services.
	L	Mental Health support should be an integrated offer within the Urgent Treatment Centre.
17	N	All urgent treatment centres should have arrangements in place for staff to access an up-to-date electronic patient care record; this may be a summary care record or local equivalent. This access will be based on prior patient consent, confirmed where possible at the time of access, or in the patient’s best interests in an emergency situation where the patient lacks capacity to consent.
	L	The Urgent Treatment Centre clinicians will have access to the up-to-date electronic patient care record for a T&G registered patient following consent.
		The Urgent Treatment Centre should ensure that patients are supported in line with any Advance Care Plans in place.
18	N	There must be the ability for other services (such as NHS 111) to electronically book appointments at the urgent treatment centre directly, and relevant flags or crisis data should be made available for patients
	L	No additional requirement.
19	N	A patient's registered GP should always be notified about the clinical outcome of a patient’s encounter with an urgent treatment centre via a Post Event Message (PEM), accompanied by a real-time update of the electronic patient care record locally. For children the episode of care

		should also be communicated to their health visitor or school nurse, where known, within two working days
	L	No additional requirement.
20	N	Where available, systems interoperability should make use of nationally-defined interoperability and data standards; clinical information recorded within local patient care records should make use of clinical terminology (SNOMED-CT) and nationally-defined record structures.
	L	No additional requirement.
21	N	Urgent treatment centres should make capacity and waiting time data available to the local health economy in as close to real-time as is possible for the purposes of system-wide capacity management; relevant real-time capacity information should also be made available for use across Integrated Urgent Care nationally.
	L	The Urgent Treatment Centre data is managed as a key component of the Emergency and Urgent Care dataset and is available as required by GM and the Locality.
22	N	Urgent treatment centres should refer to and align with the Integrated Urgent Care Technical Standards to ensure effective service and technical interoperability.
	L	No additional requirement.
23	N	Urgent treatment centres should provide the necessary range of services to enable people with communication challenges to access British Sign Language, interpretation and translation services.
	L	No additional requirement.
24	N	Where appropriate, patients attending an urgent treatment centre should be provided with health and wellbeing advice and sign-posting to local community and social care services where they can self-refer (for example, smoking cessation services and sexual health, alcohol and drug services).
	L	Patients should be linked to Neighbourhood and T&G wide based support.
25	N	All urgent treatment centres should collect contemporaneous quantitative and qualitative data, including patient experience. From October 2018 all urgent treatment centres must return the data items specified in the Emergency Care Data Set (ECDS). Locally collected data should be used in a process of continuous quality improvement and ongoing refinement of the service.
	L	No additional requirement.
26	N	All healthcare practitioners working in urgent treatment centres should receive training in the principles of safeguarding children, vulnerable and older adults and identification and management of child protection issues.
	L	No additional requirement.
27	N	All urgent treatment centres to ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child.
	L	The Urgent Treatment Centre should ensure that any adult safeguarding concerns are raised promptly through the appropriate process.
28	L	The Urgent Treatment Centre should be a multi professional learning environment with links to local Higher Education Institutes.

5 IMPLEMENTATION EXPECTIONS

5.1 The consultation identified four key concerns regarding car parking and communication. The following mitigations were agreed by Strategic Commission Board in March and will need to be addressed by the Strategic Commission and the Tameside and Glossop Integrated Care NHS Foundation Trust during the implementation phase.

- Availability of car parking
  Mitigation
  A development scheme in partnership with the hospital will provide an additional 240 parking spaces.

