

STRATEGIC COMMISSIONING BOARD

Day: Wednesday
Date: 20 June 2018
Time: 1.00 pm
Place: Lesser Hall 2 - Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	WELCOME AND APOLOGIES FOR ABSENCE To receive any apologies for the meeting from Members of the Panel.	
2.	DECLARATIONS OF INTEREST To receive any declarations of interest from Members of the Panel.	
3.	MINUTES OF THE PREVIOUS MEETING To receive the minutes of the previous meeting held on 23 May 2018.	1 - 10
4.	FINANCIAL CONTEXT	
a)	COMMUNITY SERVICES CONTRACT To consider the attached report of the Deputy Executive Leader / Director of Finance.	11 - 16
5.	QUALITY AND PERFORMANCE CONTEXT	
a)	QUALITY CONTEXT To consider the attached report of the Director of Safeguarding and Quality.	17 - 32
b)	PERFORMANCE REPORT To consider the attached report of the Assistant Director for Policy, Performance and Communications.	33 - 72
6.	COMMISSIONING FOR REFORM	
a)	COMMUNITY CARDIOLOGY DIAGNOSTICS To consider the attached report of the Interim Director of Commissioning.	73 - 96
b)	CONTRACT FOR THE PROVISION OF A GARDEN MAINTENANCE AND DAY SUPPORT SERVICE AT SUPPORTED DOMESTIC PROPERTIES IN TAMESIDE To consider the attached report of the Director of Adult Services.	97 - 100
c)	MENTAL HEALTH COMMUNITY BASED SERVICES - CONTRACT EXTENSION To consider the attached report of the Director of Adult Services.	101 - 104

Item No.	AGENDA	Page No
d)	LIST OF APPROVED DAY TIME ACTIVITIES - CONTRACT EXTENSION To consider the attached report of the Director of Adult Services.	105 - 110
e)	PRIMARY CARE ACCESS SERVICES - PROCUREMENT EVALUATION STRATEGY To consider the attached report of the Director of Commissioning.	111 - 140
7.	OUTLINE BUSINESS CASE FOR TRANSFER OF ADULT SOCIAL SERVICES FUNCTION To receive the attached report of the Director of Adult Services.	141 - 204
EXCLUSION OF THE PRESS AND PUBLIC		
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.		
8.	DOMESTIC ABUSE SERVICE To consider the attached report of the Assistant Director of Operations and Neighbourhoods.	205 - 212
9.	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).	
10.	DATES OF NEXT MEETING To note that the next meeting of the Strategic Commissioning Board will take place on Wednesday 25 July 2018.	

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

23 May 2018

Commenced: 9.00 am

Terminated: 11.00 am

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 Bill Fairfoull – Tameside MBC
Councillor Leanne Feeley – 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
Councillor Jean Wharmby – Derbyshire County Council

In Attendance: 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)
Gideon Smith – Consultant, Public Health Medicine
Stephanie Sloane – Strategy and Business Planning Manager
Cheryl Pike – Group Manager, Derbyshire County Council

Apologies: Councillor Gerald Cooney – Tameside MBC
Councillor Allison Gwynne – Tameside MBC

1. DECLARATIONS OF INTEREST

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

2. MINUTES OF THE PREVIOUS MEETING

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

3. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance presented a report providing an update on the year end financial position of the care together economy in 2017/18 and highlighting the increased risk of achieving financial sustainability over the long term and supporting details were attached at Appendix 1 to the report.

Reference was made to details of the summary 2017/18 budgets and net expenditure for the Integrated Commissioning Fund and Tameside and Glossop Integrated Care Foundation Trust and the outturn variances were explained in Appendix 1 to the report. While financial control totals had been achieved by the three statutory organisations in 2017/18, members were aware of significant pressures within the economy during the 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 £6.393m compared to the opening budget.

- Children's Services within the Council was managing unprecedented levels of service demand which was currently projected to result in additional expenditure of £8.609m when compared to the available budget.

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.

It was reported that there had been a significant change to the CCG Surplus position at month 11 relating to the System Risk Reserve and Category M Drugs. The net impact of these changes was an increase in the surplus to £9.347m. It was important to note that there was no mechanism through which the CCG would be able to draw down any of this surplus in 2018/19.

RESOLVED

- (i) **That the 2017/18 2017/18 financial year end position be noted.**
- (ii) **That the significant level of savings required during the period 2018/19 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.**

4. SHARED LIVES CONSULTATION – ACCESS POLICY CHANGE

Consideration was given to a report of the Assistant Director for Adult Services seeking 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 was part of a wider piece of work with Shared Lives Plus which was the national Shared Lives umbrella body and the Department for Education to expand the offer of Shared Lives services to younger people. This was supported by a Department for Education grant to assist in supporting the development.

The policy change was 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.

Working with young people leaving care was one element of the transformation plan which was 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 would better support the wider health and social care system as health and social care services continued to be integrated.

Consultation with Children's Services on the legislative requirements of this change of policy had 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 were detailed in Appendix 1 to the report. It was intended to have a specific targeted recruitment campaign for carers interested in working with young people and would link with Children's Services training and development programme in terms of providing necessary training and development requirements.

It was also reported that an Equality Impact Assessment had been undertaken and attached as Appendix 2 to the report.

The service was currently working with the Policy, Performance and Communications Team regarding questions on the Big Conversation for public consultation on this policy change. The consultation plan and documents including public information and a description of the proposed

work and questionnaire had been developed and attached to the report at Appendix 3 and Appendix 4. Consultation will also be undertaken with the Children in Care Council to seek their views and comments on the proposal. A combination of focus groups and drop in sessions would be arranged to run in parallel with Carers Forums over a range of day / evening sessions.

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

RESOLVED

That approval be given to undertaken consultation to change the Shared Lives age of service entry from 18 to 16 years.

5. SHARED LIVES CONSULTATION – BANDED SYSTEM FOR SHARED LIVES PLACEMENTS

Consideration was given to a report of the Assistant Director (Adult Services) seeking permission to enter into consultation with Shared Lives Carers and key stakeholders to consider a banded payment system for carers. Shared Lives primarily worked with adults with learning disabilities but more recently had started to diversity and promote services to other vulnerable adult groups such as older people. Shared Lives carers were approved to provide a range of community support services to individuals meeting the criteria for Adult Services.

There were currently 125 service users being supported by 88 carers and any person aged 18 or over meeting the eligibility criteria for services could use Shared Lives. The Shared Lives carers provided a range of services dependent upon the needs and health of the individuals. Shared Lives carers were self-employed and to become approved were DBS checked and had to complete an in-depth assessment and approval process and required to undertake regular mandatory training.

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

Shared Lives supported 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 could support service users to maintain independence in the community and as a support to family carers to maintain their roles. As people progressed into long term placements Shared Lives carers offered an asset based approach as a less costly alternative to traditional services. The Shared Lives Scheme was 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 was pivotal to these aims.

This consultation aimed to discuss a proposed banded payment system for Shared Lives carers, which ensured the payment made to carers was 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 could, provide at a certain cost. A banded payment system would also support the attraction of a larger number of prospective carers to meet the varying degrees of need. There was a need to review the fixed payments that were currently offered to carers, and consider a payment mechanism that was more reflective of the complexity of service users that carers currently supported, and could support in the future as service expanded. It would also support us in recruiting more carers to the service.

Some individuals might be willing to provide accommodation but not much support while others might be willing and indeed want to provide a substantial amount of support on the basis that the level of support and commitment was 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.

It was important that there was communication and consultation 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 would be done using various approaches including letters, focus groups, drop-in sessions and individual interviews.

RESOLVED

That the proposal for the Shared Lives Service to enter into consultation with carers and key stakeholders on the implementation of a banded system for carers be supported.

6. PUBLIC HEALTH INVESTMENT – PREVENTING AND MANAGING LONG TERM CONDITIONS

Consideration was given to a report of the Interim Director of Commissioning and the Interim Assistant Director of Population Health which stated that 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.

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.

The report outlined 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.

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

RESOLVED

(i) That the proposals set out in the business cases be supported.

(ii) That the investment outlined in the report of £313,401 for 2017/18, £329,751 for 2018/19 and £190,000 for 2018/20 be agreed.

7. MENTAL HEALTH INVESTMENT – MENTAL HEALTH NEIGHBOURHOOD DEVELOPMENT BUSINESS CASE

The Interim Director of Commissioning presented a report outlining a business case 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.

Reference was made to section 2 of the report which outlined the ambitions for 2018/20. Further work had taken place within the locality, in Greater Manchester and with partner Clinical Commissioning Groups in the Pennine Care footprint. From this learning a range of ambitions were proposed:

- Increase opportunities for people to stay well in the community;
- Increase opportunities to get help before / during crisis;
- Make effective use of secondary care.

The report outlined requests for Strategic Commissioning Board agreement to progress with two elements:

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

RESOLVED

- (i) **That the proposed ambitions be endorsed.**
- (ii) **That investment be agreed for two proposals for £58,000 for the 101 Days for Mental Health Project and £144,000 recurrently for the Dementia Practitioner capacity.**

8. MENTAL HEALTH INVESTMENT – SELF-MANAGEMENT EDUCATION BUSINESS CASE

Consideration was given to a report of the Interim Director of Commissioning explaining that a co-ordinated vision for self-management education that aimed to align and develop resources that supported individuals to self-care, across physical health, mental health and lifestyle change had been developed within Care Together.

The business case proposed that two funding streams be brought together - £27,000 recurrent funding used in the past to commission Self-Management UK to deliver self-management courses and £80,000 of Public Health Investment Fund, committed for two years. The £107,000 would be used to invest in a new programme for Tameside and Glossop to develop a co-ordinated self-management education offer that consisted 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 Wellbeing College.
- Developing a generic self-management course for Tameside and Glossop and equipping local trainers to deliver it.
- Co-ordinating existing SME assets and developing new ones in partnership with local organisations.
- Ensuring people had 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.

Going forward it was 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 outline resource to help people self-manage, with associated neighbourhood hubs.
- Supporting access to specialised health coaching, specifically for people with long term conditions who had lower activation levels and required more intensive one to one support.
- Embedding self-management consistently in clinical pathways ensuring a dual role in supporting people's conditions and empowering them to be effective self-managers.

Reference was also made to the national, strategic and local context, outcomes and benefits, the evidence base and performance monitoring and evaluation. It was intended that the proposal would be implemented from July 2018 preceded by a continuing planning phase in May and June 2018.

RESOLVED

That the Strategic Commissioning Board RECOMMEND to Council and the Clinical Commissioning Group that the proposals for investment outlined in the report be supported.

9. INTERMEDIATE CARE IN TAMESIDE AND GLOSSOP

The Interim Director of Commissioning presented a report which stated that the Tameside and 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 the Strategic Commissioning Board of the consultation progress and process, initial themes and the next steps to ensure a final report to the January 2018 Board meeting.

A report containing the full detail of the consultation analysis, an Equality Impact Assessment responding to issues arising during the consultation and explored mitigations, was presented to the Strategic Commissioning Board in January 2018. On the basis of this report, the Board 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 Strategic Commissioning Board, including a letter from the Clinical Chair and Chief Executive of the Clinical Commissioning Group, 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 and appended to the report at Appendix 1.

Commissioners had been working with Integrated Care Foundation Trust and other partners in the locality to ensure the mitigations are being delivered and to develop the implementation plan set out in the report. The Integrated Care Foundation Trust had established a dedicated Intermediate Care project group which was led by the Chief Nurse and Director of Human Resources and reports into the Trust Executive Management Group. The Group's objectives were outlined in the report. Senior leads had been identified and sub-groups established to progress key actions prior to the relocation of services.

It was reported that a key principle of the intermediate care model was that wherever possible a person should have their care requirements met within their own place of residents and that the system would be responsive to meeting this need in a timely manner. The Integrated Care Foundation Trust had 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 documentation supported discussions with patients, carers and social care services on discharge planning and a choice of services attached to the report at Appendix 3.

The Integrated Care Foundation Trust had established a project group to develop a revised model for the whole of the Stamford Unit and agree policies and procedures for the new state. This included the process for identifying and referring patients into the specific Glossop bed based intermediate care.

Reference was also made to staffing implications and the process for staff consultation for the relocation of staff and a recruitment event had been held to recruit to vacant posts. Safe staffing of intermediate tier services would be monitored through quality and performance contract meetings between the Strategic Commission and the Tameside and Glossop Integrated Care Foundation Trust to ensure a focus on quality and safety during and after transition.

In conclusion, the Interim Director of Commissioning made reference to the letter from the Clinical Chair and Chief Executive of the Clinical Commissioning Group 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 Integrated Foundation Trust's response to this letter had been included in detail in the report.

The Board discussed at length 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 families / carers to deliver their optimum outcome.

It was emphasised that in line with the outcome of the consultation, bed based intermediate care for the population of Tameside and Glossop would be delivered from the Stamford Unit on the Tameside Hospital site and, in addition, the commissioning of intermediate care beds in Glossop to be purchased on an individual basis to meet an individual's needs should this be appropriate. This was ongoing and being led by the Integrated Care Foundation Trust Glossop Neighbourhood team with involvement from primary care, commissioning, social care, Derbyshire County Council and patient representation.

The Interim Director of Commissioning stated that this offer for the population of the Glossop neighbourhood had been developed and enhanced over recent months.

In particular, the Chair sought assurances and made reference to the minutes of the February Strategic Commissioning Board and read out the following extract:

"The Interim Director of Commissioning provided assurances that the Home First offer would be fully established and operational in the Glossop area before any implementation. This would ensure consistency, help build public confidence and ensure the new care models were understood before changes were implemented.

Resolution

3)c The need for assurance of the home based Intermediate Care offer working in Glossop."

In response the Interim Director of Commissioning made reference to her review of the response of the Integrated Care Foundation Trust outlined in detail in the report and was satisfied that:

- Processes were in place to identify and refer intermediate care patients in Glossop, offer choice and fulfil the expectation of Commissioners;
- There was a plan to develop a commissioning process to support the additional bed based intermediate care provision in Glossop should this be appropriate. The Interim Director of Commissioning was working with the Strategic Commission's Director of Quality and the Integrated Care Foundation Trust Director of Nursing to ensure the process was robust and agreed.
- The Integrated Care Foundation Trust was offering service provision at all levels of Intermediate Care. However, this would be kept under review and assurance gained via the National Audit.

- That in relation to Glossop Integrated Neighbourhood Services and Glossop Primary Care Centre utilisation, the ICFT had met the Strategic Commissioning Board recommendation as described in the letter to the ICFT and attached at Appendix 1 to the report.

Having considered the report and responses provided by the Interim Director of Commissioning it was –

RESOLVED

- (i) That the progress against mitigations outlined in the conclusions to the report be noted.**
- (ii) That the move to implementation of the agreed model of care be approved.**
- (iii) That the Quality and Performance meeting undertake a review of the delivery of Intermediate Care and report the findings to the Strategic Commissioning Board in January 2019.**

10. INTEGRATED URGENT CARE IN TAMESIDE AND GLOSSOP

The Interim Director of Commissioning presented a report explaining that in 2017/18 the Tameside and Glossop Strategic Commission had led the development of a locality vision for an enhanced offer of urgent care. Following a public consultation, the Strategic Commissioning Board, 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 the strategic way forward for Tameside and Glossop Integrated Care NHS Foundation Trust, meant that the Urgent Treatment Centre element would be commissioned within the Integrated Care Foundation Trust contract. The report set out the National and Local Requirements of the Tameside and Glossop Urgent Treatment Centre. A Quality Impact Assessment had been completed and was attached to the report at Appendix 1.

Particular reference was made to financial implications and it was reported that the business cases for the Primary Care Access Service had already been approved and this was proceeding to procurement with an expectation of a 15% saving versus the current cost. The recurrent cost of A&E and Walk in Centre at present was £10,900 per annum. In addition to this, GP streaming was being funded on a non-recurrent basis for approximately £50,000 per month. Non-recurrent money was included in budgets to continue funding GP streaming until July.

When the new Urgent Treatment Centre was in place, the requirement for GP streaming would cease. It was also expected that efficiencies could be generated by bringing the Walk in Centre and A&E together. As such it was proposed that an additional £900,000 was varied into the Integrated Care Foundation Trust contract to run the Urgent Treatment Centre. This would create a commissioner saving of £118,000 per annum versus the current cost of the GP led Walk in Centre and ending the requirement for non-recurrent funding of GP streaming.

In order to enable these savings and before the Urgent Treatment Centre could go live, some capital work was required on the A&E site. The cost of these works was estimated at £1m and was subject to a separate business case for a capital grant from the local authority.

However, it was reported that initial time lines expected the Urgent Treatment Centre to be operational in July 2018. The Board heard that this was now feeling unachievable and some degree of slippage was inevitable while capital funding issues were addressed and work to reconfigure the hospital site took place. Until capital works were complete, the current arrangements for the Walk in Centre and GP streaming would need to be extended, delaying

realisation of planned savings and creating a cost pressure of £50,000 per month for every month GP streaming was required beyond July.

RESOLVED

The Board confirmed its intention to commission an Urgent Treatment Centre that delivered the standards and outcomes stated in the report and recommended the same to the Clinical Commissioning Group.

11. EXCLUSION OF THE PRESS AND PUBLIC

RESOLVED

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 involved the likely disclosure of exempt information as defined in paragraph 3 of Schedule 12A to the Local Government Act 1972. Information relating to the financial or business affairs parties (including the Council) had been provided to the Council in commercial confidence and its release into the public domain could result in adverse implications for the parties involved.

12. WOMEN AND THEIR FAMILIES SERVICE

Consideration was given to a report of the Interim Director of Commissioning, which explained that the purpose of the Women and Families Centre was to use asset-based approaches to focus on early detection and help for women and their families who had the often overlapping issues of domestic abuse, mental health issues and harmful drug and alcohol use and were ready to make changes in their life. The report had been prepared in accordance with Procurement Standing Order D3.3 which required authorisation to be obtained where procurement activity had resulted in the receipt of fewer than three tenders. Having tested the market via OJEU and on The Chest, two compliant tenders were submitted.

It was reported that the core service elements of the Service was the provision of advice and support, risk assessment and safety planning, referral and assistance to engage with other relevant agencies to help overcome issues related to the women and their families. Where appropriate, crèche facilities were provided allowing women with children to ensure care for their children aged 5 years and under whilst utilising the Service.

At its meeting on 14 February 2017, the Strategic Commissioning Board agreed to the continuation of the current grant of £99,570 per annum to the Women and Families Centre for 2016/17 and an extension to 31 March 2018 and market testing to support consideration of funding of the Centre beyond 31 March 2018. Following a further report to the Strategic Commissioning Board on 31 October 2017, the Board agreed to extend the existing grant arrangement from 1 April 2018 to 30 September 2018 to allow time for the procurement to be completed with a view to a five year contract being procured.

Given the size of the contract, the specialist nature of the service and the market intelligence, the likelihood was that only a very limited number of providers had the necessary expertise and capacity to tender for these services. Particular reference was made to the procurement approach and evaluation exercise, which had been undertaken.

RESOLVED

- (i) That the recommendations of the evaluation process be accepted and permission be granted to award the contract for the Women and Their Families Service to the successful tenderer, New Charter Homes Ltd.**
- (ii) That commissioners regularly review the need for and alignment of this service with associated local service provision and consider revisions to the contract if indicated.**

13. URGENT ITEMS

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

14. DATE OF NEXT MEETING

It was noted that the next meeting of the Strategic Commissioning Board would take place on Wednesday 20 June 2018.

CHAIR

Report to: STRATEGIC COMMISSIONING BOARD

Date: 20 June 2018

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

Subject: TAMESIDE AND GLOSSOP COMMUNITY SERVICES CONTRACT ARRANGEMENTS WITH THE TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST

Report Summary: The report explains the proposed revised payment arrangements for the commissioning of community service provision by the Council and NHS Tameside & Glossop Clinical Commissioning Group across the locality from the Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT). These revised payment profiles will enhance the ICFT's cashflow position and allow it to avoid interest costs of £300k per annum. The Council will be compensated by £100k per annum for its own loss of interest caused by changing the payment profile.

The change in the arrangements will help ensure more funds are retained within the local health economy to optimise improved services for residents.

Recommendations: Strategic Commissioning Board Members are recommended to approve:

1. The advance payment arrangements set out in the report, which is intended to commence from 20 June 2018 for 2018/19 and from 1 April each financial year thereafter.
2. To note that Tameside Council will continue to be the host organisation and accountable body for the Section 75 pooled fund agreement.
3. That the change will, if expedient, be documented in the Section 75 and contracts between the CCG, ICFT and Council, otherwise through a separate agreement.

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

Budget Allocation	Council : £ 5.075 m CCG : £ £23.607 m Total : £ 28.682 m
Integrated Commissioning Fund Section	Section 75
Decision Body	Strategic Commissioning Board
Additional Comments The report explains the proposed arrangements for implementation from 20 June 2018 and associated financial implications. It should be noted that the annual net saving to the ICFT of these arrangements will be c £0.2m. There will however be a part year saving in 2018/19 due to implementation from the aforementioned date.	

Legal Implications: (Authorised by the Borough Solicitor)	<p>The proposal involves an advance payment for the year's community services that both the Council (£5.075m) and the CCG (£23.607m) are in contract with the ICFT for. The budget which funds the current contractual services are held in the pooled section 75 budget held and accounted for by the Council. This change will result in improved cash flow for the hospital which will result in total savings of £300K for the whole Tameside health economy as it will not be necessary for the ICFT to borrow money to cashflow existing services. The Council is obliged to demonstrate value for money. The advance will ensure the services are delivered on time and result in a reduction in costs of £100K for the benefit of the advance. This is to compensate for the loss of available capital to otherwise invest. If the Council retains the funding on the current basis given the current financial markets it would not be able to achieve such a return. The arrangement requires the necessary legal documentation to be put in place.</p>
How do proposals align with Health & Wellbeing Strategy?	<p>The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy</p>
How do proposals align with Locality Plan?	<p>The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan</p>
How do proposals align with the Commissioning Strategy?	<p>The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Strategic Commissioning Strategy</p>
Recommendations / views of the Health and Care Advisory Group:	<p>Reported directly to the Strategic Commissioning Board.</p>
Public and Patient Implications:	<p>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.</p>
Quality Implications:	<p>Quality considerations are included in the re-design and transformation of all services.</p>
How do the proposals help to reduce health inequalities?	<p>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.</p>
What are the Equality and Diversity implications?	<p>Equality and Diversity considerations are included in the re-design and transformation of all services</p>
What are the safeguarding implications?	<p>Safeguarding considerations are included in the re-design and transformation of all services</p>
What are the Information Governance implications? Has a privacy impact assessment been	<p>There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.</p>

conducted?

Risk Management:

Whilst making an advanced payment can be risky when made to a third party. The ICFT is a public sector body and underwritten by the Government. Other associated risks will be managed within the Section 75 and supporting Financial Framework

Access to Information :

Background papers relating to this report can be inspected by contacting :

Stephen Wilde, Finance Business Partner, Tameside Metropolitan Borough Council



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



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1. INTRODUCTION

- 1.1. Within the Section 75 element of the Integrated Commissioning Fund, the Council and NHS Tameside and Glossop Clinical Commissioning Group (CCG) have two contracts respectively with the Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT).
- 1.2. The Council's contract is to deliver community service provision across the locality. These services include :
 - The universal Healthy Child Programme 0-19 (this includes Health Visiting and School Nursing services)
 - Early Attachment Service
 - Infant Feeding
 - Family Health Mentors
 - Children's Nutrition Team
 - Falls Prevention programme
 - Infection Prevention
 - Children's Safeguarding
- 1.3. The CCG also commissions community services from the ICFT across the locality. These services include (but are not restricted to) :
 - District Nursing
 - Health Visiting
 - Physiotherapy
 - Speech & Language Therapy
 - Palliative Care (MacMillan Nurses)
 - Continence services
- 1.4. These services form part of the Council and NHS Tameside & Glossop Clinical Commissioning Group's contract with ICFT with each service having a detailed 'service specification' in place, a description of the service provided and the care offered to Tameside & Glossop residents by that service. The services each have a list of objectives and key performance indicators which are monitored by commissioners through the ICFT contract management processes. This process includes discussions relating to issues of performance and quality and enables commissioners to highlight any areas of concern and ensure these are addressed.

2. CONTRACT VALUE

- 2.1. The value of the 2018/19 Council commissioned community services contract for 2018/19 is £5.075m and is financed via the Population Health directorate revenue budget
- 2.2. The value of the 2018/19 CCG commissioned community services contract for 2018/19 is £23.607m and is financed via the CCG's core funding allocation.
- 2.3. These contracts are both accounted for within the 2018/19 Section 75 agreement of the Integrated Commissioning Fund of the Council and NHS Tameside and Glossop Clinical Commissioning Group arrangements, for which the Council is the host body
- 2.4. The Council currently pays the total contract value in advance instalments during the first quarter of the financial year. This is to support the cashflow of the ICFT and associated loan interest payments which are explained further in section 3 of the report.
- 2.5. The CCG currently pays the contract value in equal monthly instalments in line with the draw down arrangements of the annual core funding allocation.

3. FINANCIAL STATUS OF THE INTEGRATED CARE FOUNDATION TRUST

- 3.1. The ICFT is one of the hospitals defined by the Department of Health as being in “finance distress” as they have an annual deficit control total set by their regulatory body, NHS Improvement. The organisation is reliant upon cash from the Department of Health and Social Care (DHSC) in the form of loans in order to balance its books on an annual basis. The loans have to be requested on a monthly basis and interest of 3.5% is accrued from the date of draw down and paid on six monthly instalments.
- 3.2. NHS Improvement (NHSI) and the Department of Health have requested from the ICFT a monthly deficit profile, a daily cash plan and Board resolution.

4. PROPOSAL

- 4.1. The Council is fully responsible for its own cashflow and has the flexibility to alter payment terms with suppliers unlike the CCG who is governed by NHS England rules. Any such arrangements implemented by the Council are assessed against the potential risk of supplier failure and the benefits to the Council.
- 4.2. In order to reduce the value of loan interest payments incurred by the ICFT, it is proposed that the Council will commission the total value of the community services contract in 2018/19 (£28.682m) and each year thereafter in accordance with the terms of the existing Tameside MBC and NHS Tameside & Glossop Clinical Commissioning Group Section 75 agreement.
- 4.3. The Council will then pay this sum in an accelerated payment profile to be agreed with the ICFT to enable them to delay the loan drawdown and as a result reduce the value of the loan interest sum payable thereby retaining more funds within the local economy
- 4.4. The Council will be fully reimbursed for the CCG commissioned community services in line with the CCG’s monthly funding drawdown profile. This arrangement will be reflected within the Section 75 agreement and supporting Financial Framework duly approved by both parties.
- 4.5. The proposal does not affect the CCG’s cashflow and there are no direct financial costs or benefits to the CCG. They continue to pay their drawdown of funding from the DoH for the contract into the Section 75 pool. However, this arrangement benefits the wider health economy by saving the ICFT interest costs which can be invested in service delivery for the benefit of Tameside residents.

5. ESTIMATED FINANCIAL SAVINGS



- 5.1. This arrangement would enable the ICFT to make an annual gross saving of c£0.3m per annum in reduced loan interest payments, by deferring the date of the draw down of loans by the ICFT from the DoH. The ICFT is expected to have an in year deficit of more than £20m, for which it has to borrow. For illustrative purposes the deferring the drawdown by around 5 months would save around £0.3m on a straightline basis.
- 5.2. The Council, by making the advanced payment will lose some of its investment income on those balances which is estimated to be at 0.9%, which over the course of the year based on the revised cashflows would cost around £0.1m. It has therefore been agreed that in exchange for making the advanced payment, the contract value is reduced by £0.1m which will be retained by the Council to compensate it for the lost of interest.

- 5.3. It should be noted there will be part year saving implications in 2018/19 of this arrangement as it will commence on 20 June 2018 once approval is in place.

6. RECOMMENDATIONS

- 6.1. As detailed on the report cover.

Report to:	STRATEGIC COMMISSIONING BOARD
Date:	20 June 2018
Officer of Single Commissioning Board	Gill Gibson, Director of Safeguarding and Quality Slawomir Pawlik, Quality and Patient Safety Lead
Subject:	BIMONTHLY QUALITY ASSURANCE REPORT
Report Summary:	The purpose of the report is to provide the Strategic Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned; to highlight any quality concerns and to provide assurance as to the action being taken to address such concerns.
Recommendations:	The Strategic Commissioning Board is asked to: <ol style="list-style-type: none">1. NOTE the contents of the report; and2. COMMENT on the report format.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The quality assurance information in this report is presented for information and as such does not have any direct and immediate financial implications.
Legal Implications: (Authorised by the Borough Solicitor)	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account, understanding where best to focus resources and oversight. A framework needs to be developed to achieve this. It must include complaints and other indicators of quality.
How do proposals align with Health & Wellbeing Strategy?	Strengthened joint working in respect of quality assurance aim to support identification or quality issues in respect of health and social care services.
How do proposals align with Locality Plan?	Quality assurance is part of the locality plan.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by providing quality assurance for services commissioned.
Recommendations / views of the Health and Care Advisory Group:	This section is not applicable as the report is not received by the Health and Care Advisory Group.
Public and Patient Implications:	The services are responsive and person-centred. Services respond to people's needs and choices and enable them to be equal partners in their care.
Quality Implications:	The purpose of the report is to provide the Strategic Commissioning Board with assurance that robust quality assurance mechanisms are in place to monitor the quality of the services commissioned and promote joint working.

How do the proposals help to reduce health inequalities?	As above.
What are the Equality and Diversity implications?	None currently.
What are the safeguarding implications?	Safeguarding is part of the report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications. The reported data is in a public domain. No privacy impact assessment has been conducted.
Risk Management:	No current risks identified.
Access to Information :	<p>The background papers relating to this report can be inspected by contacting Slawomir Pawlik, Quality and Patient Safety Lead, by:</p> <p> Telephone: 07788647611</p> <p> e-mail: slawomir.pawlik1@nhs.net</p>

1. PURPOSE

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

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

Issues of concerns/remedy

District Nursing - staff capacity

- 2.1 The Strategic Commissioning Function (SCF) has raised concerns with Integrated Care Foundation Trust (ICFT) in relation to staffing capacity within District Nursing Teams and how this is impacting on the service's capacity to support the Neighbourhood delivery model. As such the SCF has requested a deep dive into the District Nursing which will be presented back to the ICFT Contract Quality and Performance Assurance Meeting..

Tameside and Glossop Q4 Assurance meeting with GM Health and Social Care Partnership

- 2.2 The Tameside and Glossop Q4 Assurance meeting with GM Health and Social Care Partnership was scheduled to take place on the 24 May 2018. In anticipation of this meeting the partnership has requested assurance on the following two areas of quality relating to the ICFT contract.

MRSA Bacteraemia:

- 2.3 In 2017/18 there have been 10 cases of MRSA bacteraemia for Tameside and Glossop Clinical Commissioning Group (CCG); 9 x community and 1 hospital attributed case. This has shown that Tameside and Glossop CCG have a higher rate of infection. All MRSA bacteraemia cases are examined using the national Post Infection Review tool. Two cases were avoidable; in that they identified lapses in care that could have led to the infection. One of these cases, through arbitration process, was apportioned to Stockport NHS Foundation Trust (community). The second case, from March 2018 is apportioned to Tameside and Glossop CCG with the learning outlined from this case found to be required at Tameside and Glossop ICFT.

- 2.4 Learning from this specific case is summarised below with action already implemented by the Trust:

- Adherence to MRSA policy to be reinforced on ward areas where admissions screens not completed;
- Hand hygiene education;
- Documentation when patients are transferred out of Trust;
- Appropriate sites swabbed for MRSA.

- 2.5 The remaining 8 cases were unavoidable and all community; 3 of the cases had no health care involvement (this is known as third party). The main theme from these unavoidable cases is that most of these patients were at significant risk due to their co-morbidities and had numerous admissions or attendance at other hospitals and care providers; they were very poorly patients. Where wider opportunity for learning and improving best practice was found; this has been actioned and shared. Opportunity for system improvements, identified as a result of thematic learning from all health care associated infection cases in 2017/18, are captured in the Infection Prevention Integrated forward plan. This plan informs priority areas for action and improvement for 2018/19 and is monitored via the Health Protection Group.

- 2.6 The Infection Prevention Matron will present quarterly assurance updates at the SCF Quality and Performance Contract meeting with the ICFT.

Never Events

- 2.7 The ICFT have reported two Never Events in 2017/18; both incidents are STEIs reported and undergo a robust investigation process by the ICFT. The CCG / SC quality assure all completed root-cause analysis to ensure there is evidence of a robust investigation, learning has been identified and appropriate action taken to reduce the likelihood of a similar incident occurring in the future. The learning from investigations, which includes the 2 x Never Events, is a standard agenda item at the Quality and Performance Contract meeting held with the Trust.

Good practice

Hand Hygiene Week (Part of the GM Ambition to reduce gram negative infections by 50% by 2022).

- 2.8 The Infection Prevention team worked with the hospital and community throughout the week to celebrate and reinforce the benefits of hand hygiene day on 5 May 2018.
- 2.9 On Tuesday the team held a hand hygiene event running from 10:00-14:00, and used the opportunity to educate and improve hand hygiene technique; staff picked up supporting goodies and resources for their areas
- 2.10 On Wednesday the Trust hand hygiene soap and sanitiser supplier 'Deb' visited wards to identify hand hygiene champions. Promotional stands were displayed at Ashton Primary Care. Staff were encouraged to sign their name on our hand hygiene board and post a picture on the Tameside Facebook page to share their commitment to hand hygiene, #TeamTameside.
- 2.11 On Thursday and Friday promotional stands were displayed in Hartshead South and the Infection prevention and the Sepsis team were based in Emergency Department promoting managing Sepsis and hand hygiene.



- 2.12 The next key stage of the project is the launch of the hydration campaign; 'Drink More, Stop Infections' week commencing 4 June 2018. Coverage of the event was promoted by ICFT and SCF communication departments via Social Media.

@morganupnorth

@tandgicft

@TGCCG

#teamtameside

#handhygiene

#sepsis



<http://www.who.int/infection-prevention/campaigns/clean-hands/2017/en/>

Horizon scanning

- 2.13 The SCF continues to work with the ICFT to formalise the new set of measures for the ICFT contract; this is in addition to the existing national quality requirements reported as part of the NHS Standard Contract. This work includes developing how the ICFT will contribute to the economy wide commissioning intention priority outcomes to reduce homelessness and domestic abuse and new quality standards for the Intermediate Care and home based beds.
- 2.14 The ICFT will publish its Quality Account 2017/18 prior to 20 June 2018.

Conclusion

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

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

Issues of concerns/remedy

Mixed Sex Accommodation (MSA)¹

- 3.1 During February 2018 there was 1 mixed sex accommodation breach on Tamside Hague Ward. There were no breaches recorded in March 2018..
- 3.2 A Communications and Engagement Plan for Single Sex Accommodation reconfiguration was presented to Trust Board in April 2018. Over the next 2-3 months the organisation will be talking to staff, patients, families and carers asking for their views and considerations, PCFT will act on this feedback in terms of how it take any proposals forward. The Trust will ensure that any final decisions are based on what matters most to staff and patients. The Trust Board approved this plan.

Information Governance Compliance

- 3.3 The Trust submitted a non-compliant Information Governance Toolkit submission to the Department of Health for 2017/18. Although there was a small overall improvement in its compliance score from the 2016/17 submission the non-satisfactory rating was submitted, as the Toolkit operates on a minimum Level 2 compliance for all criteria requirement and the Trust did not meet criteria 112 – Mandatory Information Governance training.
- 3.4 The training criteria target is 95% of staff completing IG training, and despite the best efforts of many officers, the Trust had only achieved 82% compliance by 31 March 2018 and had not met the 95% target at any point within the qualifying period (1 April 2017 to 31st March 2018).
- 3.5 The Trust are in the process of drafting an action plan in order to achieve compliance in 2018/19 and communication for Commissioners in relation to the non-satisfactory submission, where required.

General Data Protection Regulation (GDPR)

- 3.6 The Trust is undergoing a review of its General Data Protection Regulation (GDPR) readiness by our Internal Auditors. The new Regulations, which will replace the existing Data Protection Act 1998, will be in effect from 25th May 2018. One of the requirements of the new Regulations is for the Trust to have a Data Protection Officer, who must be a Senior Officer with access to the Board. The Trust proposal that the DPO role sits within

¹ MSA- sleeping breaches i.e. defined as instances where patients are admitted into a ward where patients of the opposite sex are also admitted.

the Information Governance Team has been considered as part of the initial Internal Audit review.

Delayed Transfer of Care (DTOC)

- 3.7 The Trust has undertaken a review of Delayed Transfers of Care (DTOC) reporting and recording to ensure a consistent and robust recording and escalation of DTOC's. Targeted work to improve DTOC performance across the Trust footprint has been completed.
- 3.8 At the end of March there were 2 Delayed Transfers of Care on Summers ward out of 11 beds. These patients are waiting for vacancies within a suitable 24-hour placement which are not currently available within the borough. The DTOC for these are: 180 & 78 days in length at the end of March. There is 1 DTOC on Hague who is currently homeless and has been a DTOC for 100 days. Work is underway with housing and the local authority to find suitable accommodation for this patient. The Trust anticipates that discharge will occur in April 2018.

Good practice

Reducing Restrictive Practices (Patient Experience)

- 3.9 The aim of the initiative is to develop a culture in which people using the Trust's services are able to fully participate in formulating plans for their well-being, risk management and care in a collaborative manner, promoting recovery and reducing the need for restrictive interventions.
- 3.10 Following delivery of workshops, a framework for reducing restrictive practices was developed to support teams with making decisions and developing a culture where service users could participate in making decisions about their risk management and care and the safety of the wards.
- 3.11 Monthly reducing restrictive practices meetings were established for staff and service users across the directorate to increase understanding of restrictive practices and to identify blanket restrictions in place on the units.
- 3.12 Care planning training was established with the support of Manchester University's EQUIP team to support staff in developing collaborative care plans with service users.

Horizon scanning

Quality Accounts 2017/18

- 3.13 The Trust has consulted with the key commissioners who make up the Pennine Care Footprint. A collective response was provided on the 8 May 2018.
- 3.14 The Quality Account will be published on NHS Choices on 30 June 2018

Conclusion

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

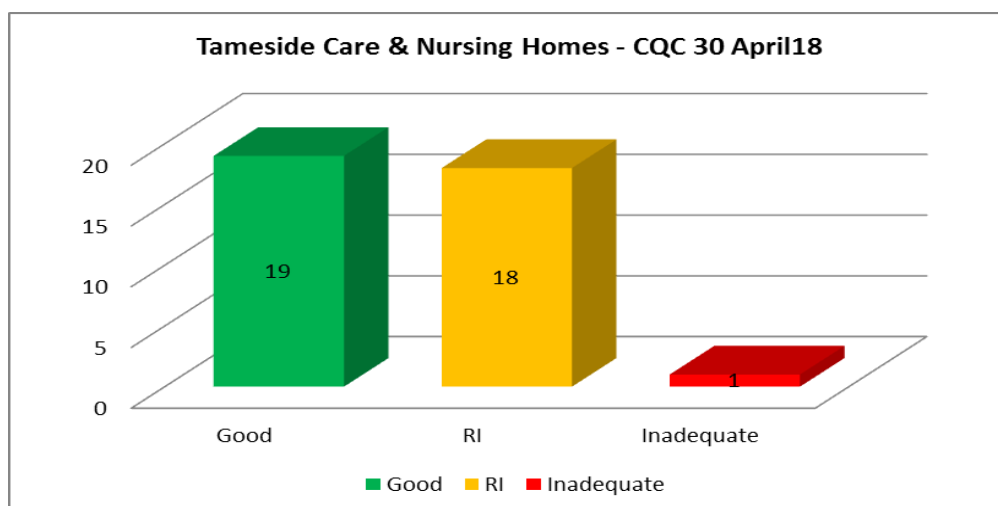
4. CARE HOMES/HOME CARE

Issues of concerns/remedy

Care Homes and with Nursing

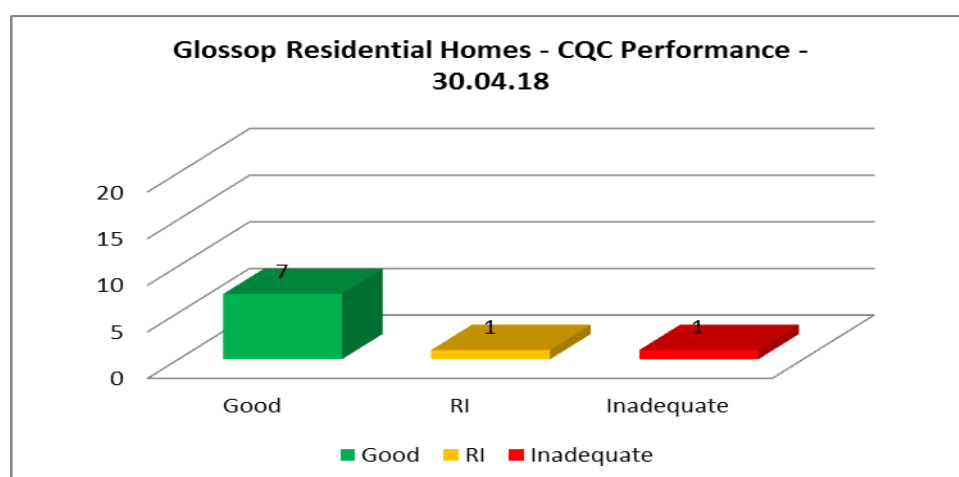
- 4.1 The Care Quality Commission (CQC) picture for Care Homes and with Nursing is provided in the graph below.

Tameside position, 30 April 2018)



- 4.2 Kingsfield Residential Home is included in this data but is currently closed for refurbishment.

Glossop Position, 30 April 2018



- 4.3 St Christopher's and Jabulani are included in the data and are included in the scope of the Care Home Data-set discussions.
- 4.4 There are currently two residential homes rated inadequate within the Tameside and Glossop locality, a short summary of key issues and support provided is given.

Inadequate Care Quality Commission Ratings

Oakwood Care Centre

- 4.5 The Home was rated Inadequate by the Care Quality Commission (CQC) on 22 March 18 (previously rated inadequate on 22 April 2017). Issues related to environmental risk assessments, incident reporting, systems/processes, medicines management, staffing and training. This Home has been a primary focus of the new Quality Improvement Team (QIT) with significant support being provided. There is a new manager in post who has been working closely with the QIT to develop an improvement plan.

Regency Hall (Glossop)

- 4.6 The Home was suspended on a voluntary basis following a CQC inspection on 11 January 2018. The report was published on 7 April 18 with an inadequate rating. Concerns were raised over the high turnover of Home Managers, lack of leadership, poor documentation,

cleanliness and staffing levels. A new Manager has been appointed and a Management Consultancy firm is working with the Provider in response to the actions outlined by the CQC. The suspension was lifted on 12 March 2018 following significant improvements observed at a Contractual Visit on 8 March 2018.

Published CQC Ratings (March and April 2018)

Sandon House

- 4.7 The Home has an improved CQC rating of Good following publication of the report on 29 March 18 (visit 8 February 18). The Provider achieved a Good rating across all 5 of the CQC domains.

The Beeches

- 4.8 The Home has retained its CQC rating of Good following publication of the report on 3 March 18 (visit 1 February 18). The Provider achieved a Good rating across all 5 of the CQC domains.

Suspensions Update

Carson House

- 4.9 This Home is currently under suspension with effect from 28 March 2018. The Home has recently been inspected by the CQC and the report is awaited. Ongoing close monitoring continues with this Home and a Director level meeting with the Home Owner is being arranged.

Stamford Court

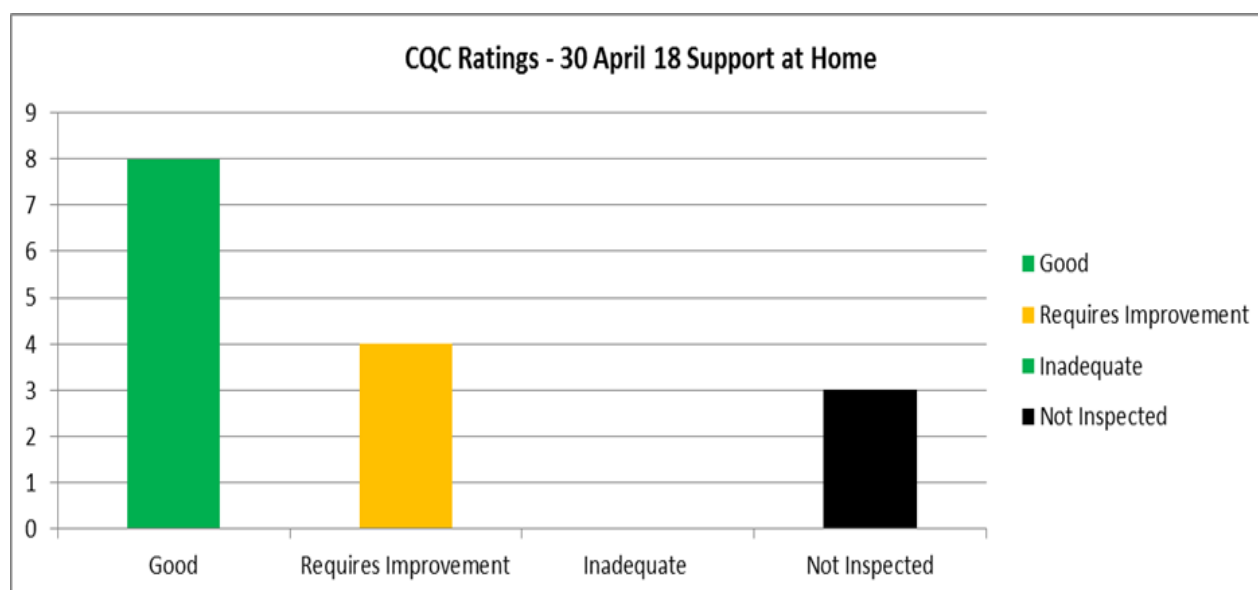
- 4.10 This Home is currently under suspension with effect from 29 March 18. Key issues relate to ongoing medicines management issues. Safe and well checks have been completed and a Commissioner/Provider meeting is being arranged to discuss the ongoing issues in respect of medicines management and systems and processes.

Hurst Hall

- 4.11 This Home has voluntarily suspended admissions with effect from 18 April 2018. Safe and well checks have been completed on all residents. An improvement plan is in place and ongoing close monitoring. Support is being provided to the Home.

Support in the community

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



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

Quality Improvement Team

- 4.14 A Quality Improvement Team is now operational to support independent providers across the health and social care sector in Tameside to improve the quality of service provision delivered to vulnerable people. The primary focus of the work will initially be on the Care and Nursing Home sector, with a particular focus on those homes rated “Inadequate” or “Requires Improvement” by the CQC, and an overall aim that with the support on offer from the team all homes will achieve good or outstanding ratings. In the longer term, the team would then programme in time to extend the work across the Support at Home Services and more widely across supported accommodation. We have worked with both Homes that are Inadequate /RI but also supported those with a Good rating. We are working with our colleagues from LA/CCG/ICFT and other Community services to provide additional training /resources or guidance that can take place within the Homes to ensure that the outcomes for residents are improved and enhanced.

Good Practice

Auden House

- 4.15 Auden House has been rated as one of the best Care Homes in Greater Manchester by residents and their families on www.carehome.co.uk, this was published in a Manchester Evening News article dated 3 April 2018. Auden House was rated 9.9/10, Guide Lane was also rated extremely positively with a 9.8/10. Ratings are calculated based on residents and relatives reviews of their experience of cleanliness, staff, security, care and value for money.

The Oakwood Care Centre

- 4.16 The Oakwood Care Centre Team and Provider have embraced the support being given by the QIT and significant changes have been made in terms of the cosmetic elements of the Home but also the regulatory requirements. The management within the Home appears to have been strengthened. This has been complimented on by the Neighbourhood Team:

“The client knowledge for the individual was very detailed and person centred. It was evident every attempt had been made to try and support the individual in a person centred way. The individual was also able to speak openly and there was a good working professional relationship between both parties”.

- 4.17 A relatives meeting was held on 27 April 2018 with the Manager and Owner, the relatives were very complimentary about the improvements that have been made so far

Conclusion

- 4.18 The new monthly contractual returns have now been implemented for Care Homes and the Care Home Quality Review Group is meeting monthly. The Terms of Reference for this group are in the process of being updated with the inclusion of the Neighbourhood Managers. The overall aim is to ensure that all intelligence is being gathered and reviewed to allow early identification of issues and focused support to be provided. The Neighbourhood Managers are supporting the model by establishing their own local forums to gather intelligence and identify areas for support. Care Homes and Nursing Homes are also now being identified for support by the Quality Improvement Team

5. SAFEGUARDING

Children’s Safeguarding

- 5.1 There are currently no serious case reviews. During recent weeks there has been a significant injury caused to a child. Dates have been arranged for screening of information

to assess that criteria is reached for a serious case review to be commissioned by the Tameside Strategic Commissioning Board. Further information has been requested of Tameside and Glossop CCG to review GP records. This request has been made by Oldham Local authority with respect to a domestic homicide review. The children of the victim are currently looked after in Glossop.

- 5.2 The Department of Education have requested bids from all local authorities and their partners to be “early adopters” in revision of safeguarding arrangements for children within the locality. Tameside Safeguarding Children’s Board is submitting a bid which will need to be received by the department by 20 May 2018.
- 5.3 Ofsted undertook a recent review of early help services, a part of the ongoing inspections timetabled as a result of the Tameside Safeguarding Children Improvement Plan. The results have been published on the website. Overall Tameside received positive feedback about services which are currently in place for early help for families. A further review will be undertaken by Ofsted in July 2018. This will review services for looked after children.
- 5.4 Further work is underway to develop a Multi -Agency Screening Hib (MASH) for Tameside and to coordinate this work with the development of multi-agency integrated neighbourhood teams for children. It is envisaged that both MASH and integrated neighbourhood services for children will be in place by September 2018.

Looked After Children (LAC)

- 5.5 The CCG, provider, and LA are continuing to work together to resolve issues with timely notification processes between services and considering how we improve partnership working. The Improvement Board, whose function is to review the multi-agency action plan for the authority since it was allocated an inadequate judgement, is overseeing the progress being made to ensure that children and young people who are looked after receive appropriate help and support. It is expected that LAC will be the focus of the Ofsted monitoring visit in June. Although progress made so far has been considered satisfactory, partners are not complacent and are continually seeking to improve systems, services and outcomes for LAC.

Adult Safeguarding

- 5.6 A case presented to the Learning and Accountability Sub Group for consideration for a Safeguarding Adult Review did not meet the threshold for a SAR (Care Act 2014). The partnership however agreed that a multi-agency learning review would offer opportunity for learning. The review is planned for June 2018.
- 5.7 Work has been ongoing to develop local guidance for Safeguarding Adult Managers which will support them in their safeguarding decision making. A guidance document is now complete and has been presented to Board Members for their approval and sign off. A launch date will be organised later in the year.

Learning Disability Mortality Review Programme (LeDer)

- 5.8 Tameside hosted the Greater Manchester LeDer development Day, held on 23 March 2018. Guest speakers across GM shared best practice and initiatives and Tameside & Glossop Learning Disability Services presented their work on the development of an anaesthesia pathway.
- 5.9 Local Area Contacts and Reviewers continue to support the LeDer programme. We now have 8 reviewers trained and registered with the Bristol Team. We have had a total of 8 notifications of death and have 8 allocated reviews all undergoing the review process

6. PRIMARY CARE

Issues of concerns/remedy

Risk and Mitigation Stakeholder Event

- 6.1 There is concern within the primary care team that we remain aware of the current and future risks that may arise in primary care, which operates in an ever changing landscape. To better understand what those risks are and to be in a position to mitigate them, the primary care team is hosting a Risk and Mitigation Stakeholder Event in June 2018 to canvass the wider primary care workforce on the potential risks that may be faced by primary care in the future. Representatives are being invited from the following cohorts; patients, practice managers, practice nurses, GPs, Greater Manchester Health and Social Partnership (both from general practice and the wider primary care team), ICFT neighbourhood operational managers and the primary care team. Once current and future risks are better understand the aim is to manage their mitigation

Good practice

Manor House Surgery Hadfield

- 6.2 Manor House Surgery Hadfield was inspected by CQC on 11 January 2018. It has been rated as outstanding by CQC in the report, which was published on 22 March 2018. In the five key lines of enquiry the practice was rated outstanding for services being effective and for services being well-led. It was rated good for services being safe, caring and being responsive to people's needs.
- 6.3 CQC found the following to be areas of outstanding practice at Manor House Surgery Hadfield:
- The practice used new tools and tests to improve outcomes for patients, for example C-reactive Protein (CRP) tests to reduce unnecessary antibiotic prescribing and introduced Exhaled Nitric Oxide (FeNO) to maximise asthma management for patients led by the advanced nurse practitioner. Since initiating FeNO early results showed improved symptom control, reduced exacerbations and hospital admissions. Of 203 tests audited, 33 patients had medication reduced, 11 patients had medication stopped, 50 patients had medication increased and 35 reported improvement in their symptoms.
 - The practice worked closely with colleagues from adult social care (ASC) to support patients and their carers. At any one time the practice was engaged jointly in coordinating the care of around 50 patients. ASC advised that the involvement of the practice was unique and the joint working enabled positive outcomes for patients. We were provided with numerous examples especially in relation to end of life care where joint working was crucial but also examples of enabling patient with dementia to remain at home or where patients in crisis due to mental health accessed swift coordinated response led by the GP.
 - The practice initiated a minor injuries service with aim to provide the treatment direct to the presenting patient rather than referring on to the A&E for their management. Data provided by the practice showed of 77 patients treated under the scheme only 5 patients were sent to A&E, 45 were examined and given advice and 20 were sent direct for and x-ray.
 - The practice worked closely with The Bureau (Glossop's Voluntary & Community Network who work to support people to stay physically and socially active, improve mental wellbeing and live independently for longer.) to launch social prescribing (community navigation) as a single point of contact to offer support to patients with their health and social needs. The Bureau, hold a drop in session and booked appointment at the practice weekly. The aim was to reduce repeat attendances and multiple GP appointments where the issues were social. Data provided by the practice showed 23 social referrals have been made by GPs as well as staff promoting the drop in sessions. Evaluation by The Bureau in November 2017 showed Manor House Hadfield were

actively engaged in social prescribing and had referred patients for a range of support including mobility, anxiety/depression, loneliness and social isolation.

Horizon scanning

- 6.4 As technology provides new avenues for patients to access their GP, which may also alleviate workforce issues in general practice the primary care team has been exploring some of the options that are available.
- 6.5 Recent years have seen rapid development of a number of online consultation systems for patients to connect with their general practice. Using a mobile applications or online portal, patients can contact the GP. This may be a follow-up or a new consultation. The e-consultation system may be largely passive, providing a means to pass on unstructured input from the patient, or include specific prompts in response to symptoms described. It may offer advice about self-care and signposting to other sources of help, as well as the option to send information to the GP for a response.
- 6.6 In early adopter practices, these systems are proving to be popular with patients of all ages. They free time for GPs, allowing them to spend more time managing complex needs. Some issues are resolved by the patient themselves, or by another member of the practice team. Others are managed by the GP entirely remotely, in about a third of the time of a traditional face to face consultation. Others still require a face to face consultation, and these are enhanced by the GP already knowing about the patient's issue.
- 6.7 In Tameside and Glossop one practice has implemented an online consultation system and are experiencing positive impact both for practice staff and for patients.
- 6.8 The practice states that the system *"is being promoted at every front desk conversation. Patients have loved it as means on occasion they don't have to have face to face consultations and from our perspective we know it's clinically safe via all relevant questions being asked as per condition and should it not be suitable for online it points patient in a different direction. Nice to have something to offer other than lengthy wait for face to face."* In the early months of adoption the practice was averaging about 20 online consultations per week, circa 4-5 per day and these numbers are increasing.
- 6.9 A GM wide market place event was held at the end of February with a number of providers demonstrating products. In addition, a local demo of the EMIS product was arranged for the Stalybridge neighbourhood in February 2018.
- 6.10 Consideration needs to be given as to how best to utilise the resource available with recognition of the non-recurrent nature of the funding and therefore the longer term continuation of this model of consultation system to support improvements in experience of accessing services and support patients to understand appropriateness of self-care as the first route of care where appropriate and also alternative means of accessing services within primary care.

7. PUBLIC HEALTH

Issues of concerns/remedy

Substance misuse

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

- 7.2 Tameside MBC Internal Audit have carried out a review which is expected to report this month, Tameside MBC Risk Management are liaising with the Information Commissioner's Office, and CGL are making progress with a Root Cause Analysis. A further update will be given in the next report

Conclusion

- 7.3 Quality assurance will continue to be sought via monthly contract monitoring meetings.

8. SMALL VALUE CONTRACTS (<5MLN)

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

Broomwell Healthwatch, Specsavers (Audiology, NWCATS, GM Primary Eyecare Ltd: Tameside and Glossop Glaucoma Repeat Reading Service, Minor Eye Conditions Service and gtd Healthcare².

- 8.1 No quality issues in Quarter 4.

9. RESEARCH AND DEVELOPMENT

- 9.1 Research is vital to improve the knowledge needed to develop the current and future quality of care for patients. Carrying out high quality research gives the NHS the opportunity to minimise inadequacies in healthcare and improve the treatments patients receive. Below is the summary of the research conducted by our providers in the last financial year.

Tameside and Glossop Integrated Care Foundation Trust

- 9.2 The Research Department is committed to providing patients with the opportunity to participate in research, if they wish. The Trust aims to ask all eligible patients if they would like to participate in a clinical trial.
- 9.3 The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 588 (at 23/01/2018). This has surpassed their target of 544 participants, set by the Clinical Research Network.
- 9.4 Currently, there are 108 research studies, a growth from 2016/17, either in the planned stage, are active or in follow up. They have 34 actively recruiting studies which are adopted on to the National Institute for Health Research (NIHR) Clinical Research Network portfolio. These studies are high quality trials that benefit from the infrastructure and support of the Clinical Research Network (CRN) in England. The Trust currently hosting 4 actively recruiting clinical trials involving medicinal products, with two further Clinical Trial of an Investigational Medicinal Product (CTIMP) studies in the planning stage, which demonstrate the Trusts.

Pennine Care Foundation Trust

- 9.5 During 2017/18, Pennine Care NHS Foundation Trust was involved in the conduct of 44 clinical research studies.
- 9.6 Key achievements within FY2017/18 include the development of a Children's' and Young People's (CYP) Research Unit, the establishment of an integrated clinical practice and academic research partnership with Manchester Metropolitan University (MMU), and the provision of opportunity for over 600 patients to participate in high-quality research that has been badge by the Department of Health (DoH) NIHR as of benefit to patients and the NHS.

² gtd Healthcare- the company uses this spelling in their reports.

- 9.7 There have been a number of important research studies that have recruited mental health (MH) service user participants from the Tameside and Glossop. Included below is a brief summary of a few of these projects:

CARMS (Cognitive AppRoaches to coMbatting Suicidality)

- 9.8 Around 6% of people with experiences of psychosis die by suicide. Many more think about it and attempt suicide. The University of Manchester have developed a psychological therapy which is delivered over 6 months in up to 24 weekly sessions. The therapy targets suicidal thoughts, intentions and plans. The Trust aims to test the efficacy of delivering CARMS therapy in the context of NHS mental health services to see whether it offers any benefit over treatment as usual.

IF CBT (Individual & Family Cognitive Behavioural Therapy)

- 9.9 This study from the Manchester based Psychosis Research Unit (PRU) aims to look at whether combined individual and family cognitive behavioural therapy (CBT) is beneficial for people, who are at risk of developing psychosis. This study has recruited a number of participants that access our Early Intervention in Psychosis services.

MAPS (Managing Adolescent Psychosis)

- 9.10 This feasibility study from the Psychosis research Unit aims to support and develop an evidence base regarding the clinical and cost effectiveness of psychological therapy compared with antipsychotic medication alone for young people aged 14 to 18 years with a first episode of psychosis.

Patient Preferences for Psychological Help

- 9.11 The aim of this University of Oxford research study is to learn more about patient difficulties so that we can improve the psychological help ('talking therapy') offered in the future. We wish to assess the types of problems that are occurring (e.g. sleep problems, self-esteem, worry) and which of them patients would particularly like treated and that this will lead to services being more responsive to patient needs in the future.

10. AMBULANCE CLINICAL QUALITY INDICATORS

- 10.1 Ambulance Clinical Quality Indicators (CQIs) have been in place since 2011 to measure and monitor the impact of ambulance services on patient outcomes, and in particular to provide an overview of the clinical quality achieved by ambulance services.
- 10.2 Following the engagement exercise, and after discussion with the Secretary of State for Health and Social Care, the following focus areas have been agreed:
- STEMI: 999 call to angiography (Mean & 90th percentile)
 - Stroke: 999 call to CT scan, and 999 call to thrombolysis (Mean & 90th percentile)
 - OHCA: Survival to hospital discharge following out of hospital cardiac arrest (Utstein group).
- 10.3 The first set of CQIs was published in April 2018, and reported data from November 2017. This time lag is due to the preparatory work required for the new indicators.
- 10.4 The results for North West Ambulance Service NHS Trust (NWAS) are as follows:
- Cardiac Arrest: Return of Spontaneous Circulation (ROSC) for Ambulance Trusts in England.

			All patients			Utstein comparator group**		
			SQU03_3_1_2	SQU03_3_1_1		SQU03_3_2_2	SQU03_3_2_1	
Region	Code	Name	Number of patients who had resuscitation commenced / continued by ambulance service following an out-of-hospital cardiac arrest*	Number of patients who had ROSC on arrival at hospital	Proportion of those who had ROSC on arrival at hospital	Number of patients who had resuscitation commenced / continued by ambulance service following an out-of-hospital cardiac arrest*	Number of patients who had ROSC on arrival at hospital	Proportion of those who had ROSC on arrival at hospital
-	Eng	England	2,649	754	28.5%	411	195	47.4%
Y54	RX7	North West Ambulance Service NHS Trust	317	111	35.0%	49	28	57.1%

** The Utstein comparator group are patients with cardiac arrest of presumed cardiac origin, where the arrest was bystander witnessed, and the initial rhythm was Ventricular Fibrillation (VF) or Ventricular Tachycardia (VT).

NWAS performed better than average England.

- Cardiac arrest: Survival to discharge for Ambulance Trusts in England

			All patients			Utstein comparator group**		
			SQU03_7_1_2	SQU03_7_1_1		SQU03_7_2_2	SQU03_7_2_1	
Region	Code	Name	Number of patients who had resuscitation commenced / continued by ambulance service following an out-of-hospital cardiac arrest*	Number of patients discharged from hospital alive	Proportion discharged from hospital alive	Number of patients who had resuscitation commenced / continued by ambulance service following an out-of-hospital cardiac arrest*	Number of patients discharged from hospital alive	Proportion discharged from hospital alive
-	Eng	England	2,555	213	8.3%	384	105	27.3%
Y54	RX7	North West Ambulance Service NHS Trust	301	34	11.3%	43	13	30.2%

NWAS performed better than average England.