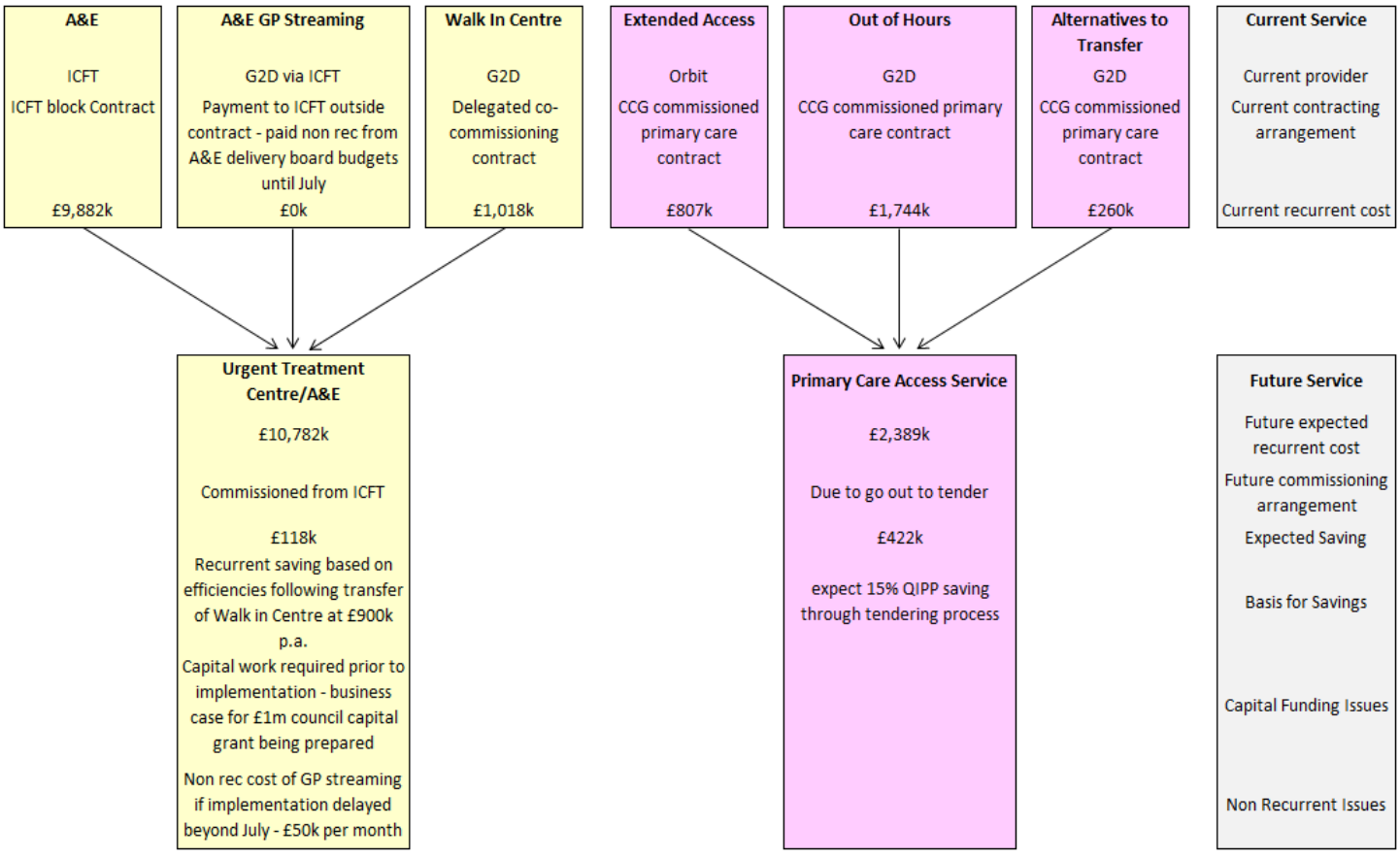
- Accessibility
  Mitigation
  The implementation phase will consider the drop off and pick up arrangements at the Urgent Treatment Centre and availability of Disabled car parking.

- Confusion regrading where to attend
  Mitigation
  The implementation phase will ensure the development of clear signage that directs individuals that walk-in to the correct building and access point.

- Communication of new arrangements
  Mitigation
  A communications plan will be used to ensure that local people are aware how they can access urgent care effectively.

6 FINANCIAL IMPLICATIONS

6.1 The diagram below maps out the financial consequences of the proposed vision for integrated urgent care in Tameside and Glossop:



6.2 Business cases for the Primary Care Access Service have already been approved and this is proceeding to procurement with an expectation of a 15% saving versus the current cost.

6.3 The recurrent cost of A&E and Walk in Centre at present is £10,900k per annum. In addition to this, GP streaming is being funded on a non-recurrent basis for approximately £50k per month. Non recurrent money is included in budgets to continue funding GP streaming until July.

6.4 When the new Urgent Treatment Centre is in place, the requirement for GP streaming will cease. It is also expected that efficiencies can be generated by bringing the Walk in Centre and A&E together. As such it is proposed that an additional £900k is varied into the ICFT contract to run the Urgent Treatment Centre. This will creating a commissioner saving of £118k per annum versus the current cost of the GP led Walk in Centre (and ending the requirement for non-recurrent funding of GP streaming).