- Outcomes from Acute ST-elevation myocardial infarction (STEMI) for Ambulance Trusts in England

			SQU03_5_3_2	SQU03_5_3_1		M1n	M3n	M3m	M390
Region	Code	Name	Number of patients with a pre-hospital diagnosis of suspected STEMI confirmed on ECG	Number of patients who received an appropriate care bundle	Proportion who received an appropriate care bundle	Patients directly admitted with an initial diagnosis of "definite Myocardial Infarction"	Patients in M1n who had primary percutaneous coronary intervention (PPCI)	For patients in M3n, mean average time from call for help to catheter insertion for angiography (hours:minutes)	For patients in M3n, 90th centile time from call for help to catheter insertion for angiography (hours:minutes)
-	Eng	England	1,540	1,171	76.0%	927	785	2:12	2:58
Y54	RX6	North East Ambulance Service NHS Foundation Trust	85	73	85.9%	33	28	1:57	3:17

NWAS underperformed compare to the England average

- Outcomes from stroke for Ambulance Trusts in England

						Call to door				Door to scan				Door to thrombolysis			
			SQU03_6_2_2	SQU03_6_2_1		K1n	K1m	K150	K190	K2n	K2m	K250	K290	K3n	K3m	K350	K390
Region	Code	Name	Number of suspected stroke or unresolved transient ischaemic attack patients assessed face to face	Number of who received an appropriate diagnostic bundle	Proportion who received an appropriate diagnostic bundle	Number of patients either FAST positive, or with provisional diagnosis of stroke, transported by Ambulance Service	For patients in K1n, mean average time from call to hospital arrival	For patients in K1n, 50th centile (median) time from call to hospital arrival	For patients in K1n, the 90th centile time from call to hospital arrival	Number of stroke patients in SSNAP who had a CT scan	For patients in K2n, mean average time from arrival at hospital to CT scan	For patients in K2n, median time from arrival at hospital to CT scan	For patients in K2n, the 90th centile time from arrival at hospital to CT scan	Number of stroke patients in SSNAP who had thrombolysis	For patients in K3n, mean average time from arrival at hospital to thrombolysis	For patients in K3n, median time from arrival at hospital to thrombolysis	For patients in K3n, 90th centile time from arrival at hospital to thrombolysis
-	Eng	England	8,153	7,907	97.0%	7,668	1:13	1:06	1:49	4,855	3:03	0:44	3:58	639	0:54	0:46	1:33
Y54	RX7	North West Ambulance Service NHS Trust	950	940	98.9%	923	1:18	1:12	2:02	737	3:20	0:46	3:32	75	1:06	0:53	1:54

NWAS underperformed compare to the England average on some elements of the indicator.

11. SUMMARY

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

12. RECOMMENDATIONS

- 12.1 As set out on the front of the report.

Report to:	STRATEGIC COMMISSIONING BOARD
Date:	20 June 2018
Officer of Strategic Commissioning Board	Sarah Dobson, Assistant Director Policy, Performance and Communications.
Subject:	DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – PERFORMANCE UPDATE
Report Summary:	<p>This report provides the Strategic Commissioning Board with a Health and Care performance report for comment.</p> <p>This report provides the Strategic Commissioning Board (SCB) with a health & care performance update at June 2018 using the new approach agreed in November 2017. The report covers:</p> <ul style="list-style-type: none">• <u>Health & Care Dashboard</u> – including exception reporting for measures which are areas of concern, i.e. performance is declining and/or off target• <u>Other intelligence / horizon scanning</u> – including updates on issues raised by Strategic Commissioning Board (SCB) members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board (SCB) are asked to note, and any other data or performance issues that Strategic Commissioning Board (SCB) need to be made aware.• <u>In-focus</u> – a more detailed review of performance across a number of measures in a thematic area. <p>This is based on the latest published data (at the time of preparing the report). This is as at the end of March 2018.</p> <p>The content of the report is based on ongoing analysis of a broader basket of measures and wider datasets, and looks to give the Strategic Commissioning Board (SCB) the key information they need to know in an accessible and added-value manner. The approach and dashboard are aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group (QPAG).</p> <p>The following have been highlighted as exceptions:</p> <ul style="list-style-type: none">• A&E Standards were failed at Tameside Hospital Foundation Trust;• 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 <p>Attached is Appendix 3 on Urgent care.</p>

Recommendations:

The Strategic Commissioning Board are asked:

- Note the contents of the report, in particular those areas of performance that are currently off track and the need for appropriate action to be taken by provider organisations which should be monitored by the relevant lead commissioner
- Support ongoing development of the new approach to monitoring and reporting performance and quality across the Tameside & Glossop health and care economy

Financial Implications:

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

The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.

Legal Implications:

**(Authorised by the Borough
Solicitor)**

As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all part to account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality.

**How do proposals align with
Health & Wellbeing Strategy?**

Should provide check & balance and assurances as to whether meeting strategy.

**How do proposals align with
Locality Plan?**

Should provide check & balance and assurances as to whether meeting plan.

**How do proposals align with
the Commissioning Strategy?**

Should provide check & balance and assurances as to whether meeting strategy.

**Recommendations / views of
the Professional Reference
Group:**

This section is not applicable as this report is not received by the professional reference group.

Public and Patient Implications:

Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care.

Quality Implications:

As above.

**How do the proposals help to
reduce health inequalities?**

This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.

What are the Equality and Diversity implications?

None.

What are the safeguarding implications?

None reported related to the performance as described in report.

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

There are no Information Governance implications. No privacy impact assessment has been conducted.

Risk Management:

Delivery of NHS Tameside and Glossop's Operating Framework commitments 2017/18

Access to Information :

- **Appendix 1** – Health & Care Dashboard;
- **Appendix 2** – Exception reports;
- **Appendix 3** – Urgent Care in-focus report.
- **Appendix 4** – End of Life Dashboard

The background papers relating to this report can be inspected by contacting Ali Rehman by:



Telephone: 01613425637



e-mail: alirehman@nhs.net

1.0 BACKGROUND

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

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

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

2.0 HEALTH & CARE DASHBOARD

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

EXCEPTIONS (areas of concern)	1	A&E 4 hour wait
	3	Referral To Treatment-18 Weeks
	42	Direct Payments
	43	LD
ON WATCH (monitored)	7	Cancer 31 day wait
	11	Cancer 62 Day Wait
	47	65+ at home 91days

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

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

2.3 The A&E performance for April was 89.2% for Type 1 & 3 which is below the target of 95% nationally, and the 90% target. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. T&G ICFT are ranked first in GM for the month of April 2018.

18 Weeks Referral to Treatment

- 2.4** Performance for April is below the Standard for the Referral to Treatment 18 weeks (92%) achieving 91.69%. This is an improvement in performance compared to the previous month, March which also failed to achieve the standard at 91.5%. The national directive to cancel elective activity was expected to reduce performance from January. The impact for Tameside and Glossop was expected to be greatest at Manchester Foundation Trust (MFT) and the recovery plan submitted to GM reflected that fact that failure at MFT could mean T&G performance would be below the required standard. MFT is failing to achieve the RTT national standard. MFT (formerly UHSM) revised its improvement trajectory and is currently on track. MFT (formerly CMFT) is slightly below target although there have been improvements in children's services. We will discuss with lead commissioners the need for comprehensive recovery plans.

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

- 2.5** Performance for Quarter 4 is below the threshold for total proportion of people using social care who receive self-directed support, and those receiving direct payments (28.1%) achieving 13.19%. This is a deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 13.48%. Tameside performance in 2016/2017 was 12.47%, this is a decrease on 2015/2016 and is below the regional average of 23.8% for 2016/2017. Nationally the performance is 28.3% which is above the Tameside 2016/17 outturn. Additional Capacity to be provided within the Neighbourhood teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the ASC transformation funding. The project post was not successfully recruited too therefore in order to increase capacity a different approach has been implemented. We use to have 2 Direct Payment workers this has now been increased to 4 Direct Payment Workers, one in each neighbourhood. A publicity campaign will now be developed to increase numbers over the coming months

Total number of Learning Disability service users in paid employment

- 2.6** Performance for Q4 is below the threshold for total number of learning disability users in paid employment (5.7 %) achieving 4.17%. This is deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 4.39%. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. In order to improve performance, additional resource is required to increase capacity. An additional post has been funded through the ASC transformation funding and a vacant post that was held in the team has also been released to increase capacity in the team with an expectation that more people will be supported into paid employment. Work has been undertaken with Routes to Work to strengthen their recording of Supported Employment services and to clarify the links with this indicator.

3.0 OTHER INTELLIGENCE / HORIZON SCANNING

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

'Winter crisis'

Influenza

- 3.2** The provisional February 2018 Tameside and Glossop CCG vaccine uptake for this period was 76.2% against a target of 75% meaning that the CCG has met the target set by NHS

England (NHSE). There were 39 GP practices participating in the 2017-18 seasonal flu campaign. Of these, 25 GP practices (64%) either met or exceeded the target set by NHSE and 14 GP practices (36%) were below the target. We are currently performing better than GM and England averages and ranked 3rd amongst GM CCGs for data up to Week 52. (as at January 2018)

Children aged 2,3 &4

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

For data up to Week 52 we have been performing better than GM and England averages; and are ranked against other GM CCGs as 4th for 2 year olds and 3rd for 3 year olds. (as at January 2018)

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

- 3.4** The national ambition is 55% for under 65s at risk. A downward trend is observed from last year's performance; however, the absolute number of patients vaccinated has increased during 17/18. To achieve the 75% target 6,649. We have achieved the interim ambition of 55%.

We are ranked 2nd against other GM CCGs (week 52). (as at January 2018)

- 3.5** The latest flu surveillance report for influenza like illness at upper tier local authority level shows that there is an increasing trend in Tameside over the last 10 weeks. Currently ranked sixth in GM for the rate per 100,000 population. (as at January 2018)

NHS 111

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

- Calls Answered (95% in 60 seconds) = 67.03%
- Calls abandoned (<5%) = 11.77%
- Warm transfer (75%) = 25.38%
- Call back in 10 minutes (75%) = 54.40%

Average call pick up for the month was 3 minutes 26 seconds. Performance was particularly difficult to achieve over the weekend periods. There is a remedial action plan in place with Commissioners.

3.7 52 Week waiters.

The CCG has had a number of 52 week waiters over the last few months. The table below shows the numbers waiting by month, which provider it relates to and the specialty.

		Better is...	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
CCG	Patients waiting 52+ weeks on an incomplete pathway	L	Zero Tolerance	0	1	2	3	2	1	4	4
Provider	Manchester Foundation Trust	L	Zero Tolerance	0	1	2	3	2	1	4	4
Specialty	Plastic Surgery	L	Zero Tolerance	0	1	2	3	2	1	4	4

All of the breaches have occurred at Manchester Foundation Trust and in the specialty of Plastic Surgery which has had capacity pressures.

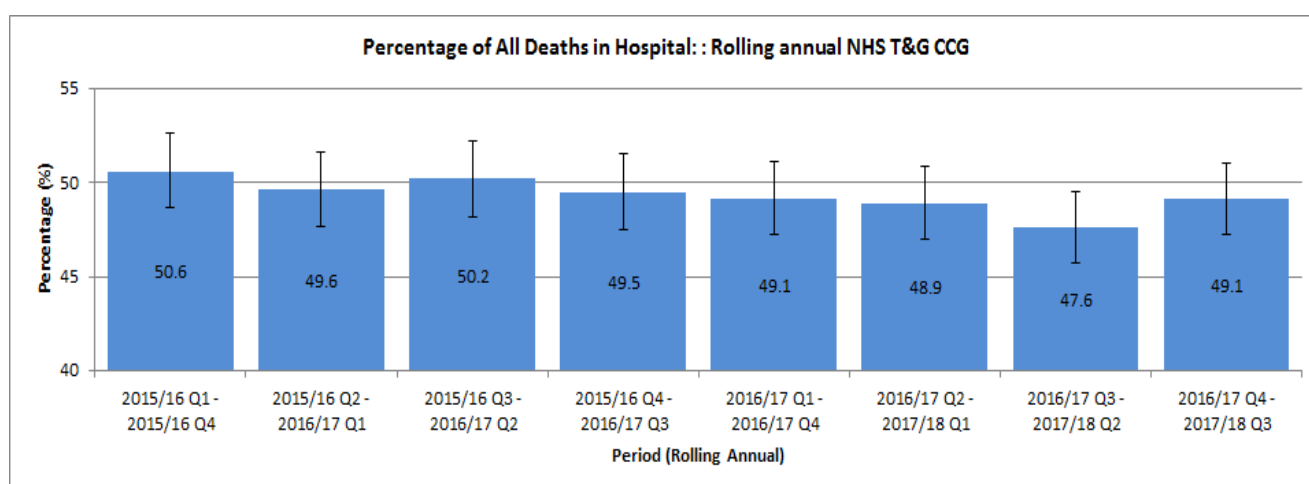
A significant increase in demand for the highly-specialised DIEP (deep inferior epigastric perforator) flap reconstructive surgery procedure at Wythenshawe Hospital (part of Manchester University NHS FT) has resulted in patients waiting in excess of 18 weeks (and in some cases over 52 weeks) for treatment.

The following actions are being undertaken by the Trust, working closely with the lead CCG, to address the current long waiting times for DIEP flap reconstructive surgery and develop a sustainable future service model.

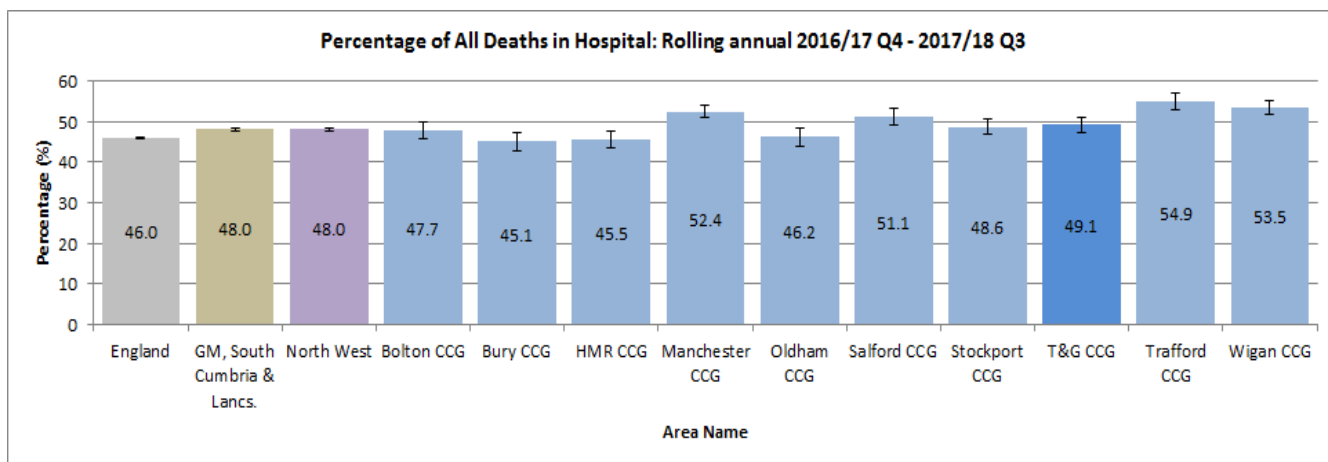
- Manchester Health and Care Commissioning has agreed a local tariff with the Trust in late 2017;
- The Trust has since undertaken extensive demand and capacity modelling to better understand the infrastructure requirements moving forward to ensure women are seen and treated in this service within national waiting time standards;
- A business case is in the final stages of development that outlines the expansion requirements to meet current and likely future demands;
- All women who have waited in excess of 52 weeks are being clinical validated and choice discussions taking place;
- A proposed recovery action plan is being developed, outlining the plans to see and treat existing patients and assurances on future service provision;
Fortnightly assurance meetings are held with representatives for the Lead CCG (NHS Manchester) and performance is reported to CCGs at the monthly (formal) Finance & Performance meeting.

3.8 Deaths In Hospital

The table below shows the rolling annual percentage of all deaths in hospital by quarter for Tameside and Glossop CCG. The latest rolling annual period (2016/17 Q4 – 2017/18 Q3) shows the percentage at 49.1%, this is an increase from the previous rolling annual period (2016/17 Q3 – 2017/18 Q3) at 47.6%.



The chart below shows the Tameside and Glossop CCG percentage of all deaths in hospital for the rolling annual period as at 2017/18 Q3 benchmarked against GM, North West and England. This shows that Tameside and Glossop CCG has the 5th highest percentage of all deaths in GM. It is also higher than the Northwest figure (48.0%) and higher than the England figure (46.0%).



Attached at **Appendix 4** is an end of life dashboard for info.

4.0 IN-FOCUS – Urgent Care






















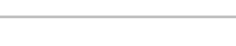

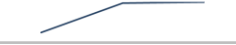


4.1 The thematic in-focus area for this report is Urgent Care. The full report is attached at **Appendix 3**.

5.0 RECOMMENDATIONS

5.1 As set out on the front of the report.

Health and Care Improvement Dashboard

June 2018

	Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
1	Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95%	Apr-18	83.9%	84.8%	89.2%	p	
2	* Delayed Transfers of Care - Bed Days	3.5%	Mar-18	3.2%	3.2%	2.9%	q	
3	* Referral To Treatment - 18 Weeks	92%	Apr-18	91.7%	91.3%	91.7%	p	
4	* Diagnostics Tests Waiting Times	1%	Apr-18	0.7%	1.3%	1.0%	p	
5	Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93%	Feb-18	96.7%	95.9%	96.5%	p	
6	Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93%	Feb-18	94.9%	90.1%	96.3%	p	
7	Cancer - 31-Day Wait From Decision To Treat To First Treatment	96%	Feb-18	100.0%	98.8%	96.2%	q	
8	Cancer - 31-Day Wait For Subsequent Surgery	94%	Feb-18	100.0%	100.0%	100.0%	tu	
9	Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98%	Feb-18	100.0%	100.0%	100.0%	tu	
10	Cancer - 31-Day Wait For Subsequent Radiotherapy	94%	Feb-18	100.0%	95.5%	100.0%	p	
11	Cancer - 62-Day Wait From Referral To Treatment	85%	Feb-18	88.6%	86.1%	83.9%	q	
12	Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90%	Feb-18	100.0%	100.0%	80.0%	q	
13	Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade		Feb-18	83.3%	73.1%	68.2%	q	
14	MRSA	0	Mar-18	0	1	3	q	
15	C.Difficile (Ytd Var To Plan)	0%	Mar-18	-1.0%	-4.4%	-8.2%	q	
16	Estimated Diagnosis Rate For People With Dementia	66.7%	Apr-18	81.2%	81.0%	80.5%	q	
17	Improving Access to Psychological Therapies Access Rate	1.25%	Jan-18	4.0%	4.1%	4.1%	q	
18	Improving Access to Psychological Therapies Recovery Rate	50%	Jan-18	37.0%	35.7%	38.4%	p	
19	Improving Access to Psychological Therapies Seen Within 6 Weeks	75%	Jan-18	83.3%	84.6%	89.6%	p	
20	Improving Access to Psychological Therapies Seen Within 18 Weeks	95%	Jan-18	100.0%	96.2%	97.9%	p	
21	Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral	50%	Feb-18	50.0%	50.0%	66.7%	p	
22	Mixed Sex Accommodation	0	Mar-18	0.38	0.13	0.12	p	
23	Cancelled Operations		17/18 Q3		1.0%	1.1%	p	
24	Ambulance: Red 1 Calls Responded to in 8 Minutes	75%	Jul-17	62.0%	57.1%	63.3%	p	
25	Ambulance: Red 2 Calls Responded to in 8 Minutes	75%	Jul-17	64.9%	60.6%	62.9%	p	
26	Ambulance: Category A Calls Responded to in 19 Minutes	95%	Jul-17	91.6%	88.2%	89.7%	p	
27	Cancer Patient Experience		2016	9.10	8.70	8.77	p	
28	Cancer Diagnosed At An Early Stage		16/17 Q3	43.7%	54.2%	54.6%	p	
29	General Practice Extended Access		Mar-18		82.1%	92.3%	p	
30	Patient Satisfaction With GP Practice Opening Times		Mar-17		74.4%	76.0%	p	

* data for this indicator is provisional and subject to change

31	111 Dispositions- - % Recommended to speak to primary and community care (Ranking out of 40, 38 from March onwards)		Mar-18	12% (29th)	11% (31st)	12% (31st)	tu	
32	111 Dispositions- - % Recommended to dental (Ranking out of 40, 38 from March onwards)		Mar-18	2% (38th)	2% (38th)	2% (37th)	p	

	Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
33	111 Dispositions- - % Recommended home care (Ranking out of 40, 38 from March onwards)		Mar-18	3% (37th)	3% (34th)	3% (35th)	q	
34	Maternal Smoking at delivery		17/18 Q3	15.1%	14.6%	16.7%	p	
35	%10-11 classified overweight or obese		2013/14 to 2015/16	33.3%	33.6%	33.6%	tu	
36	Personal health budgets		17/18 Q1	3.60	4.50	5.30	p	
37	% of deaths in hospital		16/17 Q2	47.60	49.80	50.40	p	
38	LTC feeling supported		2016 03	62.90	62.40	61.40	q	
39	Quality of life of carers		2016 03	0.80	0.77	0.78	p	
40	Emergency admissions for urgent care sensitive conditions (UCS)		16/17 Q4	2906	3212	3066	p	
41	Patient experience of GP services		Jul-05	81.2%	83.2%	83.5%	p	
Adult Social Care Indicators								
42	Part 2a - % of service users who are in receipt of direct payments	28.1%	17/18 Q4	13.65%	13.48%	13.19%	q	
43	Total number of Learning Disability service users in paid employment	5.7%	17/18 Q4	4.50%	4.39%	4.17%	q	
44	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64	13.3	17/18 Q4	10.38 (14 Admissions)	11.86 (16 Admissions)	16.33 (22 Admissions)	p	
45	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	628	17/18 Q4	77.27 (108 Admissions)	454.42 (177 Admissions)	656.41 (256 Admissions)	p	
46	Total number of permanent admissions to residential and nursing care homes aged 18+		17/18 Q4	122	193	278	p	
47	Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital	82.7%	17/18 Q4	81.8%	81.8%	77.4%	q	
48	% Nursing and residential care homes CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	50%	49%	55%	p	
49	% supported accomodation CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	80%	80%	80%	tu	
50	% Help to live at homes CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	67%	53%	53%	tu	

q	Performance deteriorating and failing standard
p	Performance improvinging and failing standard
p	Performance improving and achieving standard
q	Performance deteriorating and achieving standard
q	Performance deteriorating no standard
p	Performance improving no standard
tu	No change in Performance and achievingstandard
tu	No change in Performance and failing standard
tu	No change in Performance and no standard

Exception Report

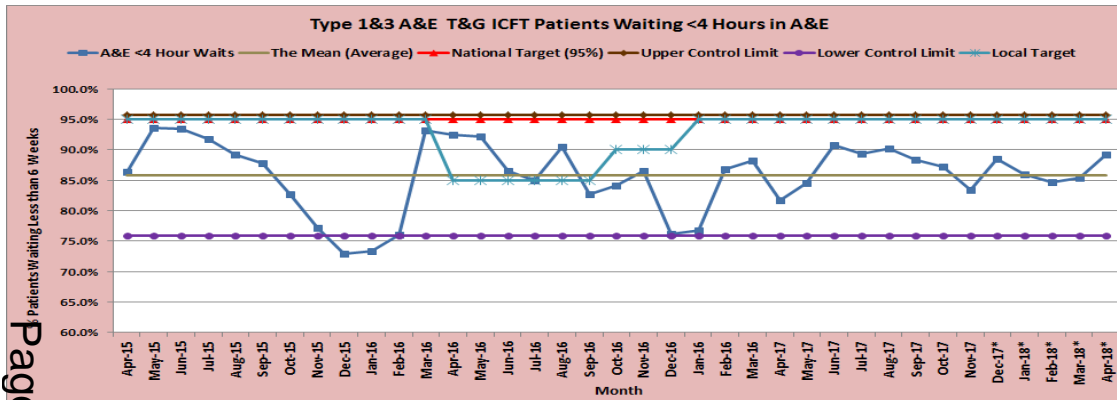
Health and Care Improvement- June

A&E: Patients waiting < 4 hours

Lead Officer: Elaine Richardson

Lead Director: Jess Williams

Governance: A&E Delivery board



April Performance: 89.2%

17/18 ytd:
81.65%18/19 ytd:
89.2%

Key Risks and Issues:

The A&E Type1 and type 3 performance for April was 89.2% which is below the National Standard of 95% and below the GM agreed target of 90%. Late assessment due to lack of capacity in the department is the main reason for breaches. Surges of attendance particularly in the evenings leading to lengthened NWAS handover times. • Lack of timely exit flow from ED leading to reduced physical capacity in the ED to see patients safely. • Patients often bedded down in ED overnight. • High risk of 12 hour breaches • Increased numbers of complex patients requiring longer lengths of hospital stay reducing flow

• High acuity of patients on AMU and IAU leading to reduced discharges from the unit and increased need for patients to be transferred to the wider wards.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.

A&E Streaming is in place but staffing of rotas challenging at times.

Actions:

Hourly reviews of patients in ED by lead nurse and consultant. • Live SMART board with predicted attendance visible to plan for surges and escalate in a timely manner • ED Dr supporting triage of patients arriving by ambulance and undertaking see and treat where appropriate • ED streaming to AEC using "push pull model" from triage. • REACT underway in ED when staffing resource and physical capacity permits. • Second triage nurse in times of surge • Helicopter nurse supporting coordinator as trouble shooter to enable internal flow • Medical in reach to ED in the evenings • Reverse queueing of patients waiting for a bed in area at the back of ED with nurse support to free up capacity in main ED area to see patients • Acute medicine consultants working weekends. • Escalation beds in use to prevent 12 hour breaches • Fit to sit project operational in ED and on wards prior to discharge • Golden ticket for next day discharges and Ticket Home project operational on wards to support flow • Roll out of Electronic Casualty Card (eCAS) progressing from minors to paediatrics • Digital Health supporting GPs to refer to appropriate areas of the hospital ie AEC/ED

We are working on a GM level recovery plan to achieve 90% by Q1.

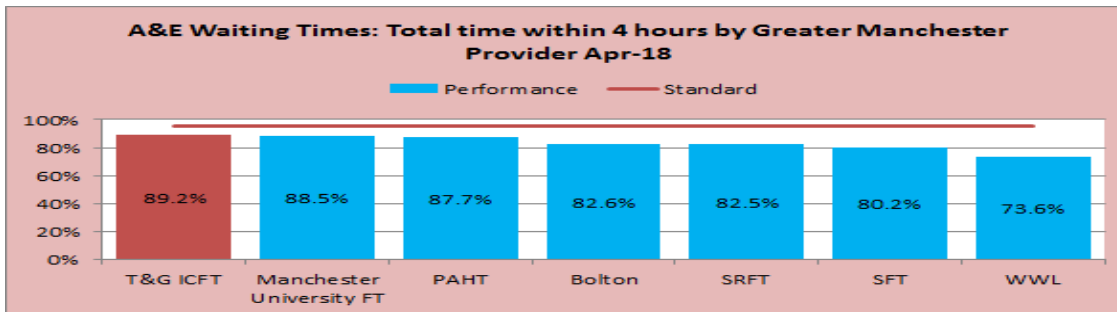
Operational and Financial implications:

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

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

Unvalidated-Next month FORECAST

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* Please note that Tameside Trust local trajectory for 18/19 is Q1, Q2 and Q3 90%, and Q4 95%.

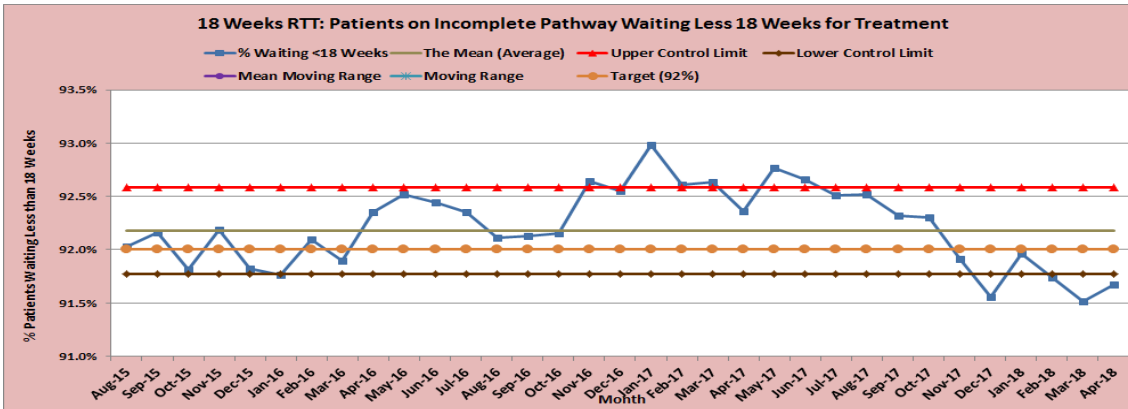
* Type 1 & 3 attendances included from July 2017.

18 Weeks RTT: Patients on incomplete pathway waiting less than 18 weeks for treatment

Lead Officer: Elaine Richardson

Lead Director: Jess Williams

Governance: Contracts

**Key Risks and Issues:**

The RTT 18 weeks performance for April was 91.67% which is below the National Standard of 92% .

Failing specialties are, Trauma & Orthopaedics (83.06%), Urology (91.53%), General Surgery (91.63%), Plastic Surgery (71.11%), Cardiology (91.78%), Neurology (83.33%), Rheumatology (87.65%), Gynaecology (90.64%).

The national directive to cancel elective activity was expected to reduce performance from January. The impact for T&G was expected to be greatest at MFT and the recovery plan submitted to GM reflected that fact that failure at MFT could mean T&G performance would be below the required standard. The performance at MFT at 89.42% is the key reason for the failure in April with 323 people breaching. Stockport, Salford and Pennine trusts also contributed to the failure accounting for a further 253 breaches.

T&O continues to be a challenge across most providers. In MFT our biggest concerns are around plastics, cardio theracic, gynecology and cardiology. As lead Commissioner.

T&G ICFT as a provider are achieving the standard.