6.5 In order to enable these savings and before the Urgent Treatment Centre can go live, some capital work is required on the A&E site. The cost of these works is estimated at £1m and is subject to a separate business case for a capital grant from the Local Authority.

6.6 Initial time lines expected the Urgent Treatment Centre to be operational in July 2018. This now feels unachievable and some degree of slippage is inevitable, while capital funding issues are addressed and work to reconfigure the hospital site takes place. Until capital works are complete current arrangements for the Walk in Centre and GP steaming will need to be extended, delaying realisation of planed savings and creating a cost pressure of £50k per month for every month GP streaming is required beyond July.

7 RECOMMENDATION

7.1 As stated on the front of the report.

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Appendix 1

Tameside Metropolitan Borough

NHS
Tameside and Glossop
Clinical Commissioning Group

Quality Impact Assessment
Urgent Treatment Centre
April 2018

Quality Impact Assessment

Title of scheme: Urgent Treatment Centre

Project Lead for scheme: Elaine Richardson

1.1 The Tameside and Glossop vision for urgent care is that people who develop an urgent care need will be assessed by the most appropriate person on the same day within primary care and either a treatment plan agreed within the service or a safe transfer made to the care of another neighbourhood based service. This will also ensure that people who have an emergency need can access the expertise they need quickly through A&E.

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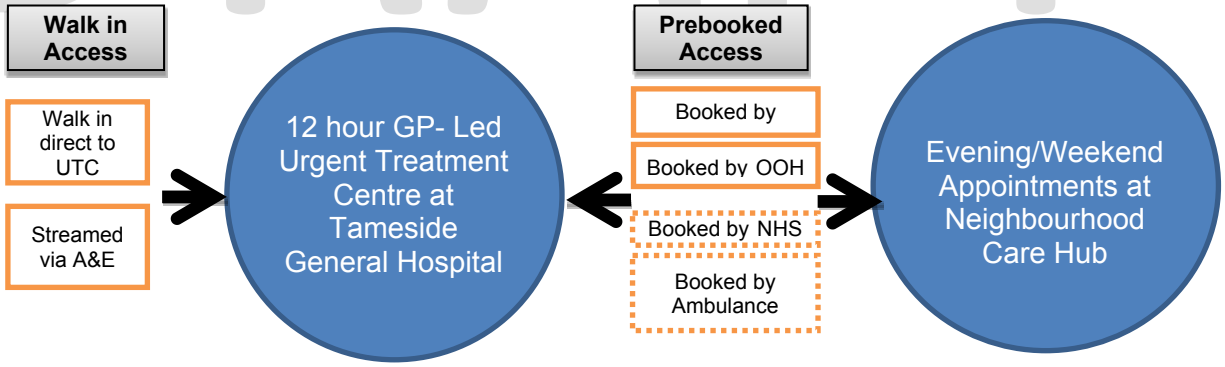
1.4 The Integrated Urgent Care Service model means people with an urgent care need will be able to access support in their neighbourhood or through an Urgent Treatment Centre based at the hospital site in Ashton. People will get 24/7 phone access to support through their practice or NHS 111 which provides appropriate advice or an appointment with the right professional on the same day either at their practice, one of the five Neighbourhood Care Hubs or the Urgent Treatment Centre. People who are not registered with a local GP or who prefer not to make an appointment can walk-in at the Urgent Treatment Centre.



1.5 The Integrated Urgent Care Service comprises the following two component parts that will work together and with General Medical Practices, to ensure people can access same day care when necessary.

- The Urgent Treatment Centre
- The Primary Care Access Service

This quality impact assessment considers the Urgent Treatment Centre which will be commissioned from Tameside and Glossop Integrated Care NHS Foundation Trust.