Actions:

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

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

Operational and Financial implications:

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

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

Unvalidated-Next month FORECAST

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

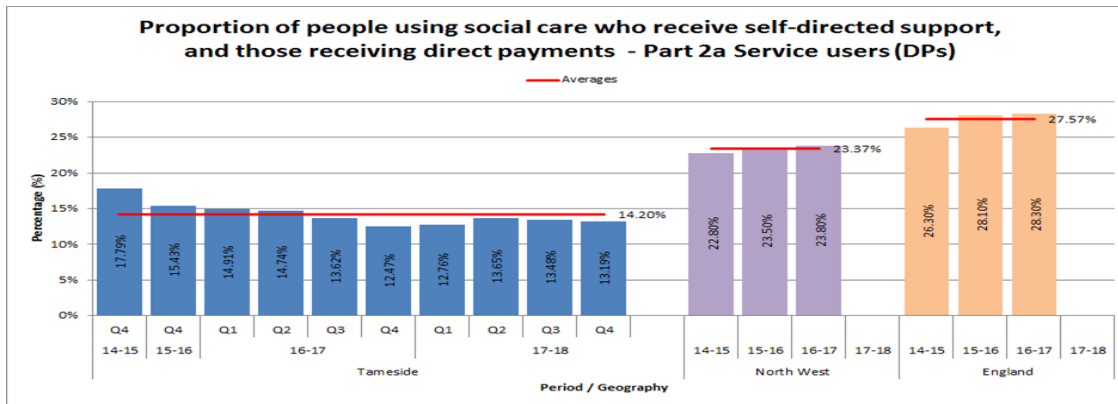
CCG	Mar-18			
	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Target
NHS Wigan Borough CCG	19524	18247	93.46%	92%
NHS Salford CCG	23257	21518	92.52%	92%
NHS Tameside and Glossop CCG	17103	15624	91.35%	92%
NHS Trafford CCG	16106	14543	90.30%	92%
NHS Manchester CCG	37503	33718	89.91%	92%
NHS Oldham CCG	15125	13598	89.90%	92%
NHS Bolton CCG	22508	20121	89.39%	92%
NHS Stockport CCG	25213	22529	89.35%	92%
NHS Bury CCG	12979	11542	88.93%	92%
NHS Heywood, Middleton & Rochdale CCG	16680	14759	88.48%	92%
NHSE North of England	1036880	916463	88.39%	92%

* Benchmarking data relates to March 2018

Exception Report

Health and Care Improvement- June

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



Key Risks and Issues:

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

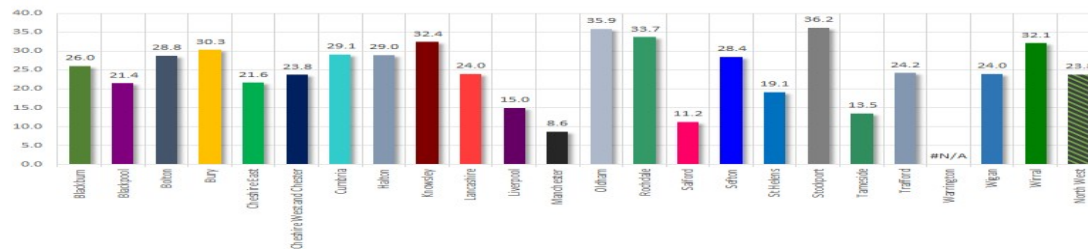
Actions:

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

Operational and Financial implications:

None

Sum of ASCOF 1C(2a) - Proportion of people using social care who receive direct payments (%) - SNAPSHOT (LTS001b)



Unvalidated Next Quarter FORECAST

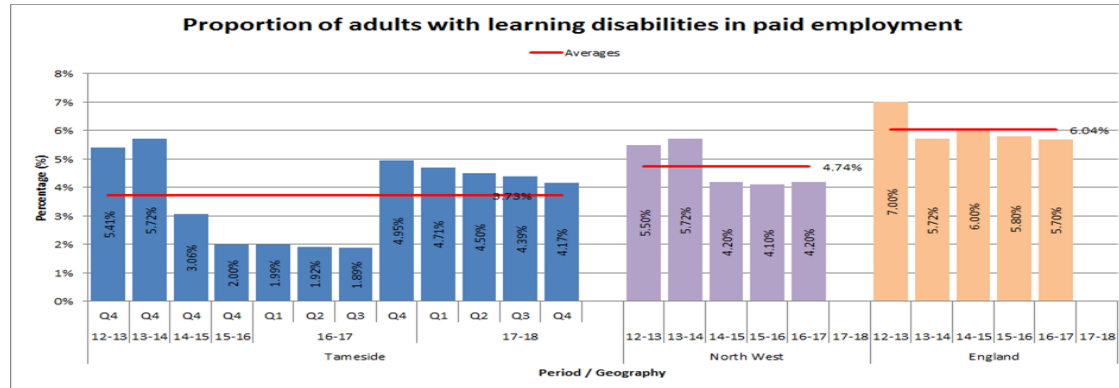
* Benchmarking data is as at Q3 17/18.

ASCOF 1E- Total number of Learning Disability service users in paid employment

Lead Officer: Sandra Whitehead

Lead Director: Steph Butterworth

Governance: : Adult Management meeting


Key Risks and Issues:

The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. 4th Quarter 2017/18 figure is 4.17%

Actions:

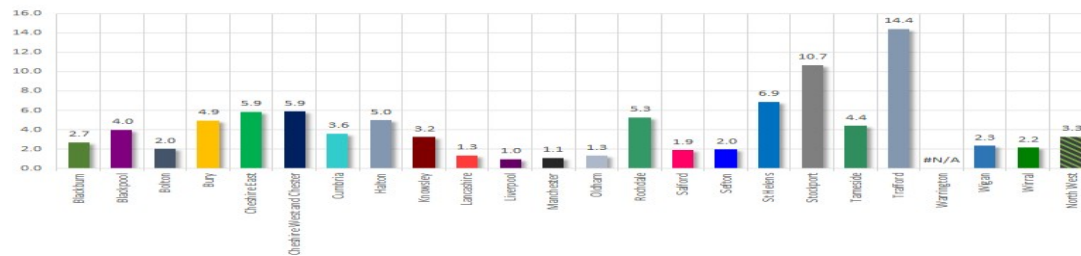
- We have moved the remaining Employment Support staff into the Employment and Skills corporate team to ensure a more focused approach to employment and access to wider resource and knowledge base
- In order to improve performance, additional resource is required to increase capacity. An additional post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

Operational and Financial implications:

None

Unvalidated next Quarter FORECAST

Sum of ASCOF 1E - Proportion of adults with a learning disability in paid employment - YTD (LTS001a)



* Benchmarking data is as at Q3 17/18

Urgent Care In-Focus

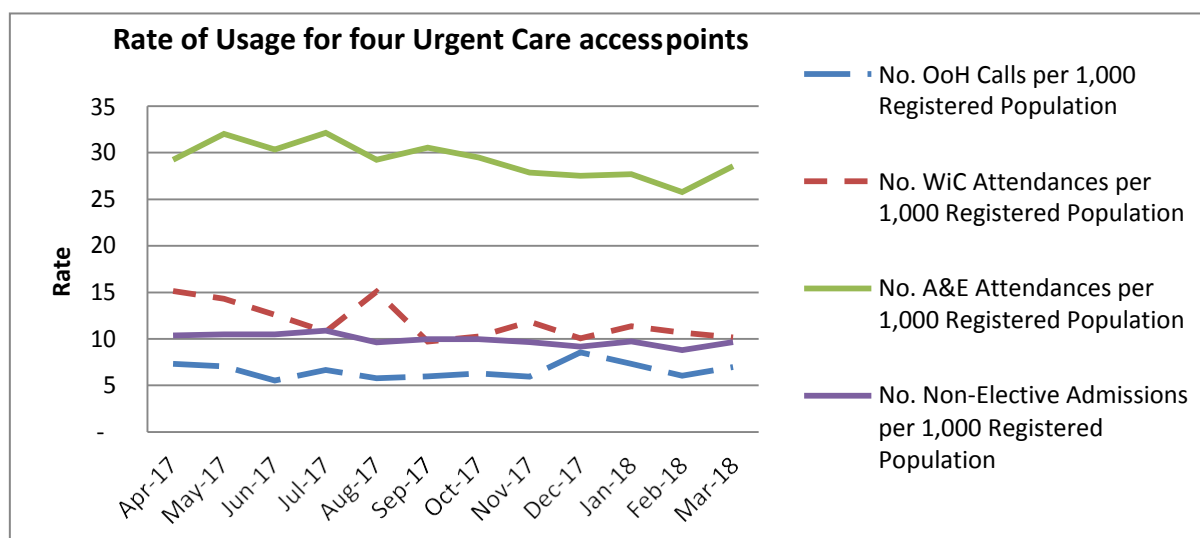
Strategic Commissioning Board

1. Introduction

- 1.1. Over the years Tameside and Glossop have developed a range of services that meet the Urgent and Emergency Care needs of local people. Some services are commissioned at a local level either independently or jointly with other CCGs and some as part of Greater Manchester/North West arrangement.
- 1.2. Services have been implemented over time to embrace new ways of working or in response to national expectations and as result the Urgent and Emergency Care system has become complex with multiple access routes and significant levels of duplication and overlap.
- 1.3. The Strategic Commission approved the development of the Integrated Urgent Care Service in March 2018 to reduce duplication and improve efficiency. The implementation of the new arrangements autumn is planned for autumn 2018 onwards.
- 1.4. In April 2018 Greater Manchester Urgent and Emergency Board set out its Transformation programme involving four workstreams (shown below) with the expectation that change will happen rapidly in 2018/19.
 1. "Stay Well" – Early identification & Prevention
 2. "Home First" – Attendance & Admission Avoidance
 3. Patient Flow
 4. Discharge & Recovery
- 1.5. In addition Tameside and Glossop are involved in the 2018/19 NHS Improvement Action on A&E programme focusing on support for Frail patients who develop an urgent care need. This area is also reflected in the local Q1 Improvement plan that was required by GM HSCP.
- 1.6. 2018/19 is therefore anticipated to be a year of significant change for urgent and emergency care. So this deep dive is based on the services currently in place and focuses on historic data whilst also signalling how these will change going forward as the Integrated Urgent Care Service and further Care Together developments are implemented.

2. Understanding Demand

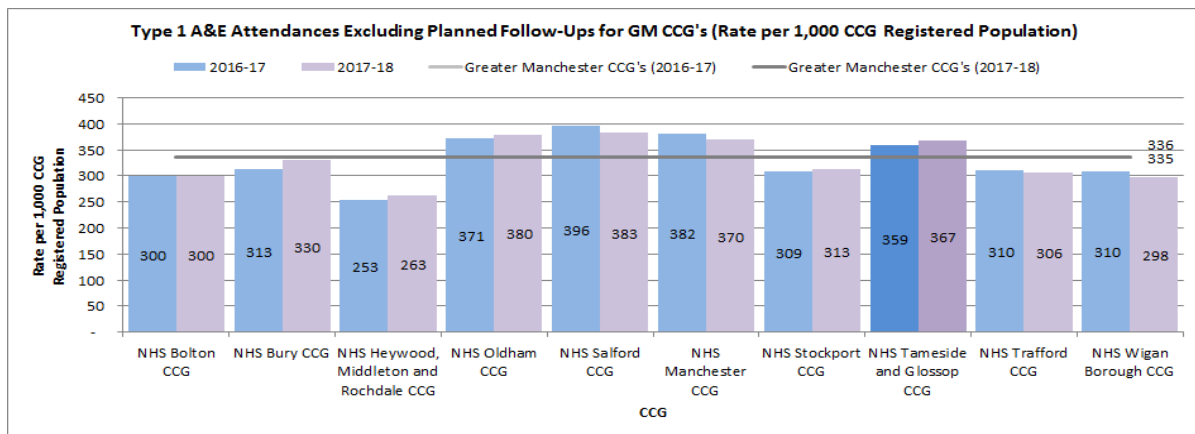
- 2.1. The number of people who seek support when an emergency or urgent care need arises is not easily quantified due to the many access routes. Demand also tends to reflect the level of concern an individual has as much as clinical need with people presenting for a range of needs some of which are problems that would usually be managed through a routine service. However, when comparing the rate of use of four key access points per 1000 registered population there is slight trend toward reduced use particularly in the winter months when demand is generally higher.



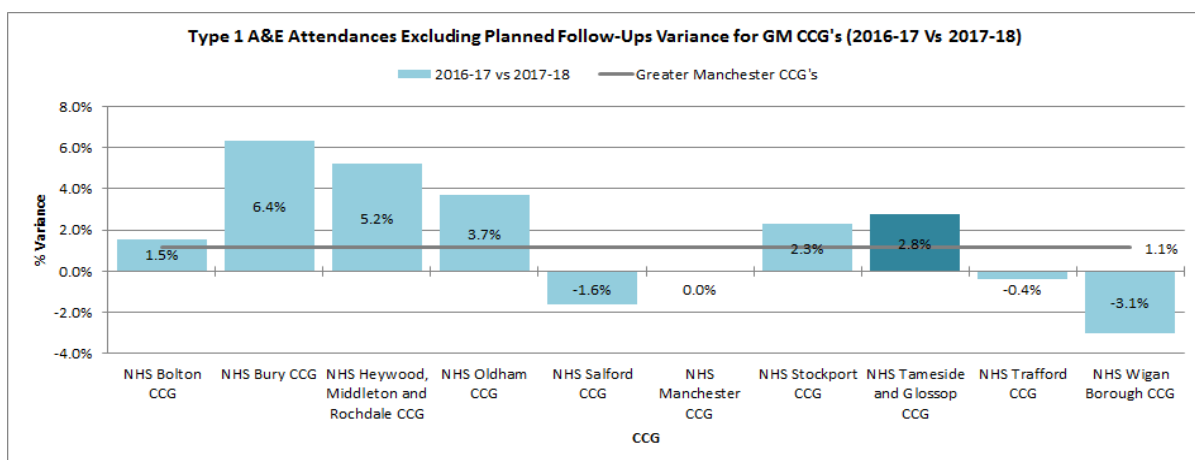
- 2.2. The level of usage varies across neighbourhoods and will not only reflect the profile of the neighbourhood population but also geography and ease of access as these particularly influence usage for the WIC and A&E.

	Out of Hours GPs (OoH)	Walk-in Centre (WIC)	A&E	Non-elective Admissions
Neighbourhood	17-18	17-18	17-18	17-18
Ashton	83	228	402	128
Denton	85	157	352	121
Glossop	57	40	258	100
Hyde	93	121	369	127
Stalybridge	65	119	324	106
NHS T&G CCG	79	142	350	119

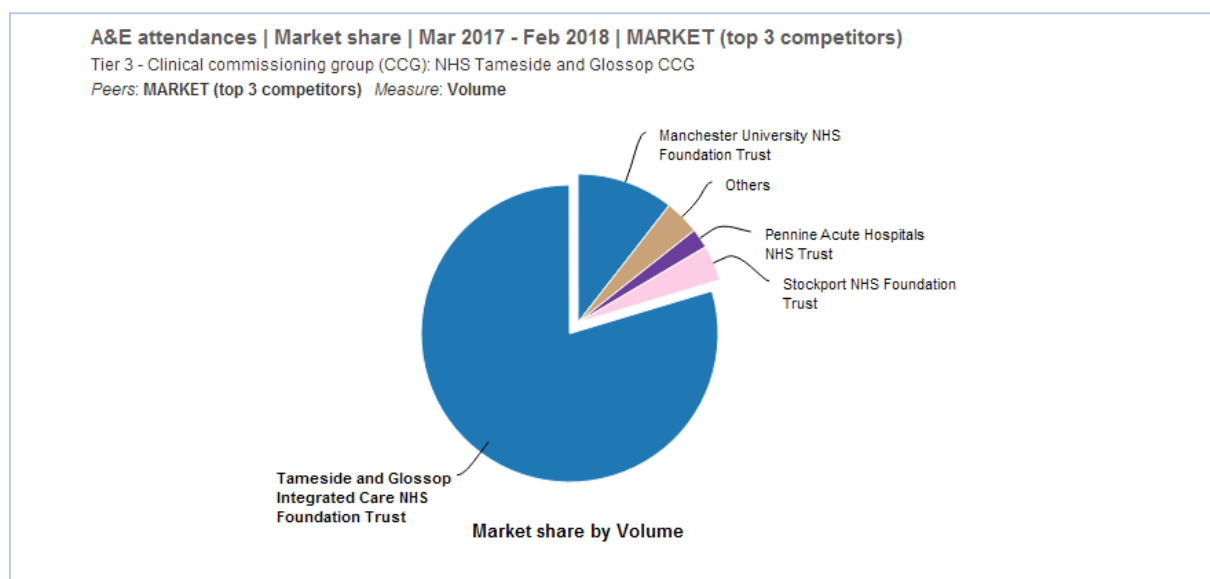
- 2.3. **A&E Attendances** - Attendance at A&E is frequently seen as the measure of demand for the emergency and urgent care system and whilst a good indicator of emergency need, for urgent need, it will equally reflect geography and ease of access to alternative support in the community. It remains however. the only indicator which can be used as a Greater Manchester comparison.
- 2.4. Comparing Tameside and Glossop registered patients with those of other CCGs shows that overall we have seen an increase in rate of A&E attendances in 2017/18 and we remain above the Greater Manchester rate.



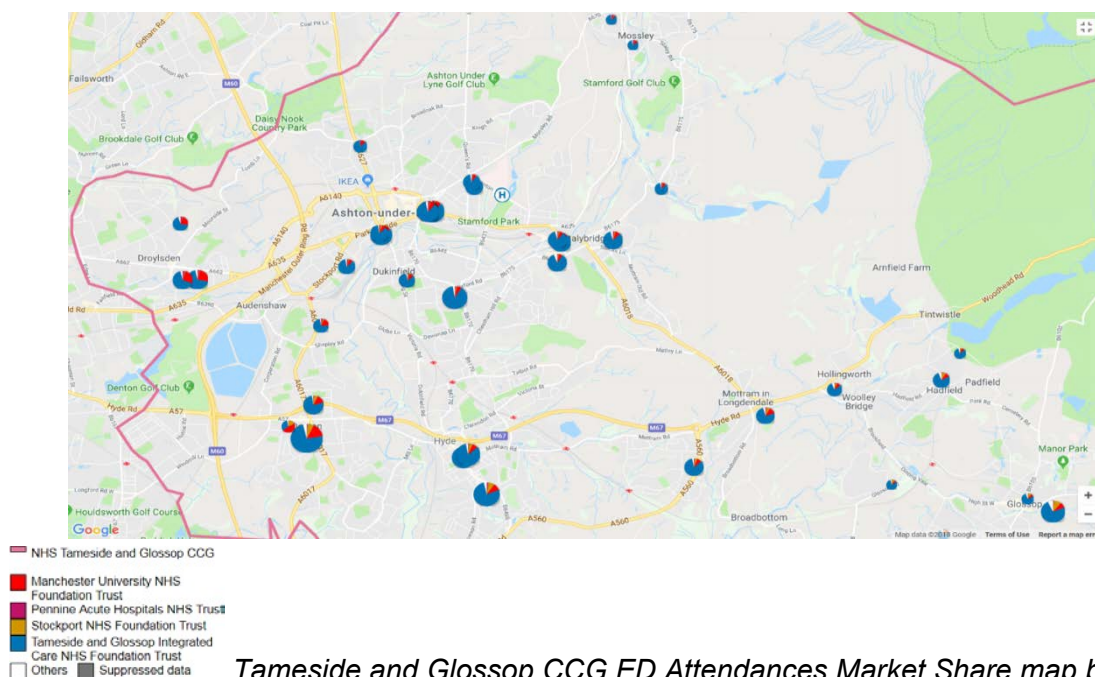
2.5. The growth is however, lower than some CCGs but above GM average.



2.6. The majority, 80%, of Tameside and Glossop patients who attended A&E between March 2017 and Feb 2018 went to the ICFT with 10% attending Manchester University FT 4% Stockport FT and 2% Pennine Acute.



- 2.7. The map below shows where people attend by GP Practice and as can be seen a higher proportion of residents migrate to Manchester rather than Tameside from the Denton/Droylsden Neighbourhood where the M60 motorway acts like a natural barrier.



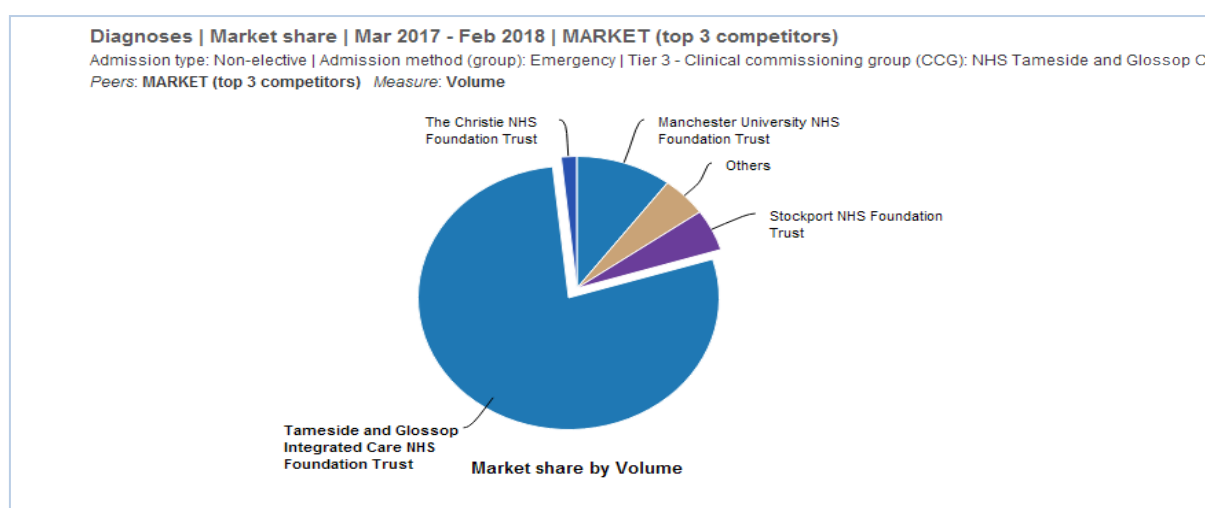
- 2.8. Analysis by age band of attendances at the ICFT (85% of which are T&G patients) shows fairly steady year on year growth overall (between 1.6% and 2.4%). The growth is mainly across the 65+ range and whilst the percentage is affected by the cohort size the difference is significant enough that statistically this is an increase not accounted for by cohort size. The 19 to 64 age range has increased by 799 attendances between 16/17 and 17/18 whereas the 75+ age range has increased by 755 attendances over the same period and is only a quarter of the cohort size.

Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	20449	20401	-0.2%	20595	1.0%	0.7%
19 to 64	44709	45266	1.2%	46065	1.8%	2.9%
65 to 74	7159	7491	4.6%	7821	4.4%	8.5%
75 to 84	7236	7490	3.5%	7868	5.0%	8.0%
85+	4748	4990	5.1%	5367	7.6%	11.5%
Grand Total	84301	85638	1.6%	87716	2.4%	3.9%

- 2.9. **Non-Elective Admissions** – When a patient needs ongoing support in a hospital setting they will be admitted as a non-elective patient. More patients are admitted to Medical specialties than Surgical specialties with the majority of admissions being at the ICFT. Almost 87% of Medical admissions and 54% of Surgical admissions are at Tameside and Glossop ICFT.

Diagnoses Market share Mar 2017 - Feb 2018 Specialty chapter (of discharge) by MARKET (top 3 competitors)											
Admission type: Non-elective Admission method (group): Emergency Tier 3 - Clinical commissioning group (CCG): NHS Tameside and Glossop CCG											
Analyse by# Specialty chapter (of disc) Peers # MARKET (top 3 competi Measure Volume											
Specialty chapter (of discharge)	MARKET (to...	Tameside and Glossop Integr...	Manchester University NHS F...	Stockport NHS Foundation Tr...	The Christie NHS Foundation ...	Others					
	Total	Volume	%	Volume	%	Volume	%	Volume	%	Volume	%
All	27,180	21,211	78.0%	2,794	10.3%	1,383	5.1%	457	1.7%	1,335	4.9%
Medical Specialties	20,421	17,698	86.7%	1,050	5.1%	737	3.6%	306	1.5%	630	3.1%
Surgical Specialties	5,447	2,920	53.6%	1,330	24.4%	532	9.8%	7	0.1%	658	12.1%
Obstetrics & Gynaecology	751	510	67.9%	91	12.1%	114	15.2%	****	****	****	****
Other Children's Specialties	412	83	20.1%	321	77.9%	0	0.0%	0	0.0%	8	1.9%
Psychiatry	****	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	****
Radiology	****	0	0.0%	****	****	0	0.0%	****	****	0	0.0%

- 2.10. As with A&E attendances about 10% of Tameside and Glossop admissions are at Manchester FT with a higher proportion of people from the west of the Tameside and Glossop footprint being admitted at Manchester FT.

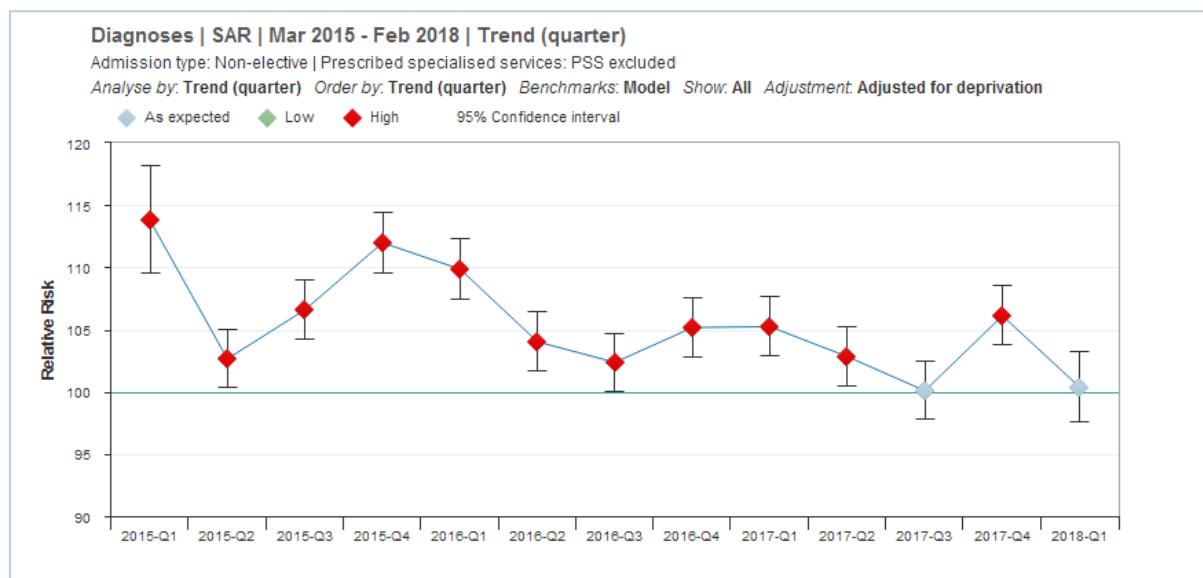


- 2.11. Analysis by age band at the ICFT shows that although non-elective admissions have been fairly stable (a 537 increase over two years) there was a 1.4% decrease in 16/17 but 17/18 saw a 4.1% increase against previous year resulting in a 2.6% increase over the two years. However the change in age cohort admissions show this is not a consistent increase and does not necessarily mirror the A&E attendance.
- 2.12. The increase in the 85+ does correlate to A&E attendances whereas the increase in 65 to 85 is much lower than the increase in attendances and the increase in 0-18 is being much higher. The reason for this would require further analysis to understand if this reflects improved access to alternative support out of hospital, reduced risk appetite to discharge or increased clinical need.

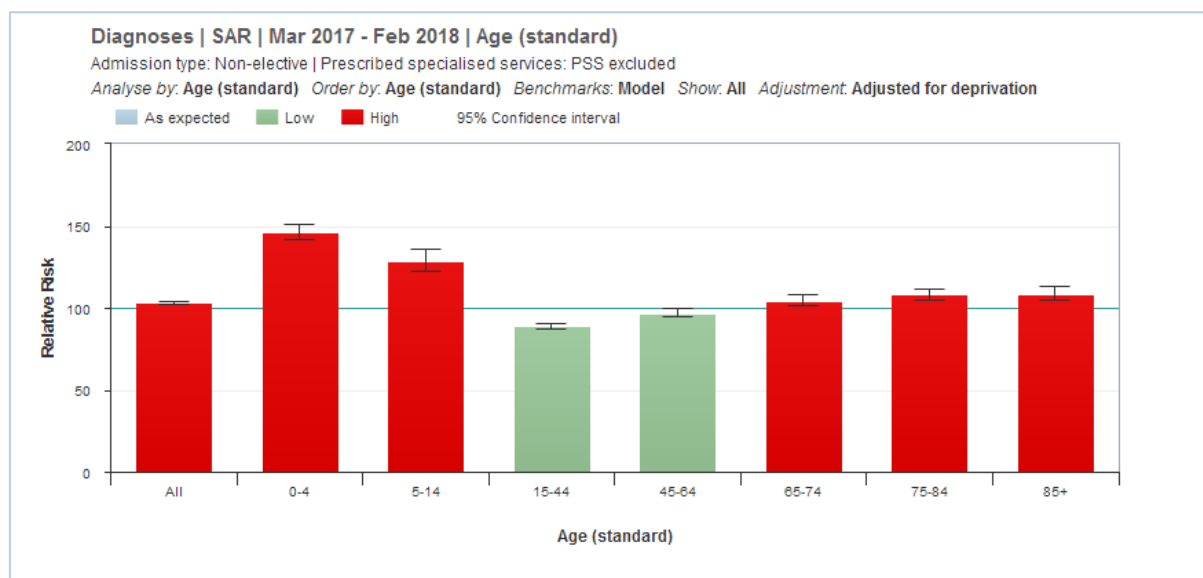
Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	2861	3074	7.4%	3249	5.7%	11.9%
19 to 64	7912	7345	-7.2%	7481	1.9%	-5.8%
65 to 74	3003	3069	2.2%	3102	1.1%	3.2%
75 to 84	3779	3694	-2.2%	3925	6.3%	3.7%
85+	2754	2852	3.6%	3089	8.3%	10.8%

Grand Total	20309	20034	-1.4%	20846	4.1%	2.6%
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- 2.13. The **Non-Elective Standardised Admission ratio (SAR)** is a tool used by Dr Foster to show the ratio of observed number of non-elective admissions to expected number of non-elective admissions, standardised by age, sex deprivation and year. The graph below shows the trend by quarter of SAR for T&G CCG from 2015 to 2018 Q1. When the SAR = 100 that means that there are as many NEL Admissions as would be expected and anything above means there are more etc. As can be seen there has been an improving picture and in two of the last 3 quarters T&G CCG were having as many non-elective admissions as would be expected given their case mix.

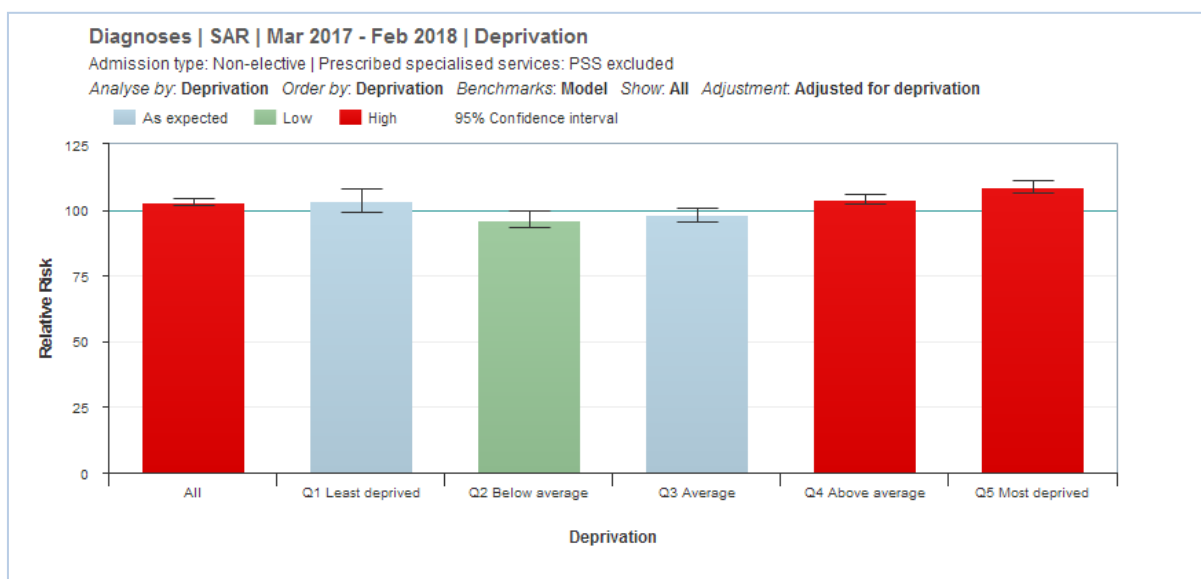


- 2.14. Comparing age bands shows the 65+ and younger cohorts having slightly higher non-elective Admissions than expected given their supporting factors. The younger cohort will be affected by the fact admissions are made to the Children's Observation and Assessment unit so may not be an accurate comparison.



- 2.15. Comparing deprivation quintile the least 3 deprived quintiles are below or not significantly above the expected range. However the two most deprived quintiles are

above expected ranges with confidence intervals also above the expected range resulting in them being RAG rated red. This is despite the fact they have been adjusted for deprivation as one of the key supporting factors of the risk model.



- 2.16. Our Commitment to improving Healthy Life Expectancy and embedding proactive and preventative management into our neighbourhoods will increase the number of people who are able to manage their condition and prevent a crisis or urgent care need arising. However, whilst this should reduce demand with respect to numbers of people who need emergency and urgent care other more social and cultural factors may increase the number of people who expect same day responses.

3. Managing Demand

- 3.1. There will always be circumstances where people need access to emergency or urgent care and ensuring people are assessed and treated by the right person first time improves both clinical outcomes and patient experience. Tameside and Glossop are committed to delivering the right care in the right place first time and use a variety of services to facilitate this.

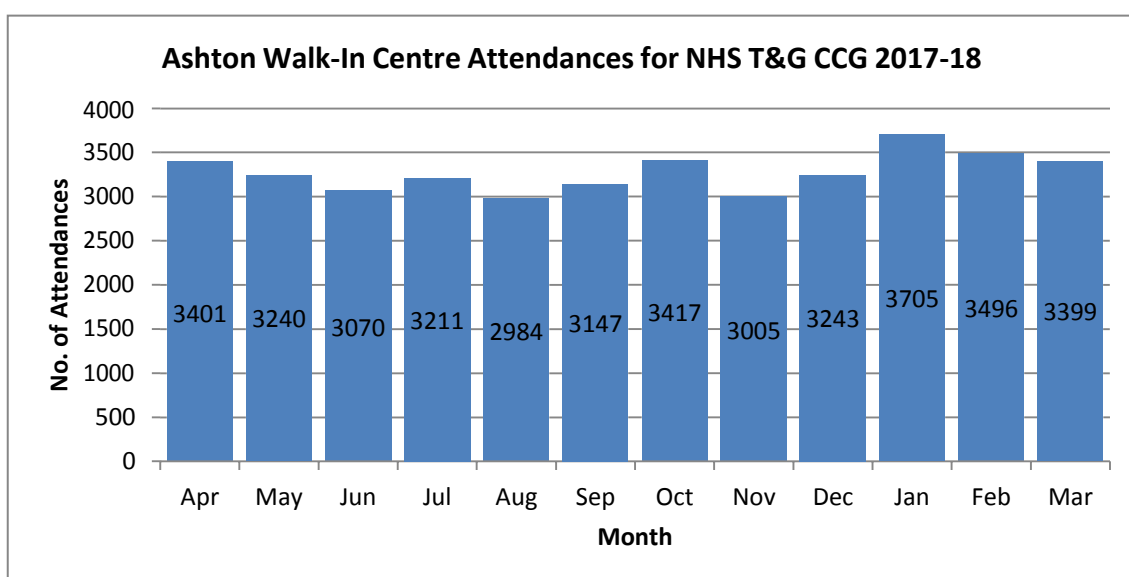
3.2. Primary Care Services

- 3.3. All our **General Practices** see patients with urgent care needs using either telephone or face to face same day consultations. The level of same day access varies practice by practice with most utilising the extended access service when the practice does not have capacity themselves. Practices, Out of Hours service and NHS 111 can all book patients into extended access slots where available.
- 3.4. Practices will also direct patients to other appropriate services such as the **Minor Aliments Service** delivered by pharmacies. This is well used locally as people are able to walk in to any pharmacy in Tameside and Glossop for support. Around 9,200 people with minor ailments are supported by pharmacies each year.
- 3.5. The **Minor Eye Conditions Service** delivered by a range of optometrists in Tameside and Glossop is equally well used with 2337 people receiving an urgent appointment (within 24 hours) in 2017/18. In addition 1433 people were seen as routine (within 5

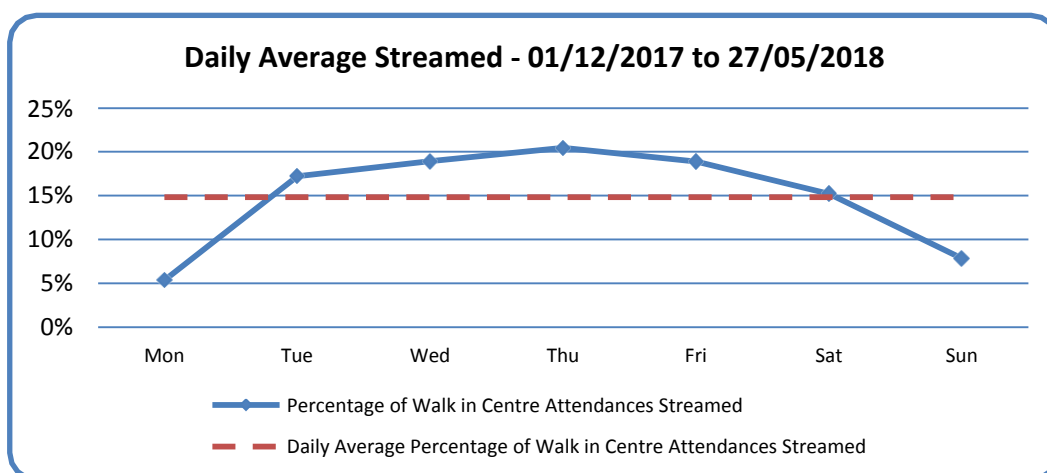
days). In total 324 people were onward referred urgently to Ophthalmology and 169 as a routine referral. Referrals are received through other services as well as patients self-presenting.

Source of Referral	2017/18	
	No. of referrals	%
NHS 111	3	0.08%
A&E	7	0.19%
GP (after seeing GP)	437	11.62%
GP staff (not seen GP)	735	19.55%
Hospital eye clinic	16	0.43%
Other	94	2.50%
Other optometrist	204	5.43%
Pharmacist	186	4.95%
Px self-referral	2028	53.94%
GP out of hours	9	0.24%
Referral following a GOS sight test	41	1.09%

- 3.6. People can also walk-in to primary care services at the **Walk-In-Centre** in Ashton Primary Care Centre between the hours of 08:00 to 20:00 seven days a week.



- 3.7. In addition since October 2018 **A&E Streaming** has been in place. This is a further primary care service supporting people who walk-in to A&E 12 hours a day in line with the national mandate. This service sees people who on initial assessment in A&E are identified as appropriate for primary care. The number of people currently recorded as streamed varies and is believed to be underreported which will be addressed as the new eCAS electronic system is implemented. The percentage of A&E attendances streamed to primary care is lower than nationally hoped but this will be due to the underreporting and the fact the other primary care walk-in service is available in the same township and only 1.5 miles away.



3.8. The role of primary care in supporting people with urgent care needs will be strengthen in 2018 as the Integrated Urgent Care Services is centred around the General Practice and the trust patients have in their own practice. Patients will be encouraged to contact their practice initially to maximise the opportunities for people to be supported through Primary Care. The ability to book into appointments at an Urgent Treatment Centre based on the hospital site or in a Neighbourhood Care hub should help the system manage demand and see people more quickly. Increased appointments along with walk-in access at the Urgent Treatment Centre should also free up A&E clinicians to support those people who need emergency support.

3.9. In addition several Practices are considering offering additional services such as Minor Injuries which will enable people to be treated at their own practice rather than having to attend A&E.

3.10. NHS 111

3.11. NHS 111 is a national service available 24/7 via the telephone as a free call. It is designed to support people by assessing symptoms and, depending on the situation, the NHS 111 team will give self-care advice, direct an individual to the most appropriate service, connect someone to a nurse, emergency dentist or GP, book a face-to-face appointment or if necessary send an ambulance directly.

3.12. Usage in Tameside and Glossop CCG has increased in 2017/18 by 4.16% with 43,144 calls being made by a total of 26,796 different patients. The outcome of those calls is summarised in the table below with 24% of calls identified as emergencies or urgent, 15.2% being sent an ambulance and 8.5% recommended to attend A&E or urgent care centre.

3.13. For those who were sent an ambulance 74.6% were conveyed to A&E and on further assessment 23.4% of these were admitted. Others were supported at home. Not all of those recommended to attend A&E or an urgent care centre follow that recommendation but of the 67% that did attend 8.1% were admitted on further assessment.

3.14. 15.3% of callers recommended to attend another service presented at A&E within 24hrs and of these 20.7% were admitted when assessed further. Some of these will have been assessed by the Out of Hours or Extended Access services and been advised to attend on further clinical assessment. Others will self-present because their concerns have not been allayed; or they are unable to get an appointment in the

alternative service in a timeframe acceptable to themselves or because the condition worsens over time.

CCG Level Selected	Time period	Cohort of calls	Distinct Patients
NHS TAMESIDE AND GLOSSOP CCG	Selected 2017/18 Financial Year	43,144	26,796

Ambulance	Other Service	Not Recommended to attend	Unknown / Not Triage	A&E Dept or UCC
No. / % 6,556 15.2%	No. / % 25,874 60.0%	No. / % 5,483 12.7%	No. / % 1,552 3.6%	No. / % 3,679 8.5%
No A&E in 24 Hours	No A&E in 24 Hours	No A&E in 24 Hours	No A&E in 24 Hours	No A&E in 24 Hours
No. / % 1,664 25.4%	No. / % 21,919 84.7%	No. / % 4,852 88.5%	No. / % 1,232 79.4%	No. / % 1,208 32.8%
A&E in 24 Hours	A&E in 24 Hours	A&E in 24 Hours	A&E in 24 Hours	A&E in 24 Hours
No. / % 4,892 74.6%	No. / % 3,955 15.3%	No. / % 631 11.5%	No. / % 320 20.6%	No. / % 2,471 67.2%
Admitted	Admitted	Admitted	Admitted	Admitted
No. / % 1,144 23.4%	No. / % 820 20.7%	No. / % 113 17.9%	No. / % 76 23.8%	No. / % 200 8.1%
Not Admitted	Not Admitted	Not Admitted	Not Admitted	Not Admitted
No. / % 3,748 76.6%	No. / % 3,135 79.3%	No. / % 518 82.1%	No. / % 244 76.3%	No. / % 2,271 91.9%

3.15. The alternative services are identified through the Directory of Services (DOS) and Tameside and Glossop have a range of alternative services which people can be directed to as self-referrals e.g. Minor Eye Conditions Service. Where services require a Health Care Professional referral callers will usually need to be advised to attend a GP service.

3.16. NHS 111 can book people directly into appointments in the extended access service and the expectation is that this will increase over time and extend to booking into the Integrated Urgent Care Service and GP surgery appointments.

3.17. 11.5% of the callers not recommended to attend any service also presented at A&E within 24hrs with 17.9% being admitted. Reasons for attending A&E will be similar to above.

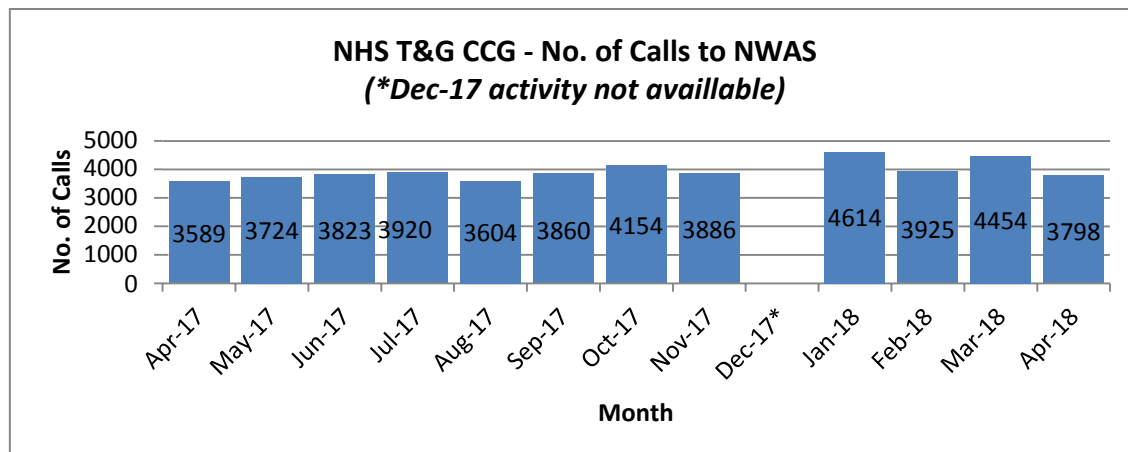
3.18. NHS 111 online is due to go live in Greater Manchester in July 2018 and will enable people to get medical help or advice from NHS 111 online using their smartphone, laptop or other digital device. The service is free to use and helps to direct patients to the right care, first time. Patients can use the online service to:

- find out where to get the right healthcare in their area
- get advice on self care
- get further advice from a nurse or doctor on the phone or during a consultation

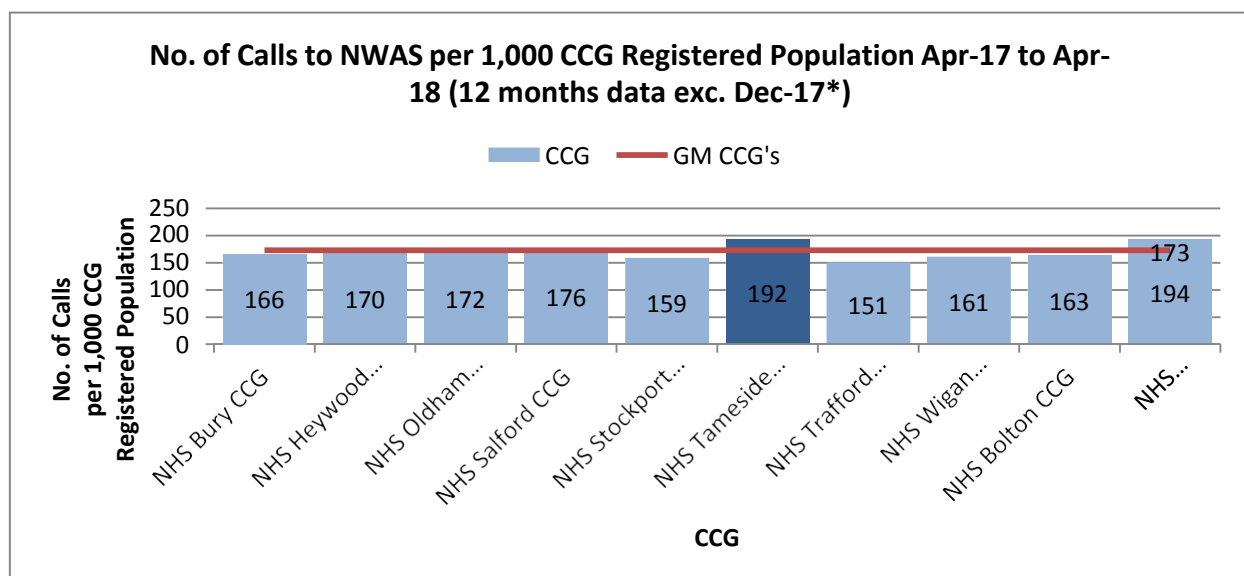
3.19. The services on the DOS are regularly reviewed to ensure that all alternatives are identified. In 2018/19 more social care and social prescribing services are likely to be included in the DOS.

3.20. 999 – Ambulance Services

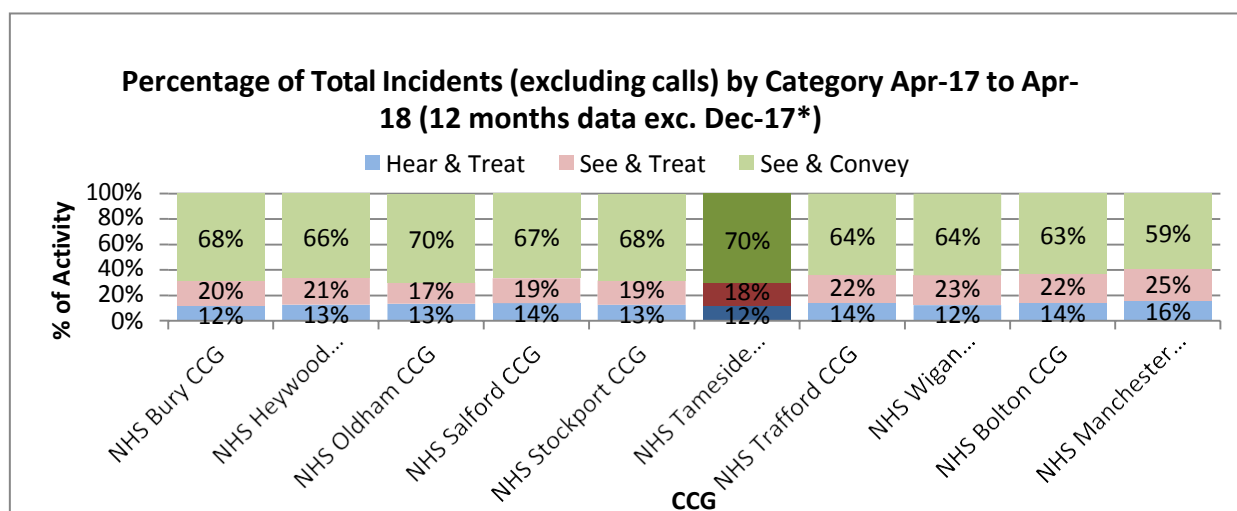
3.21. Between 3500 and 4650 calls are made to 999 by Tameside and Glossop patients every month.



3.22. The rate of calls is higher than most CCGs.



3.23. Nationally 999 ambulance services are encouraged to increase the support they can give over the telephone (Hear and Treat) or within the home (See and Treat) to reduce the level of conveyance to hospital and for Tameside and Glossop around 30% of callers are supported to stay at home. This is slightly less than most other CCGs.

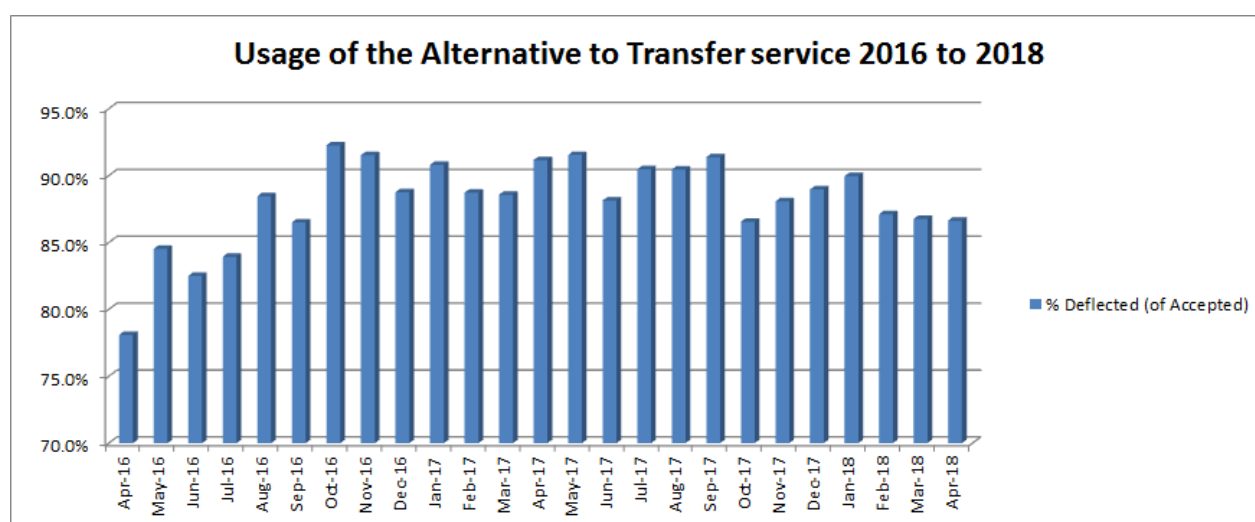


3.24. The **Community Paramedic** operating in Glossop is a key support to See and Treat and has worked with local care homes to implement the Care Home Triage Tool that helps care home staff to identify the most appropriate service to contact in any situation.

3.25. 2018/19 will see additional support through Digital Health that can respond to 999 calls directly to avoid ambulance dispatches wrapping care around the patient in their own home rather than transferring them to hospital.

3.26. Alternative To Transfer (ATT)

3.27. The **Alternative to Transfer service** is another key service that supports Hear and Treat and See and Treat as it enables paramedics to transfer the clinical care of a patient to a GP when appropriate. Use of the Alternative to Transfer service is good with an average of 8 or 9 referrals per day above 80% of which are maintained at home.



3.28. The service also ensures people who refuse to be transferred to hospital even when clinically indicated receive ongoing support.

- 3.29. The Primary Care Access Service will incorporate Primary Care support for Alternative To Transfer and continue the Health Care Practitioner Advice line that also reduces 999 calls

3.30. Digital Health Service

- 3.31. The **Digital Health Service** was initially developed to support patients in care homes and reduce the need for people to attend A&E when they could be appropriately managed in the home. Forty Care Homes are able to contact the Digital Health hub via Skype and discuss a patient's symptoms and clinical observations with an appropriate clinician in order to agree the most appropriate treatment plan.
- 3.32. By the end of the November 2017 Digital Health had received 1300 calls, avoiding 907 unnecessary A&E attendances, 510 GP call outs, over 350 nursing call outs and saved approximately 1452 hospital bed days or 6.8 beds.
- 3.33. The service incorporates the Tameside Community Response Service (CRS) has managed 190 CRS calls with 95 avoiding attendance at A&E and 43 avoiding GP involvement. CRS is able to attend people who have fallen and use lifting equipment to help them up with only those who clinically need support having to attend A&E of the 1,200 falls supported April to September 2017 only 93 ambulance were required to transfer people to hospital.
- 3.34. The support available will continue to develop as mechanisms for supporting more people living in their own residences are explored.

3.35. Mental Health Support

- 3.36. The need for increased urgent access to Mental Health support is recognised and two pilots were established in 2017/18 to facilitate rapid access to mental health support and divert pressure away from A&E.
- 3.37. **A&E Pilot** - A mental health practitioner working alongside the triage practitioner within A&E to facilitate early identification of those presenting with mental health difficulties, and increasing diversion. Early findings suggest this has reduced the numbers of people entering the department, and the duration of stay. In the first 4 weeks of the project the following outcomes were noted

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

- 3.38. **The Anthony Seddon Fund Pilot** - Practitioners from the Pennine Care NHSFT Home Treatment Team working alongside a community voluntary organisation (The Anthony Seddon Fund) providing an afternoon drop in to access professional advice and support. In the first 23 days of Drop Ins

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

3.39. It is hoped to extend these pilots and use the learning to inform future service arrangements that provide mental health support within the most appropriate setting.

3.40. Admissions Avoidance support in the community

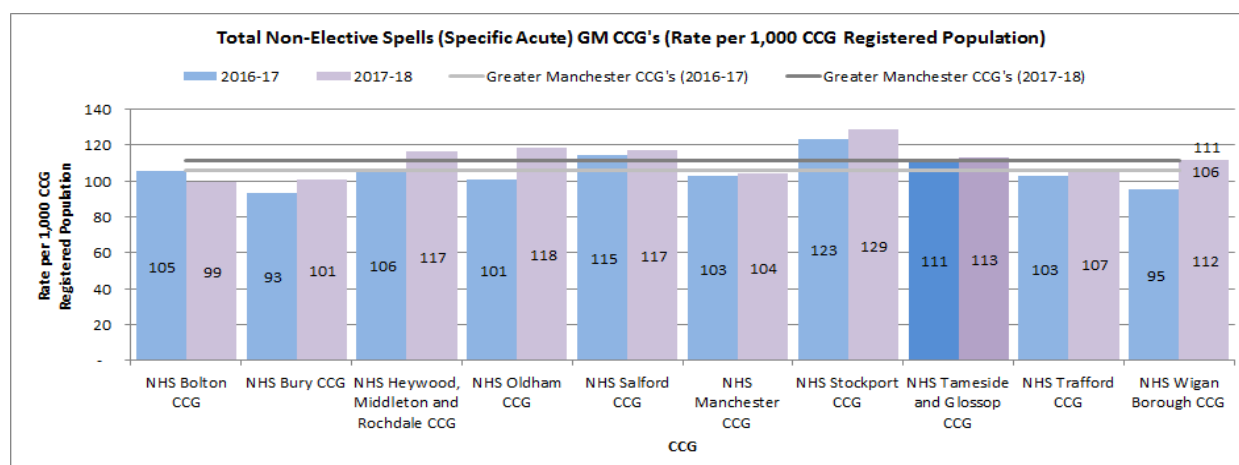
3.41. The Integrated Urgent Care Team (IUCT) supports people in their own home when wrap around care can avoid an admission. The table below shows a comparison of three months of IUCT activity which includes both admissions avoidance and discharge support and shows an increase in activity.

IUCT Activity	Jan	Feb	Mar	Average	Total
2017/18	2368	2527	2266	2387	7161
2018/19	4102	3285	3335	3574	10722
			Diff	1187	3561

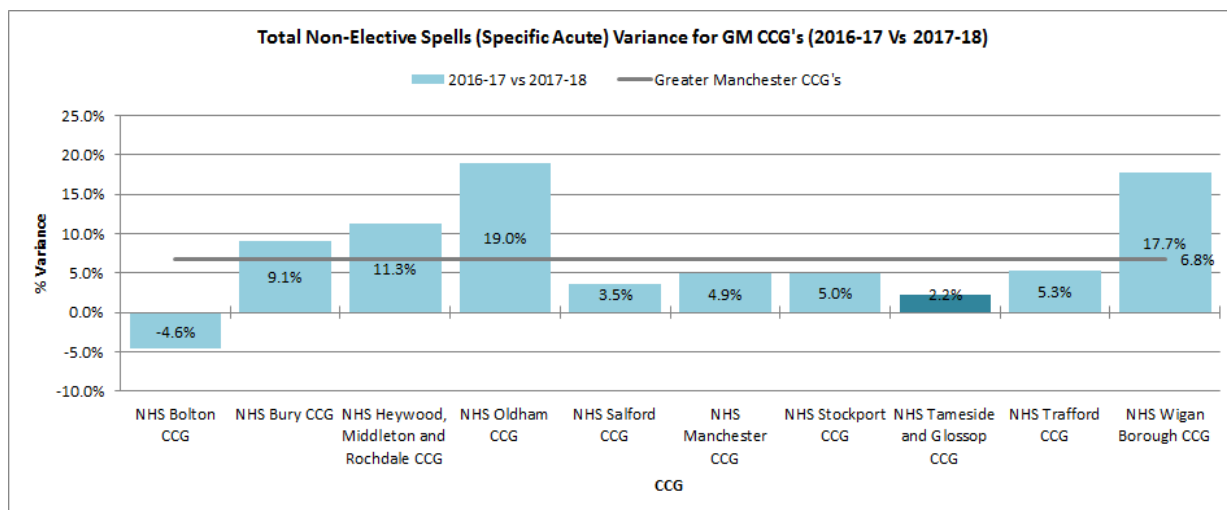
3.42. IUCT working with Integrated Neighbourhood Teams are key to maintaining people in their own homes and it is expected increasing numbers of people will remain at home receiving the care they need to support a prompt recovery.

3.43. Non-elective Admissions

3.44. There will always be a need for some people to receive more hospital based care than can be delivered in A&E and in these situations a non-elective admission will take place. The rate of non-elective admissions is just below the GM average for 2017/18.

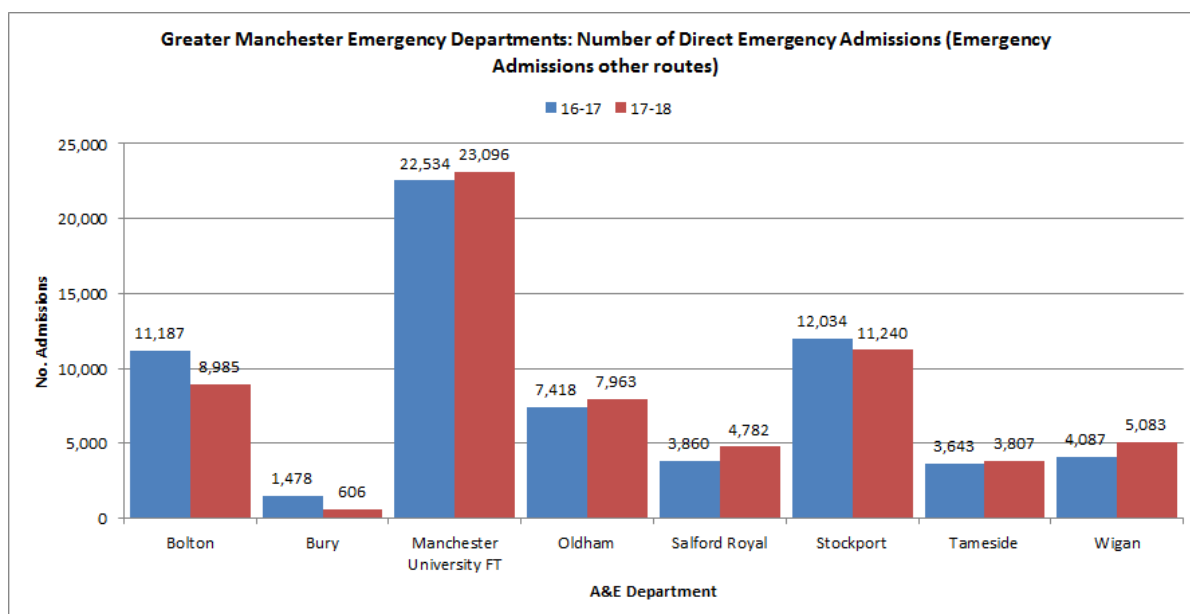


3.45. However, the level of growth is one of the lowest in GM.



3.46. Not all patients admitted attend A&E as some patients seen by a GP or other Health Care Professional in the community are identified as needing an admission but not needing A&E care in these situations a direct admission can take place.

3.47. The amount of **direct admissions** will vary by hospital as it is affected by total bed capacity, the medical/surgical split and the case mix of the Trust. The ICFT has increased the amount of people admitted directly which is likely to have improved the experience for that patient as well as reducing unnecessary activity in A&E.



3.48. The level of patients admitted from A&E can be seen as a conversion rate. As would be expected the older the patient the higher the conversion rate so 0-18 year olds are admitted 15.8% of the time in 17/18 whereas 85+ cohort are admitted 57.6% of the time.

Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	14.0%	15.1%	7.7%	15.8%	4.7%	11.3%

19 to 64	17.7%	16.2%	-8.3%	16.2%	0.1%	-9.0%
65 to 74	41.9%	41.0%	-2.3%	39.7%	-3.2%	-5.8%
75 to 84	52.2%	49.3%	-5.6%	49.9%	1.1%	-4.7%
85+	58.0%	57.2%	-1.5%	57.6%	0.7%	-0.8%
Grand Total	24.1%	23.4%	-2.9%	23.8%	1.6%	-1.4%

3.49. The table also shows the change in conversion rate over the last two years with a reduced percentage being admitted across all age ranges except the 0-18 cohort. However, this increase may be due to usage of Children's Observation and Assessment Unit which are short stay observation units that are important parts of a pathway for many youngsters and so may skew the data as they are reported as Non-elective admissions. Further analysis would be needed to verify this.