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

															Urgent Treatment Centre will reduce the use of A&E for non-life threatening conditions and free up resources to manage people who require emergency treatment. The Urgent Treatment Centre will be able to access patient records with the appropriate consent. The provider will be expected to ensure robust and consistent care and safety for patients. Safety incidents will be reported and monitoring of these will be carried out via provider governance and as part of the performance management and assurance of the contract. Access to patient notes will reduce risk when planning treatment. Safeguarding: The urgent treatment centre will ensure that Child Protection Information Sharing system is in use to identify vulnerable children on a child protection plan (CPP), Looked After Child (LAC) or in utero. This will ensure that information is shared with social care and other NHS colleagues to enable appropriate action to safeguard the child. The Urgent Treatment Centre will ensure that any adult safeguarding concerns are raised promptly through the appropriate process. The provider will need to assure the SCF of its governance and quality assurance mechanisms.
Clinical effectiveness	X						x						x			A positive impact is anticipated The ability to book appointments in advance through the registered GP will enable people to be treated at the place by the most appropriate professional which will improve effectiveness. Access to urgent diagnostics at the Urgent Treatment Centre will improve diagnosis and treatment in a single appointment. Access to patient notes will improve the planning of treatment both immediate and any follow up care. Reduced minor activity in A&E will enable A&E specialists to focus on the most complex patients

Patient experience		x								x			x			Although it is expected patient experience e will improve through alignment of access points and increased appointments, a degree of dissatisfaction from some people is anticipated as any change attracts negative responses. The Urgent Treatment Centre includes a walk-in element and is fully aligned with national and GM expectations. Through consultation we have collected people's perception of the impacts so we could identify any areas where we will need to take action to mitigate risk. The feedback shows that some people will have to travel a little further (1.5miles) which will take longer to the walk-in access when it is at the hospital but others will have shorter journeys and journey times. To address concerns regarding car parking at the hospital site a development scheme in partnership with the hospital will provide an additional 240 parking spaces. Both concerns and approval of the co-location with A&E were expressed with regard to the impact on waiting times. The specification for the service will ensure that patients are treated in line with the national expectations and we will encourage use of the Friends and Family test and Care Opinion to gain feedback and identify areas for further improvement.
Safeguarding children or adults	x						x						x			No impact expected as staff will be fully trained and the provider will have safeguarding procedures in place.

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

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

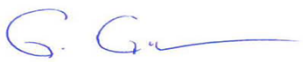
Adverse publicity/ reputation			x							x				x		The model reflects the feedback gained through a 12 week public consultation. A robust communications plan will be in place for the life of this project and communications, engagement and consultation activity will be monitored and evaluated throughout the life of the plan. The data we have relating to current usage of existing services is known. Transport mapping has been done to demonstrate the impact of relocation by car and public transport – and this shows that more people will have a shorter journey to services located at the hospital site rather than Ashton Primary Care Centre. All of the mapping and data we have available will be shared as part of the consultation documentation.
Finance				x							x			x		Existing funding will be used. The national mandate for A&E Streaming and the GM requirement for an Urgent Treatment Centre in Tameside and Glossop have to be delivered within existing funding. By maximising efficiency and reducing duplication the risk of additional costs will be minimised and the new service should be able to contribute to financial recovery. A Capital funding requirement at the ICFT site has been identified as part of the A&E Streaming project and a submission has been made to NHSE.
Service/ business interruption				x						x				x		Mobilisation phase of delivery will need to be robust and of sufficient duration to ensure transition is planned and managed to mitigate potential interruptions to service provision.
Environmental impact		x						x					x			There will be a change to the location of services specifically Ashton PCC to ICFT. The travel in relation to this will increase footfall at the hospital site, with a greater number of cars on site. There will be a corresponding positive impact at the Ashton PCC site.
Compliance with NHS Constitution	x						x						x			The ability to focus A&E on Emergency patients will reduce the risk of failure of the national standard for A&E waiting times.

Partnerships	x											x	x			A positive impact is expected as the service will involve integrated and partnership working to deliver the service.
Public Choice	x						x						x			No negative impact on quality anticipated. The Urgent Treatment Centre is one of six locations where appointments can be made outside traditional working hours and at different locations which will provide more choice and convenience.
Public Access	x						x						x			No negative impact on quality anticipated The service will enable appointments to be made outside traditional working hours and at different locations. To address concerns regarding car parking at the hospital site a development scheme in partnership with the hospital will provide an additional 240 parking spaces.

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

Sign off:

Quality Impact assessment completed by	**Elaine Richardson**
Position	**Head of Delivery and Assurance**
Signature	
Date	**30/4/18**
Nursing and Quality Directorate Review	

Name	**Gill Gibson**
Position	**Director of Safeguarding and Quality**
Signature	

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