3.50. **Ambulatory Care Pathways** admissions are also recorded as non-elective admissions (with the exception of the Outpatient DVT pathway) but involve attendance at a short stay unit rather than admission to a bed overnight.

3.51. There are eight Ambulatory Care Pathways at the ICFT as shown below but this is not the entirety of activity on Ambulatory Care as all ambulatory sensitive conditions can be seen on the Unit. The table only shows first presentation and does not include where patients come back for follow up as these are then treated as ward attenders.

Month	Pneumonia	Cellulitis	IPDVT	UTI	Chest Pain	PE	TIA	DVT	Grand Total
Q1 16/17	20	56	216	5	393	183	107	417	1397
Q2 16/17	21	72	179	7	329	162	91	402	1263
Q3 16/17	21	28	135	4	284	165	87	347	1071
Q4 16/17	30	29	145	2	490	166	100	369	1331
Q1 17/18	22	56	142	5	474	165	89	404	1357
Q2 17/18	21	64	163	10	415	131	91	389	1284
Q3 17/18	19	49	161	14	492	154	107	404	1400
Q4 17/18	34	76	179	3	416	151	96	380	1335

3.52. Patients may attend the Ambulatory Care Unit directly following a GP or other Health Care professional assessment or may be streamed from triage in A&E.

3.53. As services that can support people at home increase the numbers of non-elective admissions is likely to decrease and through increased use of the Digital Health Hub where possible opportunities for direct admissions will be maximised.

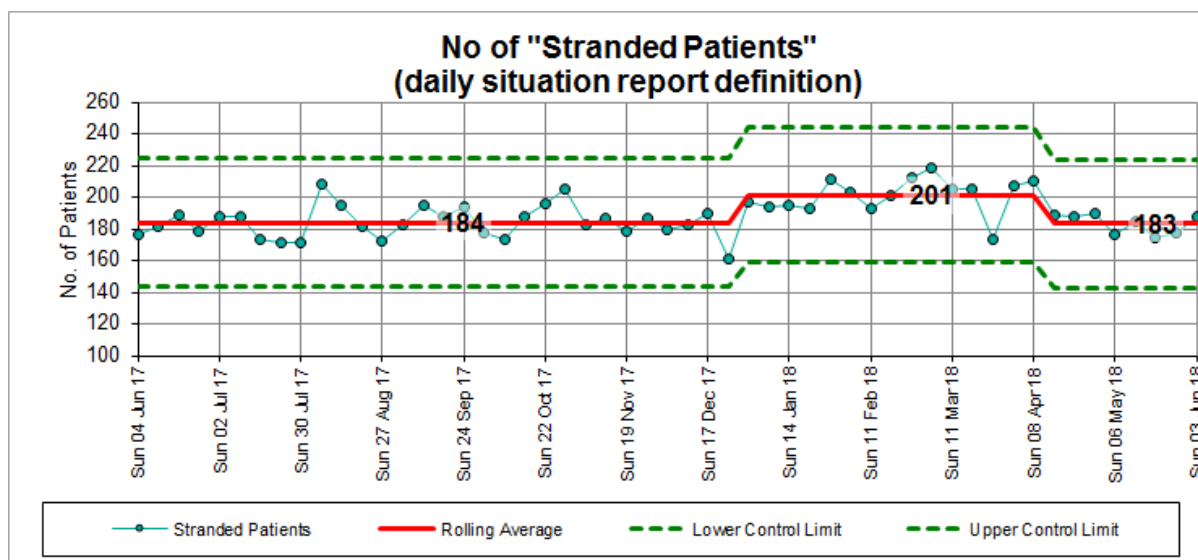
3.54. The development of frailty beds is likely to increase zero day length of stay admissions in a similar way to Children's Observation and Assessment Unit enabling people to be fully assessed out of A&E but reducing the need to admit someone to a ward.

4. Managing Bed Capacity

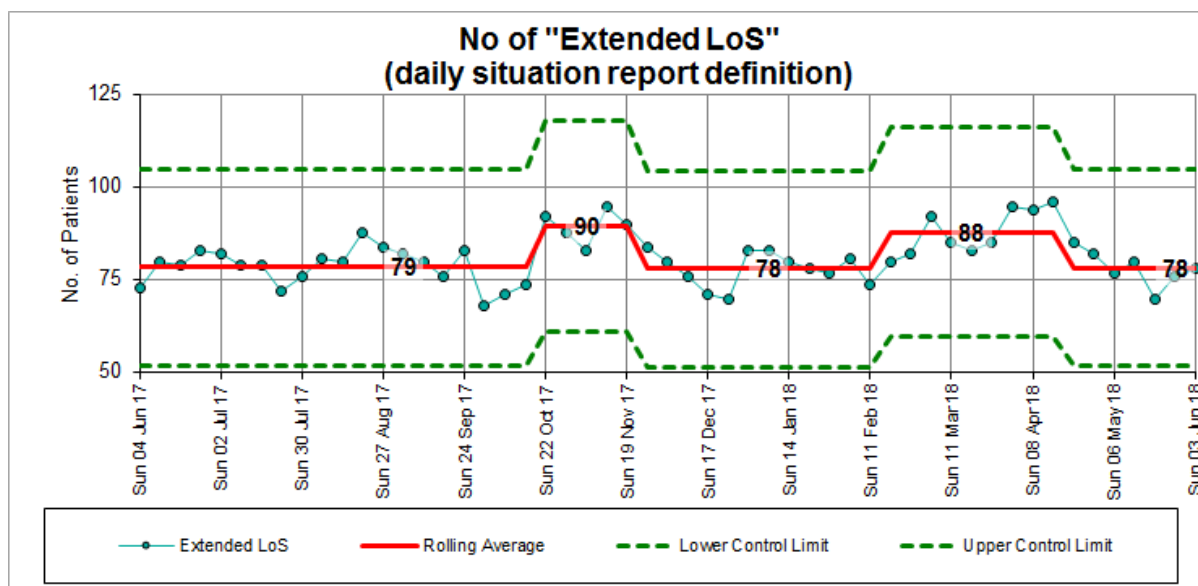
4.1. When patients are admitted the treatment plan aims to discharge them as promptly as possible. Nationally people who remain in a hospital bed for seven days or more are classed as a **Stranded Patient**. Patients may have been admitted through an elective or non-elective route and some would be normally be expected to have a seven-day or longer stay e.g. patients who have had a stroke, myocardial infarction, fractured neck of femur, or need neurorehabilitation. The measure is a snapshot taken at either midnight or 8am. Whilst comparisons are made across hospitals it is

usually not a true comparison because different hospitals provide significantly different services.

- 4.2. The numbers of stranded patients for Tameside and Glossop CCG have been fairly consistent between June and December 2017 when numbers increased over the winter period resulting in an increase in the moving average from 184 patients to 201 patients, however since April the numbers have reduced enough to reduce the moving average back down to just below levels prior to Winter.



- 4.3. Patients with stays of 21+ days are classed as **Super Stranded Patients** (Extended LoS). The graph below shows Super Stranded/Extended Length of Stay (LoS) patients for Tameside and Glossop CCG and is fairly cyclical with peaks over the Winter period and then recovery through the Summer Period.

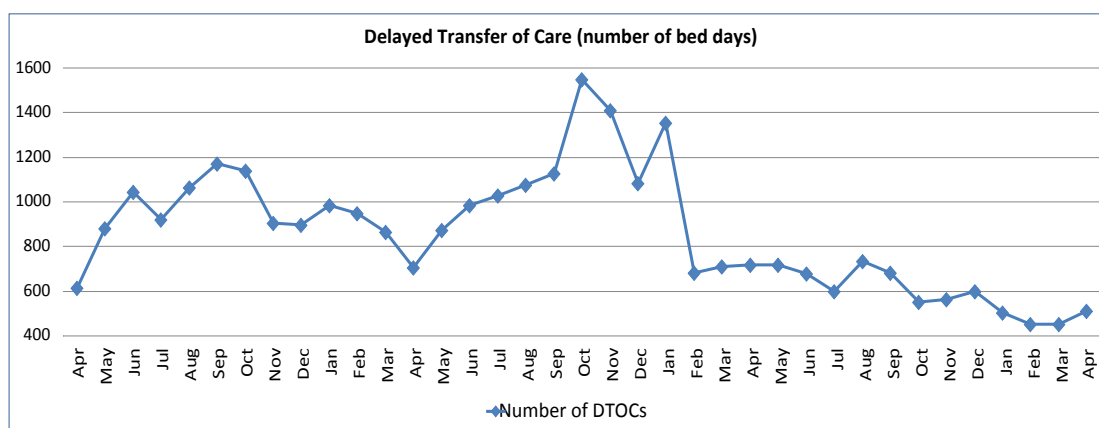


- 4.4. Within the ICFT there have been similar reductions in Stranded and Super Stranded patients with Stranded patients moving average reducing by 18 since April which matches the CCG reduction and Super Stranded moving average reducing by 14 which is higher than the CCG reduction. Very long LoS have also been reduced at the ICFT through some targeted work and reductions over the last two years are shown in the table below:

Very Long Los at T&G ICFT

LoS	Apr-16	Apr-17	Apr-18
50-99	31	24	24
100+	15	10	4
Total	46	34	28

- 4.5. When patients are well and should have been discharged but are still in a hospital bed they are classed as a **Delayed Transfer of Care (DTOC)**. There has been a significant improvement in DTOCs over the past 3 years at the ICFT. This has been supported by many of the Early Supported discharge schemes and the collaborative working between health and Social Care.



Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	511											
2017/18	716	716	678	600	734	681	550	561	598	504	453	453
2016/17	705	871	985	1027	1076	1126	1547	1407	1084	1354	682	710
2015/16	613	880	1044	920	1064	1169	1139	903	896	984	946	863

- 4.6. DTOC is generally reported on a trust or Local Authority basis, however, GM have been producing some acute DTOC analysis locally which shows that typically most of the CCG DTOCs happen at the ICFT and Manchester Foundation Trust.

Delayed Transfers of Care									
Trust	Daily - 31/05/18			DTOC Monthly			DTOC 12 Months Rolling ****		
	¥	DTOC - Delayed Days per Occupied Bed	Occupied Beds	Mar-18 Published	Feb-18 Published	Jan-18 Published	Previous 12 Months	Current 12 Months	
Greater Manchester	3.1%	90.7%		3.8%	4.1%	4.0%	4.8%	3.9%	
Bolton	4.0%	91.9%		3.4%	6.1%	8.2%	6.3%	5.6%	
MFT	4.8%	91.3%		4.2%	4.5%	4.6%	-	-	
PAHT	1.7%	89.0%		4.3%	8.7%	3.3%	2.0%	3.4%	
SRFT	1.5%	89.3%		2.7%	3.4%	3.3%	5.1%	3.4%	
Stockport	1.6%	89.6%		5.7%	4.8%	4.2%	8.9%	4.6%	
Tameside	3.8%	94.3%		2.9%	3.2%	3.2%	7.8%	4.1%	
WWL	1.0%	90.9%		1.5%	2.1%	1.5%	0.4%	1.4%	

- 4.7. Pennine Care Trust have recently reviewed the guidance around the recording of DTOCs and have now changed the way they record the information to ensure that the information is more accurate. This has resulted in the numbers of DTOCs recorded to increase.
- 4.8. IUCT and the Integrated Neighbourhood Teams are key to reducing the level of Stranded patients and DTOCs ensuring that discharge planning starts on admission and arranging care in the home as soon as possible. Effective utilisation of Intermediate Care in a patient's own homes or if needed a community bed will reduce length of stays and improve recovery.
- 4.9. The use of Discharge to Assess beds will support recovery and help ensure that people return to their own home wherever possible rather than to a long term residential bed.

5. Conclusion

- 5.1. The commitment to keeping people well and providing effective alternatives to hospital based care will support improvements in clinical outcomes and patient experience.
- 5.2. For those people who need hospital based support there will be focus on effective recovery and a Home First approach on discharge.
- 5.3. However as the system develops and only the very sick people attend A&E the current performance standards that are based on time to discharge from A&E may no longer be appropriate as the clinical level of need will determine the time needed to fully assess the patient's need and agree an appropriate care pathway and this may exceed the current 4 hour standard.
- 5.4. Likewise the increased use of LOS of zero days and home based care will result in only the sickest people being admitted overnight and these may need a LOS of greater than 7 days before they are well enough to be discharged.

End Of Life Dashboard

Dates				
Q2 (2016/17)	Q3 (2016/17)	Q4 (2016/17)	Q1 (2017/18)	Q2(2017/18)
July to Sept	Oct-Dec	Jan to March	April to June	July to Sept
1st July to 30th Sept	1st Oct-31st Dec	Jan 1st -32st March	1st April -30th June	1st July-30th Sept
* each quarter contains a complete years worth of data for data quality reasons				

Notes
* Usual Place of Residence includes Nursing and Residential Home
** Although the report is produced Quarterly, this data is for a full <u>rolling</u> 12 month period due to small numbers

RAG rating boundaries
Green = 10% lower than the T&G average
Amber= within 10% each way of the T&G average
Red = 10% higher than the T&G average

Conditions	
Cancer	C00- D48
Dementia and Alzheimer Disease	F03, F019, G309
Chronic Lower Respiratory Disease	J40-J47
Chronic Heart Failure	I25, I50
Neurological conditions	
Parkinson Disease	G20
Huntington Disease	G10
Motor Neurone	G12.2
Multiple Sclerosis	G35
progressive supranuclear palsy	G23.1
multiple-system atrophy	
Muscular Dystrophy	G71

Sources:
PCMD dates for relevant quarter (www.openexeter.nhs.uk)

Practice level mortality by place of death

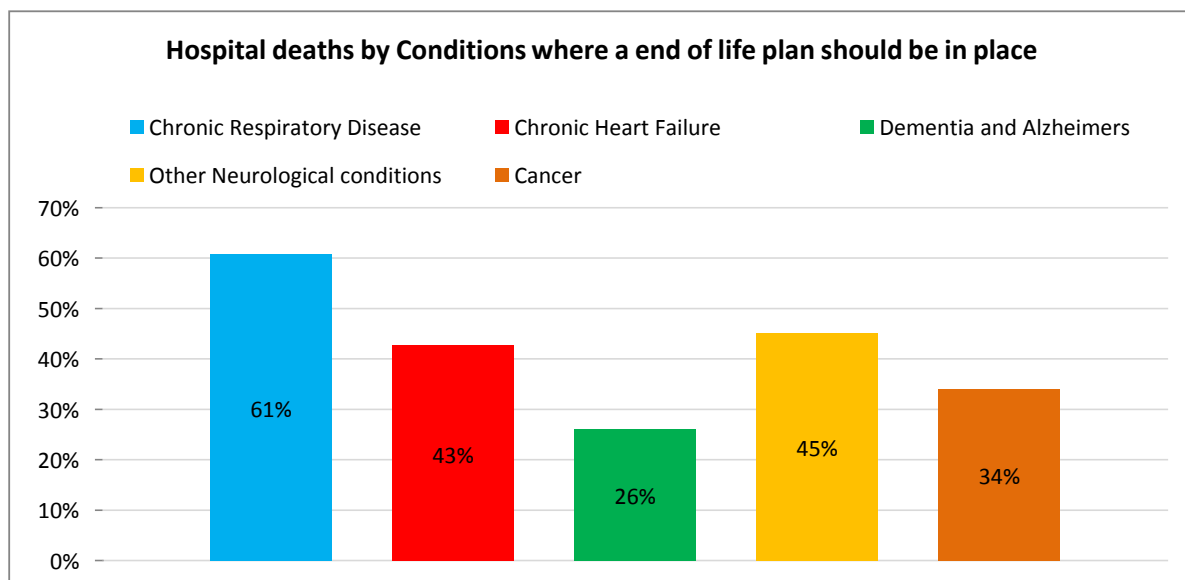
GP practice code	Prac Name	Ward	Community Neighbourhood	Health Neighbourhood	Total Observed deaths	Hospital		Usual place of residence*		Residential/Nursing home		Hospice		Other	
						number	%	number	%	number	%	number	%	number	%
P89003	Albion	St Peter's	North	Ashton	99	47	47%	37	37%	2	2%	13	13%	0	0%
Y02586	Ashton GP Service	St Peter's	North	Ashton	15	8	53%	5	33%	0	0%	2	13%	0	0%
P89008	Bedford House	St Peter's	North	Ashton	74	36	49%	24	32%	3	4%	11	15%	0	0%
P89017	Chapel Street	St Peter's	North	Ashton	38	23	61%	11	29%	0	0%	4	11%	0	0%
P89011	Gordon Street	Ashton St Michael's	North	Ashton	33	15	45%	11	33%	2	6%	5	15%	0	0%
Y02713	Guide Bridge	St Peter's	North	Ashton	23	10	43%	11	48%	0	0%	2	9%	0	0%
P89609	Stamford	Ashton St Michael's	North	Ashton	24	12	50%	10	42%	0	0%	2	8%	0	0%
P89033	Tame Valley	St Peter's	North	Ashton	60	23	38%	23	38%	3	5%	11	18%	0	0%
P89020	The Highlands	St Peter's	North	Ashton	65	31	48%	26	40%	0	0%	8	12%	0	0%
P89613	Waterloo	Ashton Waterloo	North	Ashton	24	11	46%	6	25%	1	4%	6	25%	0	0%
P89030	West End	St Peter's	North	Ashton	40	26	65%	11	28%	0	0%	3	8%	0	0%
P89616	Ashton Road	Droylsden East	West	Denton	1	0	0%	0	0%	0	0%	0	0%	1	100%
P89015	Millgate	Denton West	West	Denton	236	127	54%	67	28%	6	3%	36	15%	0	0%
P89018	Denton	Denton North East	West	Denton	107	58	54%	31	29%	0	0%	18	17%	0	0%
Y02663	Droylsden Medical	Droylsden West	West	Denton	15	6	40%	6	40%	0	0%	3	20%	0	0%
P89029	Market Street	Droylsden East	West	Denton	68	32	47%	25	37%	3	4%	8	12%	0	0%
P89010	Medlock Vale	Droylsden East	West	Denton	77	41	53%	21	27%	1	1%	14	18%	0	0%
P89004	Awburn	Longdendale	South	Hyde	72	25	35%	32	44%	4	6%	10	14%	1	1%
P89012	Clarendon	Hyde Godley	South	Hyde	69	25	36%	31	45%	3	4%	10	14%	0	0%
P89016	Donneybrook	Hyde Godley	South	Hyde	96	41	43%	39	41%	7	7%	9	9%	0	0%
P89013	Hattersley	Longdendale	South	Hyde	53	23	43%	20	38%	1	2%	7	13%	2	4%
P89014	Haughton Thornley	Hyde Werneth	South	Hyde	137	67	49%	43	31%	7	5%	20	15%	0	0%
P89002	The Brooke	Hyde Godley	South	Hyde	107	45	42%	39	36%	4	4%	18	17%	1	1%
P89602	The Smithy	Longdendale	South	Hyde	31	16	52%	9	29%	0	0%	5	16%	1	3%
C81615	Cottage Lane	Hadfield South	Glossop	Glossop	25	10	40%	11	44%	0	0%	4	16%	0	0%
C81660	Hadfield	Padfield	Glossop	Glossop	19	6	32%	11	58%	0	0%	1	5%	1	5%
C81077	Howard Street	Howard Town	Glossop	Glossop	29	10	34%	15	52%	0	0%	4	14%	0	0%
C81106	Lambgates	Padfield	Glossop	Glossop	51	26	51%	21	41%	0	0%	4	8%	0	0%
C81081	Manor House	Howard Town	Glossop	Glossop	97	37	38%	42	43%	6	6%	12	12%	0	0%
C81640	Simmondley	Simmondley	Glossop	Glossop	23	8	35%	12	52%	0	0%	3	13%	0	0%
P89021	Davaar	Dukinfield	East	Stalybridge	123	54	44%	51	41%	5	4%	13	11%	0	0%
P89026	Grosvenor	Dukinfield Stalybridge	East	Stalybridge	54	28	52%	17	31%	2	4%	7	13%	0	0%
P89022	King Street	Dukinfield	East	Stalybridge	33	19	58%	11	33%	1	3%	2	6%	0	0%
P89005	Lockside	Stalybridge South	East	Stalybridge	68	22	32%	27	40%	5	7%	14	21%	0	0%
Y02936	Millbrook	Stalybridge South	East	Stalybridge	16	6	38%	7	44%	0	0%	3	19%	0	0%
P89612	Mossley	Mossley	East	Stalybridge	8	5	63%	2	25%	0	0%	0	0%	1	13%
P89618	Pike Medical	Mossley	East	Stalybridge	21	11	52%	8	38%	0	0%	2	10%	0	0%
P89023	St Andrews	Stalybridge North	East	Stalybridge	46	21	46%	15	33%	6	13%	4	9%	0	0%
P89007	Staveleigh	Stalybridge North	East	Stalybridge	87	40	46%	29	33%	9	10%	9	10%	0	0%
P89025	Town Hall	Dukinfield	East	Stalybridge	28	16	57%	10	36%	0	0%	2	7%	0	0%
ASHTON					495	242	49%	175	35%	11	2%	67	14%	0	0%
DENTON					504	264	52%	150	30%	10	2%	79	16%	1	0%
HYDE					565	242	43%	213	38%	26	5%	79	14%	5	1%
GLOSSOP					244	97	40%	112	46%	6	2%	28	11%	1	0%
STALYBRIDGE					484	222	46%	177	37%	28	6%	56	12%	1	0%
Tameside & Glossop					2292	1067	47%	827	36%	81	4%	309	13%	8	0%

* Usual Place of Residence includes Nursing and Residential Home

Mortality by Residential Care Homes in Tameside & Glossop by place of death				
Name of Nursing home	Total number of deaths in care home	Usual Residence	Not usual residence	Usual Residence but died in hospital
Auden House Care Home, Audenshaw	5	5	0	0
Balmoral Care Home, Hyde	15	13	2	2
Beechfield, Glossop	1	1	0	1
Beechwood House Glossop	1	1	0	2
Bourne House, Ashton-under-Lyne	11	11	0	3
Bowlacre, Hyde	8	8	0	5
Carson House Care Centre, Stalybridge	6	5	1	4
Charnley House Residential Home, Hyde	7	6	1	2
Clarkson House Nursing Home, Ashton-under-Lyne	8	8	0	3
Daisy Nook House, Ashton-under-Lyne	7	7	0	2
Darnton House Ashton-under-Lyne	6		6	0
Downshaw Lodge Care Centre, Ashton-under-Lyne	8	8	0	2
Fairfield View, Audenshaw	1		1	3
Fir Trees Centre, Dukinfield	11	9	2	0
Firbank House Nursing and Residential Home, Ashton-under-Lyne	8	5	3	0
Godley Court, Nursing Home, Hyde	19	17	2	0
Grange View Intermediate Care Home, Hyde	1	0	1	2
Greatwood House, Denton	18	16	2	7
Guide Lane Nursing Home, Audenshaw	20	19	1	2
Hatton Grange Care Home, Hyde	21	18	3	2
Holme Lea Care Home, Stalybridge	9	7	2	6
Hurst Hall Home, Ashton-under-Lyne	8	8	0	4
Hyde Nursing Home, Hyde	22	18	4	3
Kings Park Nursing Home, Ashton-under-Lyne	14	13	1	0
Kingsfield, Ashton-under-Lyne	2	2	0	0
Laurel Bank Care Home, Hyde	8	6	2	1
Millbrook Care Centre, Stalybridge	10	7	3	2
Moss Cottage Care Home, Ashton-under-Lyne	11	11		0
Newton Court, Hyde Nursing Home, Hyde	1	0	1	1
Oakford Manor Nursing Home, Glossop	17	14	3	2
Oakwood Care Centre, Stalybridge	4	3	1	2
Parkhill Care Home, Stalybridge	19	15	4	1
Pendlebury Court Care Home, Glossop	7	6	1	2
Pennine Care Centre, Glossop	9	9	0	1
Pole Bank Hall, Hyde	11	9	2	5
Riverside Care Centre, Hyde	23	20	3	1
Sandon House, Market Street, Mossley	0	0	0	0
St. Lawrence Lodge, Denton	4	4	0	1
Staley House Stalybridge	7	6	1	4
Stamford Court Nursing Home, Stalybridge	34	21	13	1
Staveleigh House, Hyde	1	1	0	0
Sunnyside	9	9	0	3
The Beeches, Yew Tree Lane, Dukinfield	7	7	0	3
The Lakes Care Centre, Dukinfield	31	29	2	7
The Regency Hall Care Home, Hadfield Glossop	1	0	1	0
The Risings, Glossop	6	6	0	1
The Sycamores, Hyde	5	5	0	4
The Vicarage Care Home, Audenshaw	10	9	1	4
Thorncliffe Grange Nursing Home, Denton	16	13	3	1
Werneth Court, Nursing Home, Hyde	1	1	0	0
Willow Bank Rest Home, Hadfield, Glossop,	7	7	0	1
Yew Tree Care Home, Dukinfield	15	15	0	5
Total	511	438	73	109

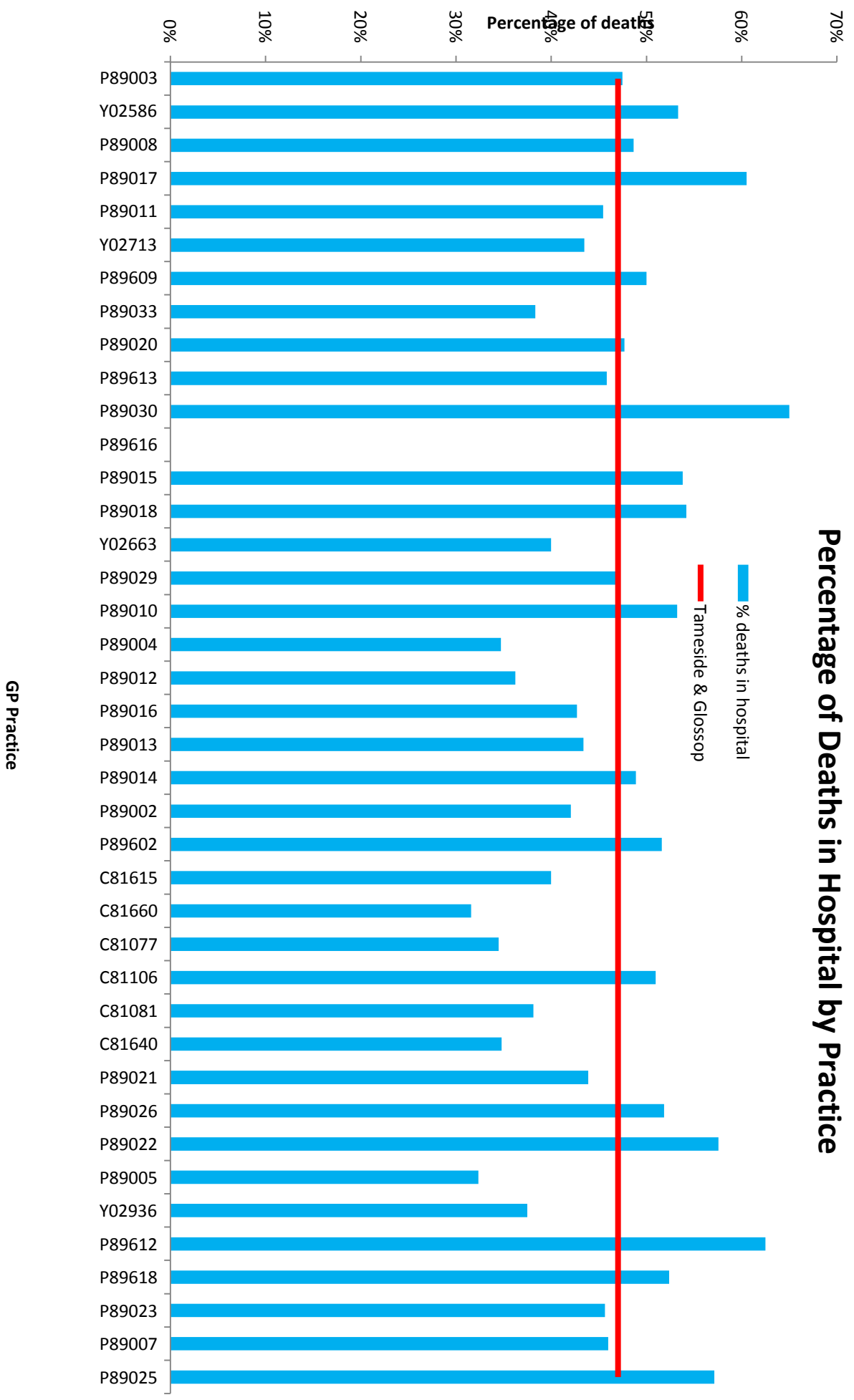
Deaths in hospital from conditions deemed applicable to end of life care

Condition	Total Deaths from condition	Hopsital	Usual Place of Residence	Hospice	Other
Chronic Respiratory	199	121	53	21	4
		61%	27%	11%	2%
Chronic Heart Failure	239	102	121	12	4
		43%	51%	5%	2%
Dementia and Alzheimers	405	106	220	44	35
		26%	54%	11%	9%
Other Neurological	31	14	12	5	31
		45%	39%	16%	100%
Cancer	739	252	263	196	28
		34%	36%	27%	4%



Neurological conditions included:

Parkinsons, Huntingtons, Motor Neurone disease, Multiple sclerosis, Muscular dystrophy, progressive supranuclear palsy, multiple-system atrophy



Hospital deaths

2017/18 2017/18 2017/18 2017/18 2018/19 2018/19 2018/19 2018/19 2019/20 2019/20 2019/20 2019/20 2020/21 2020/21 2020/21 2020/21

Q1

Q2

Q3

Q4

Q1

Q2

Q3

Q4

Q1

Q2

Q3

Q4

Q1

Q2

Q3

Q4

Neighbourhoods

ASHTON (North)

DENTON (West)

HYDE (South)

GLOSSOP (Glossop)

STALYBRIDGE (East)

Tameside & Glossop

51% 49%

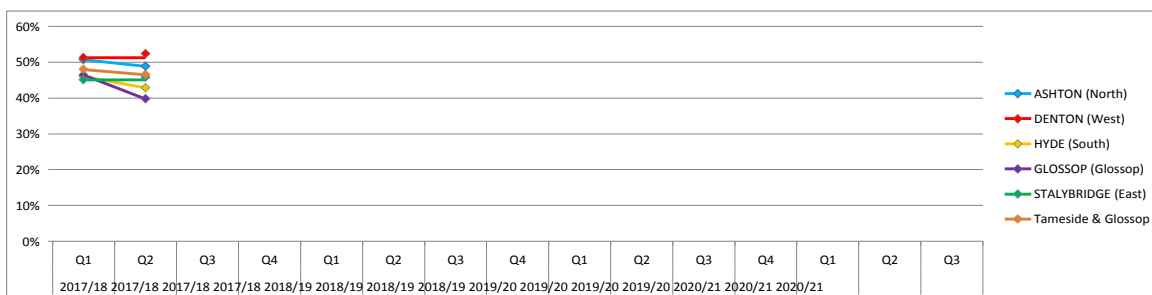
51% 52%

46% 43%

46% 40%

45% 46%

48% 47%



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Report to: STRATEGIC COMMISSIONING BOARD

Date: 20 June 2018

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

Subject: COMMUNITY CARDIOLOGY DIAGNOSTICS SERVICE: ECG AND ECG INTERPRETATION, 24 HOUR AMBULATORY ECG AND EVENT RECORDER INTERPRETATION

Report Summary: Tameside and Glossop CCG commission Broomwell Healthwatch TeleMedical Monitoring Services Ltd to deliver community cardiology diagnostic services:

- Practice based 12 lead ECG service including provision of ECG machines and remote interpretation of all ECGs.
- Neighbourhood based 24hour ECG service including provision of ECG machines and remote interpretation of all ECGs.

Broomwell have delivered services to Tameside & Glossop for a number of years. The current contract was let in 2016 (1 April 2016) as a 3 year contract following a formal procurement process. The current contract will end on 31 March 2019. The indicative annual contract value for the 2 services is c£190k.

The purpose of this report is to present options for the future commissioning of community cardiology diagnostic services for the population of Tameside & Glossop.

Recommendations: The Strategic Commissioning Board are asked to consider this report and advise on their preferred option, noting that the preferred option of the Commissioning Directorate is Option 1.

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	£310k 2018/19	-	-	£310k 2018/19
Total	£310k	-	-	£310k

Section 75 - £'000
Decision: SCB

A recurrent budget of £310k is in place to fund this service. This includes both payments under the Broomwell contract and support payments to GPs for delivery of their part of the pathway.

The service is paid for on a cost and volume basis, therefore actual payments due may vary from the budgets quoted above based on actual activity.

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

The finance task and finish group have reviewed this paper and support the recommendation to extend the contract for a

further 2 years.

Equivalent diagnostic tests performed in an outpatient setting are significantly more expensive than the current community service. On this basis, the CCG delivered substantial QIPP savings 3 years ago when this contract was first signed.

These historic savings are now fully embedded in recurrent budgets and any return to PbR would result in a financial pressure to the economy.

On the assumption that the contract can be extended on the current terms, recurrent budgets are sufficient to continue funding the service.

Legal Implications:

(Authorised by the Borough Solicitor)

This contract has provision for extension by 2 years from 1 April 2019, until 31 March 2021, on 6 months notice. If the Board agree this option is the best, it would make sense for that decision to be taken now to avoid the need to come back for further governance before the need to give notice of intention to extend on 30 September 2018.

There is no reason, given the detail provided in the report, to be concerned that the public law fiduciary duty is not being met, and so the request for a 2 year extension in this case, given the effective monitoring of the service and the service's responses and performance, would seem reasonable in this instance.

How do proposals align with Health & Wellbeing Strategy?

The proposals align with the living and ageing well elements of the Health and Wellbeing Strategy.

How do proposals align with Locality Plan?

The proposals are in line with the locality plan and the Care Together model of care as they support delivery of early and effective diagnosis and therefore treatment of cardiovascular conditions, with care delivered close to home and in the community.

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 supporting early and effective diagnosis and appropriate treatment.

Recommendations / views of the Health & Care Advisory Group:

HCAG considered a version of this report at their meeting in May 2018 and were supportive of Option 1. The request was that commissioners continue to work closely with the ICFT, through the Heart Disease Programme Board, to optimise the alignment of this service with those delivered by the ICFT. HCAG members spoke highly of the quality and effectiveness of the services delivered by the provider under the current contract.

Public and Patient Implications:

The procurement process which was undertaken when the contract was awarded to Broomwell in 2016 was informed by extensive patient engagement, supported by the (then) Tameside & Glossop NHS FT. Commissioners will ensure that if the contract extension is supported, patient reported outcomes and patient satisfaction measures form a key part of the contract monitoring process.

Quality Implications:	A Quality Impact Assessment has been completed and is attached.
How do the proposals help to reduce health inequalities?	The proposal will ensure the delivery of timely and effective diagnostic services to meet individuals' needs across the locality, delivered in community settings and close to people's own homes.
What are the Equality and Diversity implications?	An Equality Impact Assessment (EIA) has been completed and is attached to this report.
What are the safeguarding implications?	The commissioned model will include all required elements of safeguarding legislation, and if the SCB decision is to extend the current contract, commissioners will ensure this is in place for the period of any contract extension.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Broomwell receive referrals from GPs in the locality and as existing holders of a standard NHS contract work within the required IG regulations. This will continue to be assessed through the contract management process.
Risk Management:	The contract will continue to be performance managed by the commissioning directorate with support and input from colleagues in the finance directorate and contract management team.
Access to Information :	<p>The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Commissioning:</p> <p> Telephone: 07979 713019</p> <p> e-mail: alison.lewin@nhs.net</p>

1 BACKGROUND AND INTRODUCTION

- 1.1 Tameside and Glossop Clinical Commissioning Group (CCG) commission Broomwell Healthwatch Tele-Medical Monitoring Services Ltd to deliver community cardiology diagnostic services:
 - Practice based 12 lead ECG service including provision of ECG machines and remote interpretation of all ECGs.
 - Neighbourhood based 24hour ECG service including provision of ECG machines and remote interpretation of all ECGs.
- 1.2 The procurement of Community Cardiology Diagnostic services was carried out in 2015-16 following a decision made through CCG governance. The rationale for the service model was that the service would reduce the number of unnecessary referrals to secondary care, allow GPs to carry out diagnostic tests in their practices, allow patients to be seen more promptly, and ultimately to support the delivery of improved health outcomes for people with cardiovascular disease in Tameside and Glossop. The business case set out expectations that the model would reduce the number of diagnostics carried out in secondary care. 35 practices responded in support of the Broomwell service delivered prior to 2016-17 and the further development of community cardiology diagnostics. Broomwell were the successful bidders through the formal procurement process.
- 1.3 Broomwell have delivered services to Tameside and Glossop for a number of years. The current contract was let in 2016 (1 April 2016) as a 3 year contract following a formal procurement process. The current contract will end on 31 March 2019. The indicative annual contract value for the 2 services is c£190k (see section 3 below).
- 1.4 Broomwell are the provider of community cardiology diagnostics to all Greater Manchester localities (with the exception of Oldham) and have a significant number of contracts nationally.
- 1.5 The service was procured to provide a community pathway for cardiology diagnostics with the following objectives:
 - Ensure patients receive the appropriate levels of care commensurate to their need at the earliest point in the pathway;
 - Access to prompt expertise in ECG testing and interpretation;
 - Swifter confirmed diagnosis enables management care plans to be produced in primary care or onward referral to secondary care with diagnostics already undertaken;
 - Assess to diagnostics closer to home;
 - Patients may avoid unnecessary hospital attendance;
 - Patients are able to access care within their local community;
 - Ensure optimum use of resources;
 - Improved patient experience by reducing anxiety, as tests can be undertaken immediately or within a few days of referral, with results available shortly after;
 - Reduction in hospital attendances.
- 1.6 As part of the Tameside and Glossop Locally Commissioned Service arrangements with General Practice, a service specification and contract is in place for the GP element of the ECG pathway, as described in section 2 below.
- 1.7 The purpose of this report is to present options for the future commissioning of community cardiology diagnostic services for the population of Tameside and Glossop.

2 SERVICE DESCRIPTION

- 2.1 The specification in the current contract states that the Service Provider (Broomwell) shall:

- Provide a timely, locally accessible service within the community;
- Rapid access to quality assured results;
- Increased access to diagnostic procedures;
- To ensure optimal client care, related to diagnostic outcomes;
- Address health inequalities;
- Improved quality of life for patients and their relatives/ carers;
- Provide a best value patient-focused service that fulfills the clinical needs of patients and other users;
- Provide safe, efficient, responsive, comprehensive and effective services which meet National guidelines, accreditation requirements and statutory regulations;
- Provide a flexible and appropriate service that respond to changes in patient care and organisational requirements;
- Ensure that service standards are met through the appropriate use of qualified and registered staff. Maintain a balanced skill mix that provides the best value service and ensure all staff are developed and trained to be competent for the work to be undertaken;
- Work within, and meet the standards of a quality management system, ensuring all standard operating procedures comply with, National minimum standards and regulatory body's requirements;
- Ensure that training is provided to GP practice staff to ensure the equipment is fitted correctly. Any training costs should be covered within the cost of the interpretation.

2.2 As outlined in section 1.1 there are 2 elements to the service commissioned from Broomwell, and these are described below:

12 Lead ECG Pathway

A clinician records an ECG on a patient at the surgery and then contacts Broomwell Healthwatch. The ECG recording is transmitted via telephone/internet to a team of clinically trained staff who are available to interpret the results. During transmission, the Broomwell Healthwatch team are in constant communication with the patient's doctor/nurse and, having awareness of the clinical situation, are then able to provide an accurate interpretation and provide an immediate verbal interpretation of the ECG to the practice staff. Following the immediate verbal report, a full written ECG report is sent back to the surgery (usually within 30 minutes), together with a copy of the ECG usually by email for inclusion in the patient record.

24 hour ECG Pathway

The supply of ECG Ambulatory monitors is managed on a locality basis. Tameside & Glossop CCG currently have 8 hubs across the locality. Broomwell Healthwatch provides the equipment and training to the Hubs. The equipment is fitted at and returned to the Hubs following referral by the patients' GP/Practice Nurse. As with 12-lead ECGs, the recording from the ambulatory monitors is interpreted by Broomwell Healthwatch clinical staff. The results are sent to the GP Practice within 3 working days of the machine being returned to the Hub. In the cases where the test has been unsuccessful due to equipment failure, the patient will be contacted by the Hub to ask them to return and have the equipment re-fitted. This will only count as one test for financial purposes. In the cases where an event recorder has been fitted, the equipment has worked but the patient has not pressed the event button, so no recording has been made, the referring GP should be updated about this and can decide whether they want to re-refer the patient for another test. The majority of ambulatory recordings will be for 24 hours however, an event recorder is also available.

2.3 Staff training is delivered by Broomwell to ensure that service standards are met through the appropriate use of qualified and registered staff. A skill mix is maintained that provides an effective, competent and value for money service. Training is provided where required to General Practice to ensure equipment is fitted correctly.

- 2.4 The provider takes complete responsibility for all telemedicine equipment and servicing. A 'repair/replace' facility is available to the hubs enabling any equipment problems to be resolved within 48 hours by repairing or replacing said equipment.
- 2.5 There is a service specification in place, which is part of the Tameside & Glossop Locally Commissioned Service contracts with General Practice, which outlines the responsibilities of General Practice as:
- Ordering appropriate supplies from the provider;
 - Undertaking the 12 lead ECG test;
 - Downloading data to the provider in order to interpret the test;
 - Onward referral to secondary care if required.

3 FINANCE, ACTIVITY AND PERFORMANCE

- 3.1 The Commissioning Directorate with support from finance and contracting colleagues are responsible for the monitoring of this contract, and receive monthly reports from Broomwell. Annual contract review meetings are held between the provider and commissioner.

Finance

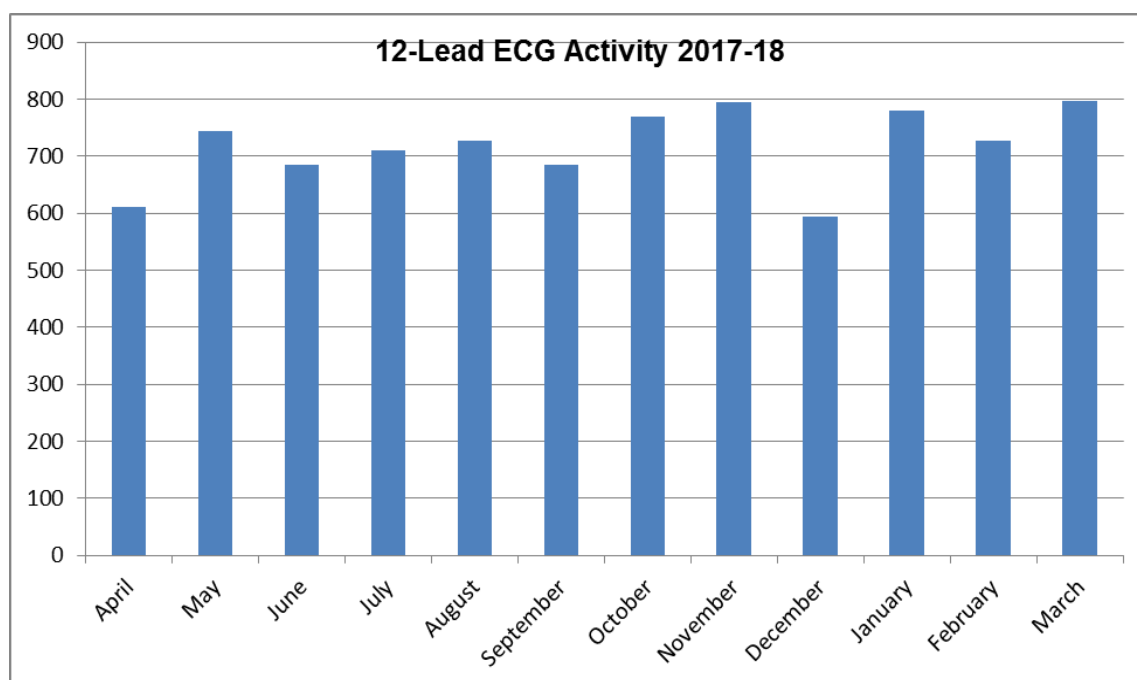
- 3.2 The annual indicative Broomwell contract value Broomwell is set out below:

Year	Indicative Value £
2016-17	185,985
2017-18	190,351
2018-19	190,544

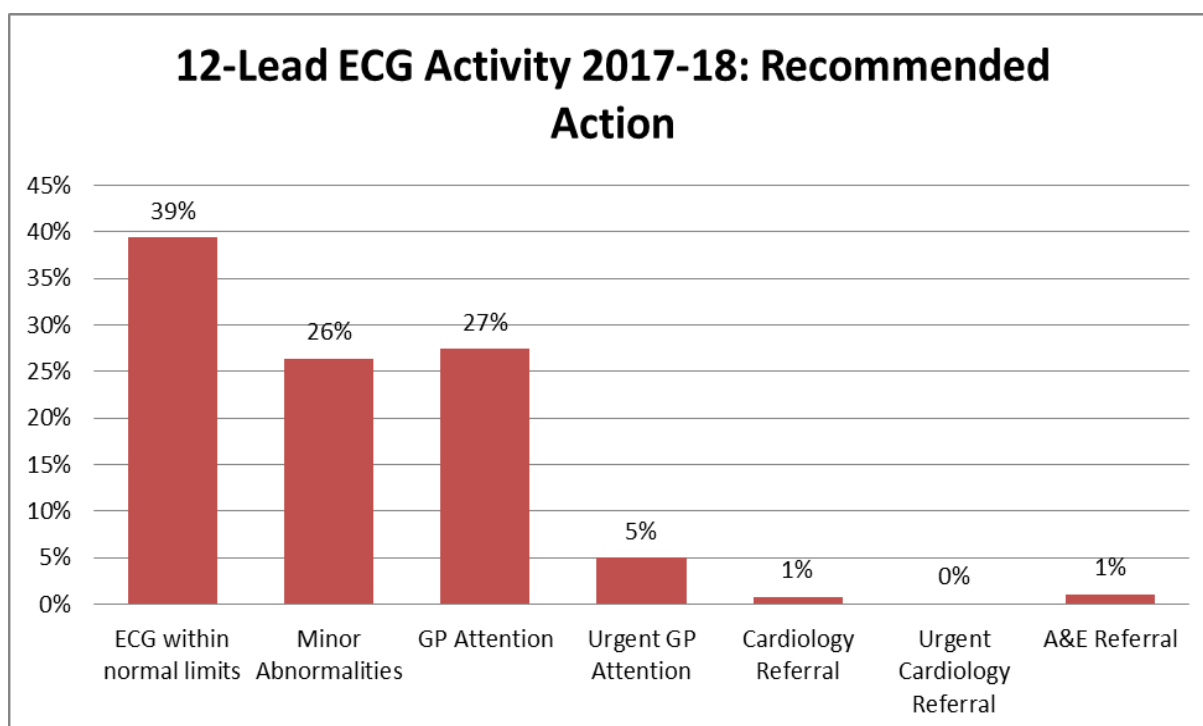
- 3.3 There is an associated budget in place as part of the whole community cardiology diagnostic service to support payments to GPs for delivery of their part of the pathway. GPs are paid £7 per test.
- 3.4 The payments are made based on activity levels as set out in the section below, and can therefore vary from the indicative contract values. This contract has been supported from a finance perspective due to the demand management nature from a secondary care perspective.
- 3.5 Indicative activity levels and contract value equate to c£24 per ECG, plus £7 GP fee.

12-Lead ECGs

- 3.6 **Activity:** In 2017-18, there were 8,620 12-lead ECGs carried out by Broomwell. The indicative activity level in the contract for Year 2 (2017-18) is 7168. The chart below shows the activity across the 12 months April 2017 – March 2018.



- 3.7 Broomwell provide commissioners with a breakdown of the outcome of 12-lead ECGs in the monthly performance reports. The chart below details the outcome of the 8,620 carried out in 2017-18.



- 3.8 **Performance:** In 2017-18, all KPIs relating to the time in which reports are sent to the practices were met for the 12 lead ECG service.

24-Hour ECGs and Loop Event Monitors

- 3.9 **Activity:** In 2017-18 there were 852 24-hour ECGs carried out by Broomwell via the 8 neighbourhood hubs. The anticipated activity level in the contract for 2017-18 (Y2) is 614. The activity for each of the hubs is included in the table below:

HUB 1	Brooke Surgery	119
HUB 2	Denton MP	130
HUB 3	Droylsden MP	48
HUB 4	King Street	58
HUB 5	Manor House	241
HUB 6	Market Street	48
HUB 7	Tame Valley	159
HUB 8	Town Hall	49
Total		852

3.10 In 2017-18 there were 146 referrals for Loop Event Monitors carried out by Broomwell via the 8 neighbourhood hubs. The activity for each of the hubs is included in the table below:

HUB 1	Brooke Surgery	28
HUB 2	Denton MP	16
HUB 3	Droylsden MP	1
HUB 4	King Street	13
HUB 5	Manor House	54
HUB 6	Market Street	13
HUB 7	Tame Valley	21
HUB 8	Town Hall	3
Total		146

3.11 **Performance:** The expectation is that referrals for 24-hour ECGs and Loop Event Monitoring will be seen for their first appointment within 3 weeks of referral. And that reports back to the referring GP will be received within 3 working days of the equipment being returned to the hubs. The table below summarises performance in 2017-18 against these indicators.

24 hour Tape MONTHLY ACTIVITY SUMMARY															
SUMMARY OF PERFORMANCE	% achieved	Ave monthly Target	Cumulative Data	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Time elapsed between Referral date and first appointment															
0-3 Weeks	66.2%	100.0%	564	61	54	44	53	36	33	40	50	31	48	52	62
4-6 weeks	33.8%	0.0%	288	11	20	24	9	30	21	9	25	44	51	26	18
Total	100.0%	100.0%	852	73	74	68	62	66	54	49	75	75	99	78	80
Time elapsed between receipt of data and reporting back to patient's registered practice															
0-3 days	98.9%	100.0%	844	72	71	68	60	66	54	47	75	75	98	78	80
3-6 days	1.1%	0.0%	9	1	3	0	2	0	0	2	0	0	1	0	0
Total	100.0%	100.0%	853	73	74	68	62	66	54	49	75	75	99	78	80
DNA Rate			38	5	4	6	1	1	3	4	2	5	0	2	5

Loop Event Monitors - MONTHLY ACTIVITY SUMMARY															
SUMMARY OF PERFORMANCE	% achieved	Ave monthly Target	Cumulative Data	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Time elapsed between Referral date and first appointment															
0-3 Weeks	51.7%	100.0%	77	6	17	3	6	9	7	6	15	8	6	15	13
4-6 weeks	48.3%	0.0%	72	14	10	8	14	7	1	2	1	15	10	9	8
Total	100.0%	100.0%	149	20	27	11	20	16	8	8	16	23	16	24	21
Time elapsed between receipt of data and reporting back to patients registered practice															
0-3 days	100.0%	100.0%	149	20	27	11	20	16	8	8	16	23	16	24	21
3-6 days	0.0%	0.0%	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	100.0%	100.0%	149	20	27	11	20	16	8	8	16	23	16	24	21
DNA Rate			12	4	1	4	1	0	0	1	0	1	1	2	4

3.12 Broomwell have reached 98.9% (24 hour ECGs) and 100% (Loop Event Monitors) for reporting back to GPs within 3 working days.

3.13 During 2017-18 Broomwell have encountered problems with regard to 4 of the 8 hubs and the referral process, leading to below expected levels of performance for the referral to appointment times and the expected 3 week waiting time. The CCG have supported Broomwell, who reporting that practices were not communicating effectively with Broomwell up booking patients for appointments. Following a contract meeting held in March, the CCG and Broomwell have supported practices with resolving the issues and are now monitoring this weekly.

4 OPTIONS FOR FUTURE COMMISSIONING OF THIS SERVICE

4.1 In light of the information outlined in this report, SCB are asked to consider the following options for the future commissioning of community cardiology diagnostics.

4.2 **Option 1:** The current contract is a 3 year standard NHS contract with an option to extend by a further 2 years. We would need to give notice to the provider that this is our intention and we would need to inform the provider that this is our intent 6 months before the current contract end date of 31st March 2018 (i.e. 30th September 2018). This option could include a review of the KPIs and addressing any concerns regarding performance and / or activity through the usual contract monitoring processes.

4.3 **Option 2:** If the decision is NOT to take the option of extending the current contract with Broomwell, the commissioners could review the current service specification and with a revised specification run a full procurement exercise to identify an alternative community provider.

4.4 **Option 3:** If the decision is NOT to take the option of extending the current contract with Broomwell, the commissioners could review the current service specification and commence discussions with Tameside & Glossop ICFT with a view to including activity within the hospital based ICFT cardiology services – this option would be dependent on the ICFT being able to confirm capacity to take on the additional activity, to deliver to the commissioner specification, and would require discussions regarding the inclusion of any additional activity in the contract arrangements for 2019-20.

5 RECOMMENDATION

As outlined on the front of this report

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

Subject / Title	COMMUNITY CARDIOLOGY DIAGNOSTICS SERVICE: ECG and ECG Interpretation, 24 hour Ambulatory ECG and event recorder Interpretation
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Team	Department	Directorate
Commissioning	Commissioning	Commissioning

Start Date	Completion Date
2 nd May 2018	4 th June 2018

Project Lead Officer	Alison Lewin
Contract / Commissioning Manager	Alison Lewin
Assistant Director/ Director	Jessica Williams

EIA Group (lead contact first)	Job title	Service
Alison Lewin	Deputy Director of Commissioning	Commissioning

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

PART 1 – INITIAL SCREENING

1a.	<p>What is the project, proposal or service / contract change?</p>	<p>Tameside and Glossop CCG commission Broomwell Healthwatch TeleMedical Monitoring Services Ltd to deliver community cardiology diagnostic services:</p> <ul style="list-style-type: none"> • Practice based 12 lead ECG service including provision of ECG machines and remote interpretation of all ECGs. • Neighbourhood based 24hour ECG service including provision of ECG machines and remote interpretation of all ECGs. <p>Broomwell have delivered services to Tameside & Glossop for a number of years. The current contract was let in 2016 (1st April 2016) as a 3 year contract following a formal procurement process. The current contract will end on 31st March 2019. The indicative annual contract value for the 2 services is c£190k.</p> <p>The purpose of this report is to present options for the future commissioning of community cardiology diagnostic services for the population of Tameside & Glossop.</p>
1b.	<p>What are the main aims of the project, proposal or service / contract change?</p>	<p>The main proposal outlined in the report is to seek approval to extend the current contract, in line with the standard NHS Contract terms, with another two options for consideration.</p> <p>The specification in the current contract states that the Service Provider (Broomwell) shall</p> <ul style="list-style-type: none"> • Provide a timely, locally accessible service within the community • Rapid access to quality assured results • Increased access to diagnostic procedures • To ensure optimal client care, related to diagnostic outcomes • Address health inequalities • Improved quality of life for patients and their relatives/ carers • Provide a best value patient-focused service that fulfills the clinical needs of patients and other users. • Provide safe, efficient, responsive, comprehensive and effective services which meet National guidelines, accreditation requirements and statutory

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

		<p>regulations.</p> <ul style="list-style-type: none"> • Provide a flexible and appropriate service that respond to changes in patient care and organisational requirements. • Ensure that service standards are met through the appropriate use of qualified and registered staff. Maintain a balanced skill mix that provides the best value service and ensure all staff are developed and trained to be competent for the work to be undertaken. • Work within, and meet the standards of a quality management system, ensuring all standard operating procedures comply with, National minimum standards and regulatory body's requirements. • Ensure that training is provided to GP practice staff to ensure the equipment is fitted correctly. Any training costs should be covered within the cost of the interpretation <p>The purpose of the report to SCB is to seek approval to extend this contract for a further 2 years in line with the conditions of the standard NHS contract. This is an initial EIA based on option 1 in support of the Community Cardiology Diagnostics Service report. If option 2 or 3 are selected by SCB then further research / engagement would need to be undertaken and a full EIA produced to evidence what this would mean for the service.</p>
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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			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Age in any significant sense. Whilst the service may be used more by older adults, if option 1 is opted for this will mean service will continue as per current provision.
Disability			✓	There is no anticipation that the development or implementation of this

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

				strategy will impact directly or indirectly on Disability in any significant sense
Ethnicity			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Ethnicity in any significant sense
Sex / Gender			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Sex/Gender in any significant sense
Religion or Belief			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Religion or Belief in any significant sense
Sexual Orientation			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Sexual Orientation in any significant sense
Gender Reassignment			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Gender Reassignment in any significant sense
Pregnancy & Maternity			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Pregnancy & Maternity in any significant sense
Marriage & Civil Partnership			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Marriage & Civil Partnership in any significant sense
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Mental Health in any significant sense
Carers			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Carers in any significant sense
Military Veterans			✓	There is no anticipation that the development or implementation of this

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

				strategy will impact directly or indirectly on Military Veterans in any significant sense
Breast Feeding			✓	There is no anticipation that the development or implementation of this strategy will impact directly or indirectly on Breast Feeding in any significant sense
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (e.g. <i>vulnerable residents, isolated residents, low income households</i>)				
Group (please state)	Direct Impact	Indirect Impact	Little / No Impact	Explanation
n/a				

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

1d.	Does the project, proposal or service / contract change require a full EIA?	Yes	No
			✓
1e.	What are your reasons for the decision made at 1d?	<p>The proposal is to continue with a service which has been commissioned for a number of years in Tameside & Glossop. The view of the commissioner is that this service does not impact directly or indirectly on any of the groups outlined above. We have a robust contract monitoring process in place which would enable us to identify any issues should they arise, and we would work with the provider to rectify these.</p> <p>This is an initial EIA based on option 1 in support of the Community Cardiology Diagnostics Service report. If option 2 or 3 are selected by SCB then further research / engagement would need to be undertaken and a full EIA produced to evidence what this would mean for the service.</p>	

Signature of Contract / Commissioning Manager	Date
Alison Lewin	4 th June 2018
Signature of Assistant Director / Director	Date
Jessica Williams	4 th June 2018

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

Quality Impact Assessment

Title of scheme: COMMUNITY CARDIOLOGY DIAGNOSTICS SERVICE: ECG and ECG Interpretation, 24 hour Ambulatory ECG and event recorder Interpretation

Project Lead for scheme: Jessica Williams, Interim Director of Commissioning (report prepared by Alison Lewin, Deputy Director of Commissioning)

Brief description of scheme: Tameside and Glossop CCG commission Broomwell Healthwatch TeleMedical Monitoring Services Ltd to deliver community cardiology diagnostic services:

- Practice based 12 lead ECG service including provision of ECG machines and remote interpretation of all ECGs.
- Neighbourhood based 24hour ECG service including provision of ECG machines and remote interpretation of all ECGs.

Broomwell have delivered services to Tameside & Glossop for a number of years. The current contract was let in 2016 (1st April 2016) as a 3 year contract following a formal procurement process. The current contract will end on 31st March 2019. The indicative annual contract value for the 2 services is c£190k.

The purpose of this report is to present options for the future commissioning of community cardiology diagnostic services for the population of Tameside & Glossop.

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)			Comments
	Neutral / Positive Impact						No risk identified									
	0	1	2	3	4	5	0	1	2	3	4	5	Low 0-5	Moderate 6-12	High 15-25	
Patient Safety	0						0						0			The Single Commission will continue to commission a service which ensures high levels of patient safety and will ensure routine quality assurance mechanisms are in place through the contract monitoring process. There have been no patient safety issues identified during the duration of the current contract since April 2016.
Clinical effectiveness	0						0						0			The proposed model described in the paper has been demonstrated to deliver clinically effective services which are outlined in contractual documentation and the monthly. The case for change included in the paper presented to the Strat reports provided by the provider to the commissioners. The details of the services provided are outlined in the full SCB report. The comments from HCAG included high praise of the services delivered by Broomwell.

Patient experience	0						0						0				There have been no negative reports in relation to patient experience during the current contract period. Commissioners will ensure that if the contract extension is supported, patient reported outcomes and patient satisfaction measures form a key part of the contract monitoring process.
Safeguarding children or adults	0						0						0				The commissioned model will include all required elements of safeguarding legislation, and if the SCB decision is to extend the current contract, commissioners will ensure this is in place for the period of any contract extension

Please consider any anticipated <u>impact</u> on the following additional areas only as appropriate to the case being presented. <u>NB please see appendix 1 for examples of impact on additional areas.</u>							What is the <u>likelihood</u> of risk occurring?						What is the overall <u>risk score</u> (impact x likelihood)			Comments
	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	
Human resources/ organisational development/ staffing/ competence	0						0						0			No impact anticipated. The provider has a strong track record of delivery in the locality and work closely with the GPs and wider stakeholders. There have never been any issues relating to human resources, staffing or competence.
Statutory duty/ inspections	0						0						0			The commissioner will work with the Quality & Safeguarding Directorate to ensure all required inspections are undertaken.
Adverse publicity/ reputation	0						0						0			There is no expectation of any adverse publicity or reputation resulting from this proposal.

Finance	0						0						0				The Finance Directorate are closely involved in the monitoring of this contract, and the proposal presented to SCB will include comments from the locality finance team.
Service/business interruption	0						0						0				This proposal recommends the continuation of the current service model therefore does not involve any potential for service or business interruption.
Environmental impact	0						0						0				Services are delivered either via telephone or close to patients' homes in the community therefore minimising environmental impact.
Compliance with NHS Constitution	0						0						0				The commissioners will ensure the contract is delivered in line with NHS constitutional requirements where applicable.
Partnerships	0						0						0				The commissioners will ensure this service is delivered in line with the plans of the locality Heart Disease Programme Board, and through contract management processes will ensure continued close working with T&G ICFT and the GPs in the locality.
Public Choice	0						0						0				The offer of a diagnostic service in the community broadens the options available for patients to receive cardiology diagnostic services.
Public Access	0						0						0				Services will be delivered either in patients' own GP surgeries or from a location in their neighbourhood, therefore ensuring patient access is optimised.

Has an equality analysis assessment been completed?	YES / NO	Please submit to SCB alongside this assessment
Is there evidence of appropriate public engagement / consultation?	YES / NO	Evidence of engagement in the initial procurement exercise in 2016

Sign off:

Quality Impact assessment completed by	Alison Lewin
Position	Deputy Director of Commissioning
Signature	Alison Lewin
Date	22nd May 2018

Nursing and Quality Directorate Review	
Name	
Position	
Signature	
Date	

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Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 June 2018

Officer of Single Commissioning Board Stephanie Butterworth, Director of Adult Services

Subject: **CONTRACT FOR THE PROVISION OF A GARDEN MAINTENANCE AND DAY SUPPORT SERVICE AT SUPPORTED DOMESTIC PROPERTIES IN TAMESIDE**

Report Summary: The report describes the rationale for an extension of the above contract for a period of two years where there this is provided for within the terms of the contract.

Recommendations: That the information provided is considered and a decision made in relation to approve a contract extension for two years.

Financial Implications:

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

ICF Funding Stream:	Section 75
Decision Required by:	Strategic Commissioning Board
Organisation and Directorate:	TMBC – Adult Services
Budget - £'000:	36
Comments	The report states that contract performance is satisfactory. The contract is wholly funded via housing benefit and is included within the Adult Services revenue budget.

Legal Implications:

(Authorised by the Borough Solicitor)

F1 of the Council's Procurement Standing Orders applies in this instance. Where there is current provision in a contract for extension this must be approved first by the relevant Director and then the Borough Solicitor and Chief Finance Officer in consultation with the Member for Performance and Finance and relevant portfolio holder for the service.

The Borough Solicitor and Chief Finance Officer who both attend the meeting need to be satisfied of the sufficiency of governance should the Board agree to an extension, and advise on any further governance required after the decision on 20 June 2018.

How do proposals align with Health & Wellbeing Strategy?

The proposals align with the Developing Well, Living Well and Working Well programmes for action

How do proposals align with Locality Plan?

The service is consistent with the following priority transformation programmes:



- Enabling self-care
- Locality-based services
- Planned care services

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

- Empowering citizens and communities

- Commissioning for the 'whole person'
- Creating a proactive and holistic population health system

Recommendations / views of the Professional Reference Group:	Reported directly to the Strategic Commissioning Board.
Public and Patient Implications:	None
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside
What are the Equality and Diversity implications?	<p>The proposal will not affect protected characteristic group(s) within the Equality Act.</p> <p>The service will be available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, marriage / civil and partnership.</p>
What are the safeguarding implications?	None
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the provider's contingency plan..
Access to Information :	<p>The background papers relating to this report can be inspected by contacting</p> <p>Sue Hogan</p> <p> Telephone: 0161 342 2890</p> <p> e-mail: sue.hogan@tameside.gov.uk</p>

1 BACKGROUND

- 1.1 The contract is for the delivery of a garden maintenance and day support service at supported domestic properties in Tameside.
- 1.2 The service consists of two components:
 - 1.2.1 A core domestic gardening and grounds maintenance service delivered to a set number of supported domestic properties in Tameside, where tenants have learning disabilities or mental health conditions.
 - 1.2.2 A day support element for two people with learning disabilities for who the service will meet some or all of their assessed needs
- 1.3 The core domestic gardening and ground maintenance service is currently delivered to 43 domestic properties across the borough. This number may vary from time to time as people using the service change address within the borough, move away from the borough, or some other reason, cease to need the service.
- 1.4 The provider makes provision for the day service element to deliver up to five places per week, Monday to Friday. The two people currently engaged with the service will have no set time limit for their continuation in the service. Consequently, they may remain with the service for the length of the contract or may, at some point, cease engagement.
- 1.5 The provider is also on the Council's Approved List of Day Services, which attracts a direct payment for each supported person. Therefore the above day support provision will be paid at £31.37 per person per day based on five places per week.
- 1.6 If one or both people cease use of the service, service delivery will continue based solely on the garden maintenance element unless there is a further referral into the service via the approved list provider.

2 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

- 2.1 Authorisation required under Procurement Standing Order F1.3 to extend the above contract by two years where this is provided for within the terms of the contract.

3 VALUE OF CONTRACT

- 3.1 The contract value is £35,604.
- 3.2 The provision of garden maintenance is identified and funded through Housing Benefits that the Service Users who live in the properties receive. Claims made by individuals for housing benefit fund the contract value in full.

4 GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

- 4.1 Following a competitive tender process in 2015 Greenscape was awarded the contract.
- 4.2 The contract was for a period of three years with an option to extend for a further two years.
- 4.3 Performance monitoring of the service has been positive and Greenscape engage well with the commissioners.

4.4 Since the contract commenced there has been no inflationary increase.

5. REASONS WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED

5.1 Procurement Standing Order F1.3 permission must be sought to extend a contract where the provision to extend is included within the contract.

5.2 The option to recommission the service and conduct a full tender exercise has been looked at but as the current provider is delivering the service in a positive way and engaging well with commissioners this has not been considered.

5.3 The option to no longer commission the service has been looked at but this has been rejected as the provision of Garden maintenance is identified and funded through Housing Benefits that the Service Users who live in the properties receive. The Housing benefits fund the contract value.

5.4 Tameside commissioners will continue to monitor the performance of the service.

6. RECOMMENDATIONS

6.1 As set out on the front of the report.

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 June 2018

Officer of Single Commissioning Board Stephanie Butterworth, Director of Adult Services

Subject: **MENTAL HEALTH COMMUNITY BASED SERVICES**

Report Summary: The report is seeking authorisation for approval to be given under Procurement Standing Order F1.3 to extend the above contract by two years from 1 April 2019 to 31 March 2021 where this is provided for within the terms of the contract.

The report outlines the service being provided, indicates the redesign work completed in partnership, and indicates the outcomes being achieved with people with mental health problems thereby making the case to extend the current contract as allowed in the existing agreement.

Recommendations: The Board are RECOMMENDED TO APPROVE a contract extension for two years from April 2019.

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

ICF Funding Stream:	Section 75
Decision Required by:	Strategic Commissioning Board
Organisation and Directorate:	TMBC – Adult Services
Budget - £'000	157
Comments The Council's medium term financial planning assumptions for this contract includes estimated inflationary increases due to proposed increases in the National Living Wage. This inflationary provision will be considered within the negotiation of contract values for the two year extension period.	

Legal Implications:
(Authorised by the Borough Solicitor)

F1 of the Council's Procurement Standing Orders applies in this instance. Where there is current provision in a contract for extension this must be approved. This is to ensure contracts are not rolled over without proper consideration of whether still necessary strategically, meeting necessary aims, still represent value for money, whether they can be undertaken more cost effectively by same provider if extended and whether performance adequate etc.



How do proposals align with Health & Wellbeing Strategy?

The proposals align with the Developing Well, Living Well and Working Well programmes for action

How do proposals align with Locality Plan?

The service is consistent with the following priority transformation programmes:

- Enabling self-care
- Locality-based services

	<ul style="list-style-type: none"> Planned care services
How do proposals align with the Commissioning Strategy?	<p>The service contributes to the Commissioning Strategy by:</p> <ul style="list-style-type: none"> Empowering citizens and communities Commission for the 'whole person' Create a proactive and holistic population health system
Recommendations / views of the Professional Reference Group:	Reported directly to the Strategic Commissioning Board.
Public and Patient Implications:	None
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside
What are the Equality and Diversity implications?	<p>The proposal will not affect protected characteristic group(s) within the Equality Act.</p> <p>The service will be available to Adults with a mental health need regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, marriage/ civil and partnership.</p>
What are the safeguarding implications?	None
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	There are no anticipated financial risks, however, there may be other risk considerations should individuals not receive the support in their recovery journey which may result in relapse and the need for a step up in services such as inpatient admission.
Access to Information :	<p>The background papers relating to this report can be inspected by contacting Sue Hogan by:</p> <p> Telephone: 0161 342 2890</p> <p> e-mail: sue.hogan@tameside.gov.uk</p>

1 BACKGROUND

- 1.1 Following a competitive tender process in 2015, Turning Point was awarded the contract to deliver a community recovery service.
- 1.2 The contract commenced 1 April 2016 for a period of three years. There is an option to extend this contract for a further two years, subject to approval and negotiation between the parties to 31 March 2021.
- 1.3 The service is available to people receiving mental health services under the Care Act Eligibility Guidance in that:
 - Each person has eligible needs;
 - Each person is ordinarily resident in the borough of Tameside.
- 1.4 The delivery of a recovery-focussed community support service remains integral to the effective functioning of the Community Mental Health Teams (CMHT) and to the support provided to people with severe and enduring mental health issues.
- 1.5 The aims of the service are to provide community-based support for people recovering from mental ill-health through the delivery of a model based on the principles of recovery and rehabilitation that enables individuals to move through the service to independence.
- 1.6 These aims are delivered through partnership working with individuals, care co-ordinators and other stakeholders, to facilitate planned interventions and actively promote social inclusion for each person in a variety of ways that includes, but is not restricted to:
 - Promoting access to training, employment, welfare benefits, voluntary activity and mainstream opportunities in the community and beyond where appropriate
 - Encouraging and empowering people to make their own informed decisions
 - Maintaining the provision of support in times of crisis and stress
 - Offering routes to leisure and social activities that promote social interaction and stimulation.
- 1.7 Performance management of the contract has focused on the delivery of outcomes and best practice in demonstrating a recovery and rehabilitation model. The provider, in collaboration with commissioners has worked to demonstrate that individuals are receiving an appropriate level of support, achieving outcomes in terms of their recovery journey and the right approach to enable individuals to move on from the service.
- 1.8 At the initial outset of the contract, the provider identified blockages in delivering a recovery model in that a considerable number of individuals were only accessing the service for medication prompts. To deliver this and ensure medication call times were met across the whole borough, a considerable amount of staff resource was required on a rota from 7am to 10pm. This freed up little time for recovery work within the remaining resource allocated to the service. In addition, on speaking to people accessing the medication calls, those individuals themselves reported they were tied into waiting for staff calls throughout the day, restricting their daily life and a number also felt they could be independent in this area. Turning Point have therefore worked in partnership with all parties including CMHTs to support individuals to safely and successfully manage their own medication administration. From the initial twenty people who required medication prompts, at end of year reporting for 2017, there are now just four people accessing support.
- 1.9 In realising the release of this resource, Turning Point has developed the service with a number of peer led and other support groups including allotment, walking, cook and eat, IT, benefits advice and understanding depression amongst others. In addition Turning Point

has supported two people who accessed the service to become active volunteers with one person moving into paid employment with the organisation.

- 1.10 The detail in clause 1.8 and 1.9 demonstrates the ability of the provider to work effectively and creatively in meeting the outcomes of the contract.

2 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

- 2.1 Authorisation required under Procurement Standing Orders F1.3 to extend the contract for two years where there is provision to do so.

3 VALUE OF CONTRACT

- 3.1 As part of the procurement exercise for the award of this contract, service redesign was considered that gave more emphasis on how it would fit alongside the CMHT's in-house community support worker capability. The main emphasis of the redesign was to have a service that had an even more enhanced emphasis on wherever possible, supporting individuals out of the service in a safe and timely manner.
- 3.2 The redesign also took into consideration budgetary pressures and a saving of £80,000 on the contract price at that time. The maximum first year budget available from 1 April 2016 was £160,000 per annum. Turning Point tendered a price of £157,342 and has delivered at this cost for the financial year 2016/17 and 2017/18 and with no inflationary increase in 2018/19. The indication is that Turning Point will require an uplift for inflation in 2019/2020 given they have held the price for the current three year period – this will be negotiated in conjunction with the Finance

4 GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

- 4.1 Following a competitive tender process in 2015 Turning Point was awarded the contract.
- 4.2 The contract was for a period of three years with an option to extend for a further two years.
- 4.3 Performance monitoring of the service has been positive and Turning Point engage well with the commissioners.
- 4.4 Since the contract commenced there has been no inflationary increase.

5. REASONS WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED:

- 5.1 All service users have been assessed as having eligible needs as defined in the Care Act 2014 or may be subject to Section 117 aftercare. Failure to provide the service would therefore put service users at risk and may increase the numbers who relapse on their recovery journey requiring higher level support services.

6 RECOMMENDATIONS

- 6.1 As set out on the front of the report.

Report to: **STRATEGIC COMMISSIONING BOARD**

Date: 20 June 2018

Officer of Single Commissioning Board Stephanie Butterworth – Director of Adult Services

Subject: **LIST OF APPROVED DAYTIME ACTIVITIES**

Report Summary: The report describes the rationale for an extension of the above contract for a period of two years where there this is provided for within the terms of the contract.

Recommendations: The Board are RECOMMENDED TO APPROVE a contract extension for two from 30 November 2018.

Financial Implications:

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

ICF Funding Stream	Section 75
Decision Required By	Strategic Commissioning Board
Organisation and Directorate	TMBC – Adult Services
Budget - £'000	£727

Comments

There is sufficient recurrent budget to support the contract value (£666k). It is essential that robust contract and performance monitoring arrangements remain in place to ensure expenditure is in line with the value of the contract during the extension period.

Members should be satisfied that the existing contract is demonstrating value for money before approving the proposed extension.



Legal Implications:

(Authorised by the Borough Solicitor)

F1 of the Council's Procurement Standing Orders applies in this instance. Where there is current provision in a contract for extension this must be approved.

The Board should be satisfied that this service is providing value for money, is being effectively monitored, and is compliant with the public law fiduciary duty, particularly given it's high monetary value, before agreeing to the extension.

It is not clear from the report as to whether this is the case, and why this provider is preferred over going to the market sooner, given a 2 year extension is requested and the only justification provided is to is required in order to enable continuity of Day Services to the people who use them. Clearly this is important, however, the Board are obliged to ensure this is delivered in the most cost effective and efficient way. It is therefore difficult to see how from the evidence before it the Board the Board can see that the contract is delivering value for money. There is no comparative data to show how it is competitive or a better outcome wouldn't be achieved from procurement, nor does it set out a reason why procurement not appropriate because a service redesign taking place etc.

How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action.
How do proposals align with Locality Plan?	<p>The service is consistent with the following priority transformation programmes:</p> <ul style="list-style-type: none"> • Enabling self-care • Locality-based services • Planned care services
How do proposals align with the Commissioning Strategy?	<p>The service contributes to the Commissioning Strategy by:</p> <ul style="list-style-type: none"> • Empowering citizens and communities • Commissioning for the 'whole person' • Creating a proactive and holistic population health system
Recommendations / views of the Professional Reference Group:	Reported directly to the Strategic Commissioning Board.
Public and Patient Implications:	None
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside
What are the Equality and Diversity implications?	<p>The proposal will not affect protected characteristic group(s) within the Equality Act.</p> <p>The service will be available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender re-assignment, pregnancy/maternity, marriage / civil and partnership.</p>
What are the safeguarding implications?	None
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider. The purchasers Terms and Conditions for services contains relevant clauses regarding Data Management.
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the provider's contingency plan.
Access to Information :	<p>The background papers relating to this report can be inspected by contacting Linsey Bell – Contracts and Commissioning Officer, Adults Directorate by:</p> <p> Telephone: 0777323370</p> <p> e-mail: Linsey.bell@tameisde.gov.uk</p>

1. BACKGROUND

- 1.1 A Key Decision in February 2011, resulted in a review of the Council's in-house learning disabilities day services which, in turn, saw the closure of two day centres and the commencement, in the summer of 2013, of a list of approved daytime activities. It was hoped that this list would, in part, stimulate the market to deliver innovative, responsive, more cost effective models of provision that better meet individual outcomes.
- 1.2 Inclusion on the list of approved daytime activities was advertised initially on The Chest during May 2013 with a focus in the first instance on older people and people with learning disabilities, but taking where appropriate, a more generic approach.
- 1.3 Successful organisations were included on the list in August 2013. Organisations included a description of their service which included the times of the service, how it is delivered and price per person per day with a maximum contribution from the Council of £31.37 per person per day. This was included in the contract and is used by care-coordinators and service users to inform decisions. The list was subsequently left 'open' so that organisations with new daytime options could apply at any point.
- 1.5 Approval was gained to re-advertise the approved list and a tender exercise commenced in July 2016.
- 1.6 Financially, the list is based on those people eligible for services paying £31.37 (excluding HC-One) per day/activity from their personal budget. Provider organisations are at liberty to charge more and/or to have a 'menu' of prices for people depending on their circumstances, but Adult Services only pay the £31.37 daily rate. Usage and payment is facilitated via the Homecare Commissioning Team.
- 1.7 The unit cost per person per day for HC-One is £35.88, this has been agreed due to the service offering a breakfast and a lunch within the unit cost.
- 1.8 Inclusion on the list brings no guarantee of placements/business, but service users have access to the list of approved day services from which to choose. Indeed, from a service user perspective, the arrangement allows for a more personalised range of options to be purchased from 'trusted' providers that have had their economic standing and their proposed service evaluated by the Council.
- 1.9 Whilst there are a number of larger organisations on the framework, notably HC –One and Mencap, there is also a range of small micro enterprises and local 3rd sector organisations. To date, nine organisations in total are on the framework with all contracts running through to 30 November 2018, for further detail see list of Approved Day Services attached as Appendix 1.
- 1.10 As of week commencing 14 May 2018, there were 460 places per week commissioned for 203 people.
- 1.11 The key aims and objectives of the service are to provide day time support/activities for people who are eligible for publically funded care and support.

2 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

- 2.1 Authorisation required under Procurement Standing Orders F1.3 to extend the contract for two years where there is provision to do so.

3 VALUE OF CONTRACT

- 3.1 The value of the contract for period 1 April 2017 to 31 March 2018 was £665,936.

4 GROUNDS UPON WHICH WAIVER/AUTHORISATION TO PROCEED SOUGHT

- 4.1 The current arrangement is due to expire on 30 November 2018. An extension for up to 2 years to 30 November, 2020 is required in order to enable continuity of Day Services to the people who use them.

5. REASONS WHY USUAL REQUIREMENTS OF PROCUREMENT STANDING ORDERS NEED NOT BE COMPLIED WITH BUT BEST VALUE AND PROBITY STILL ACHIEVED

- 5.1 Procurement Standing Order F1.3 permission must be sought to extend a contract where the provision to extend is included within the contract
- 5.2 Daytime activities for older people and people with disabilities can constitute a key part of the overall care and support that they require in terms of ensuring a degree of social inclusion, learning and retaining daily living skills and improving quality of life. Where carers and family are involved, involvement in daytime activities can provide an important level of respite, enabling people to remain living at home.
- 5.3 Provider organisations on the list will continue to deliver services to a range of vulnerable people who choose to use the services.

6 RECOMMENDATIONS

- 6.1 As set out on the front of the report.

LIST OF APPROVED DAY SERVICES

PROVIDER	LOCATION	HOURS
Mencap	Tameside Business Park, Denton	8 am – 3 pm Monday – Friday
HC-One	Fir Trees, Dukinfield Greatwood House, Denton	9 am – 4 pm Monday - Sunday
People First Tameside	St. Michaels Court, Ashton New Chapel, Denton	10 am – 3 pm Monday - Friday
Pure Innovations	Etherow Country Park, Compstall	10 am – 4 pm Monday - Friday
Tameside Arts	New Chapel, Denton The Jigsaw Centre. Hyde The Oasis, Denton Community College, Denton Astley Arms, Dukinfield	Monday 9 am – 3 pm (New Chapel) Tuesday, Wednesday, Thursday 9 am – 3 pm Friday 9 am – 3 pm The Oasis Tuesday Evening 6 pm – 8 pm (Community College) Wednesday Evening 6.45 pm – 8.45 pm (Astley Arms, Dukinfield)
Active Tameside	Medlock Sports Centre, Ashton	Monday – Friday 9.30 am – 3 pm
Tameside Countryside - Wildways	Lymefields Visitors Centre	Monday 9 am – 3 pm
Greenscape	Grange Road, Hyde	Monday – Friday 9 am – 3 pm
Noahs Art	Loxley House	Monday – Friday 10.00am-14.30pm

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Report to: STRATEGIC COMMISSIONING BOARD

Date: 20 June 2018

Reporting Member / Officer of Single Commissioning Board Jessica Williams, Interim Director of Commissioning

Subject: PRIMARY CARE ACCESS SERVICE – PROCUREMENT EVALUATION STRATEGY

Report Summary: The purpose of this report is to inform NHS Tameside and Glossop Clinical Commissioning Group (CCG) Senior Leadership Team and Strategic Commissioning Board of the proposed Procurement and Evaluation Strategy (PES) to be used in the procurement of the Primary Care Access Service.

Recommendations: To RECOMMEND TO THE CCG that:

1. approval is given to the proposed procurement and evaluation strategy, procurement timetable, financial envelope, contract term, evaluation questions, evaluation methodology, Official Journal of the European Union (OJEU) advert and to note any risks identified.
2. approval is given for the use of electronic tendering systems and approval for an authorised representative from North of England Commissioning Support (NECS) to open the bids on behalf of the CCG.

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

ICF Funding Stream	Section 75: £2.004 million recurrent CCG Aligned: £0.807 million recurrent
Decision Required By	Strategic Commissioning Board & CCG GB
Organisation and Directorate	CCG – Primary Care Commissioning
Budget - £'000	£2.811 million is the current recurrent budget but the value reported for procurement is being set inclusive of 15% efficiency to go towards economy gap (ie. savings of £0.413 million).
Comments This paper has been reviewed from a finance perspective and further clarity sought as there are areas where it would have been helpful to seek finance comments earlier in the process. It is important to highlight that the affordability limit must be inclusive of a 15% efficiency as an <u>absolute</u> minimum. When the tender is issued, VAT and inflation considerations must also be incorporated and not present any financial pressures.	

Finance colleagues question whether a five year contract term with a potential for an extension/ break clause subject to contract performance or change in circumstances would be more appropriate for a completely new type of service provision. Ten years without the above measures could potentially expose the Strategic Commission to a higher level of risk should the service not deliver in line with expectations.

It is felt the presentation of the information could be improved particularly regarding the financial values. Table 3 is a particular case in point and it is important to highlight that the total contract value being reported is for the full contract term comprising several years.

**Legal Implications:
(Authorised by the
Borough Solicitor)**

The procurement must be undertaken in accordance with the constitutional requirements of commissioning body and comply with national and international procurement legislation. Clarity will be required at the meeting as to what budget this fall in in order to determine the decision making body.

**How do proposals align with
Health & Wellbeing Strategy?**

Improved model of delivery for patients accessing care out of hospital.

**How do proposals align with
Locality Plan?**

An integrated approach to delivery of care is key to the service model in line with Care Together ethos.

**How do proposals align with
the Commissioning
Strategy?**

The service will provide improved access to services, simplifying the pathway to access care for patients. Consolidation of existing provision into a single contract will offer financial efficiencies.

**Public and Patient
Implications:**

Full 12 week consultation and engagement has been carried out in advance of this procurement taking place. Issues and mitigations have been identified.

Quality Implications:

Equality Impact Assessment carried out as part of the consultation exercise prior to procurement. Access and patient experience considerations integral to the service model.

**How do the proposals help
to reduce health
inequalities?**

Provision across five neighbourhood based hubs to provide equity of access to the whole population.

**What are the Equality
and Diversity
implications?**

Full EIA completed as part of the consultation process identified transport and travel as a key factor affecting access. Mitigating actions identified to address concerns.

**What are the
safeguarding
implications?**

None

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

None

Risk Management:

Procurement risks register in place.

Access to Information :

The background papers relating to this report can be inspected by contacting, Janna Rigby, Head of Primary Care;



Telephone: 07342 056001



e-mail: janna.rigby@nhs.net

Procurement and Evaluation Strategy

NECS305

*Primary Care Access Service
For and on behalf of: NHS Tameside and
Glossop Clinical Commissioning Group*

*Stephanie Cox
Procurement Officer*

Document	Initials	Date
Developed:	SC	29/05/2018
Quality checked:	MR	31/05/2018



1. Purpose

The purpose of this paper is to:

- 1.1. Inform NHS Tameside and Glossop Clinical Commissioning Group (CCG) Senior Leadership Team and Strategic Commissioning Board of the proposed Procurement and Evaluation Strategy (PES) to be used in the procurement of the Primary Care Access Service.
- 1.2. Request approval of the proposed procurement and evaluation strategy, procurement timetable, financial envelope, contract term, evaluation questions, evaluation methodology, Official Journal of the European Union (OJEU) advert and to note any risks identified.
- 1.3. Request approval for the use of electronic tendering systems and approval for an authorised representative from North of England Commissioning Support (NECS) to open the bids on behalf of the CCG.
- 1.4. Request that the date of the Recommended Bidder Report (RBR) is noted and this item is added to the agenda for the Strategic Commissioning Board on the 29th August 2018.
- 1.5. Request that the minutes of this meeting for this agenda item are forwarded to: necsu.neprocurement@nhs.net for audit purposes.

2. Background

- 2.1 The current Out of Hours Service including the Alternative to Transfer Service was commissioned approximately 7 years ago and has been extended 3 times. The current Out of Hours Service including Alternative to Transfer Service is delivered by GotoDoc.
- 2.2 The CCG did not undertake a competitive process when awarding the extended access contract. The Extended Access Service is delivered by Orbit (GP Federation).
- 2.3 Both contracts expire on 30th September 2018 and notice has been given.
- 2.4 A review of the service has identified through public consultation that an integrated out of hours and extended access service including alternative to transfer would benefit service users.
- 2.5 The aim of the service is to deliver a comprehensive Primary Care Access Service for patients. The Primary Care Access Service will ensure a 24/7 access offer is available to patients within primary care for both routine and same day/urgent demand. Key to the delivery of the service is the simplification of access to urgent care whilst improving the level of service available. Multiple access points will be replaced by telephone access through a patient's own GP practice to book appointments as well as a single location for urgent walk-in services. This will reduce the need for people to 'self-triage' i.e. decide if it is A&E or another service they need, and maximise opportunities for people to receive the right care in the right place at the first appointment. In addition, neighbourhood support will be strengthened through increased evening and weekend appointments alongside advice and treatment available through local opticians and pharmacists.
- 2.6 In order to develop the specification and establish the best method for securing

services a project group was established made up of the relevant subject matter experts which included:

- Head of Primary Care, Tameside and Glossop CCG
- Procurement Officer, NECS
- Head of Primary Care Finance, Tameside and Glossop CCG
- Deputy Director of Commissioning, Tameside and Glossop CCG
- Interim Director of Commissioning, Tameside and Glossop CCG
- Governing Body GP, Tameside and Glossop CCG
- Health and Social Care Estates Business Manager, Tameside and Glossop CCG
- GP IM&T Project Manager, Tameside and Glossop CCG
- Lead Designated Nurse Safeguarding, Tameside and Glossop CCG
- Quality and Patient Safety Lead, Tameside and Glossop CCG
- Head of Business Intelligence and Performance, Tameside and Glossop CCG
- Assistant Chief Operating Officer and Company Secretary, Tameside and Glossop CCG

- 2.7 A market engagement tool was completed and the recommendations from the tool were that Market Engagement was advisable.
- 2.8 Due to time restrictions to ensure the new service is in place by 1st October 2018 the lead of the project group agreed that Market Engagement would not be carried out.
- 2.9 The market engagement tool can be found at Appendix 1 to this report for information purposes.

3. Procurement Objectives

- 3.1 The procurement strategy is in place to ensure, in line with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 that the following objectives will be met:

3.1.1 Regulation 2 (a): securing the needs of the people who use the services;

- The service will provide primary care access services for the population of Tameside and Glossop;
- The integrated service will ensure that patients will be seen by the right professional for their care needs at the right time and place; and
- Extends patient choice by allowing patients to access any of the five hubs.

3.1.2 Regulation 2 (b): improving the quality of the services;

- The integrated service will ensure that patients will be seen by the right professional for their care needs at the right time and place;
- Improvement of information sharing between services resulting in better quality treatment;
- The service will improve the wider communities' understanding of primary care services pathways by providing a clear single point of access for patients; and
- Patient management will be improved as a result of additional access to primary care.

3.1.3 Regulation 2 (c): improving efficiency in the provision of the services;

- The service will be part of an integrated pathway which will facilitate a faster referral of patients into the relevant services, e.g. there will be a reduction in time taken to receive assessment by the most appropriately trained professional;
- The service will direct patients to the right professional to deliver their care therefore avoiding inappropriate referrals therefore saving time and money whilst improving patient experience; and
- The provider will work to a key set of national and local performance indicators in line with up-to-date policies, guidance and frameworks.

4. Compliance with the Public Services (Social Value) Act 2012

4.1 Under the Public Services (Social Value) Act 2012 the Contracting Authority must consider;

- How the proposed service to be procured may improve the economic, social and environmental well-being of Tameside and Glossop and
- How in conducting the process of procurement, it might act with a view to securing the improvement.

4.2 The service will offer people the opportunity to access primary care services across Tameside and Glossop. Delivery of the Primary Care Access Service across five hubs located within each of the neighbourhood areas of Tameside and Glossop will improve access for patients across the locality, acknowledging transport and travel as well as service operating times to access the service. This will then be evaluated in the technical evaluation as per the evaluation criteria detailed in this report.

4.3 Improvements will be achieved in the following ways:

- The service will ensure the population has 24/7 access to primary urgent care provision;
- The service will have quality outcomes aligned to the wider urgent care system and through commissioning a system service, consistency of quality delivery will be a given;

- The Primary Care Access Service contract will incorporate access to activity which is currently provided through 3 separate services. The procurement will remove the layering of services and contracts, with single premise, workforce and IT costs; and
- Simplification of access for patients will ensure they are provided with the appropriate care for the need that they present with. The service will be delivered from 5 hubs, one in each of the integrated neighbourhood areas within the locality.

5. Procurement Methodology

- 5.1 As a public body the CCG is required to comply with Public Contract Regulations 2015 (with effect from 18 April 2016) in respect of Health Care Services under the Light Touch Regime, Regulations 74 – 76 and the National Health Service (Procurement, Patient Choice & Competition) (No. 2) Regulations 2013.
- 5.2 A Prior Information Notice (PIN) was published on 23rd May 2018 to raise awareness within the market of the upcoming procurement. A bidder event will also be held to explain the procurement process to potential bidders.
- 5.3 Due to the value of the contract and in line with the Contracting Authority Detailed Financial Policies (DFPs), the project group have appraised the risks and benefits of each option and have concluded that a procedure which follows the basic principles of an Open Procedure is the most appropriate due to the amount of interest within the market to deliver the services required as part of the specification.
- 5.4 Bidders will be tested on the capacity, capability, and technical competence of the submission in accordance with the Light Touch Regime within The Public Contracts Regulations 2015¹.
- 5.5 The procurement will be advertised in the Official Journal of the European Union (OJEU) and on Contracts Finder, the United Kingdom Government's single platform for providing free access to public procurement related information and documentation, as governed by the Public Contracts Regulations 2015, the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013, the Public Services (Social Value) Act 2012, and the Contracting Authority DFPs.
- 5.6 NECS provides assurance that the procurement process is compliant with Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (2017) and that all required standards are complied with for those parts of the procurement process which are undertaken on behalf of the CCG.

6. ETendering

- 6.1 The Invitation to Tender and supporting documents will be available to download via a dedicated NECS eTendering portal.

¹ http://www.legislation.gov.uk/ukxi/2015/102/pdfs/ukxi_20150102_en.pdf

- 6.2 NECS utilise a secure electronic tendering system. Online tenders are published and received into a secure online eTendering portal. The bids can only be accessed by specified representatives on the pre-determined tender closing date. NECS is proposing that an authorised representative is given approval to open bids on behalf of the CCG for this procurement. This will ensure that bids are opened in the agreed timeframe.

7. Procurement Timetable

- 7.1 Table 1 shows the key milestones and timescales for the proposed procurement process.

Table 1

Milestone	Description	Date
Procurement and evaluation strategy approval	PES approved by Tameside and Glossop CCG Strategic Commissioning Board	20 th June 2018
Publish advert	Advert published via OJEU and on Contract Finder	25 th June 2018
Invitation to Tender issued	Tender published live on PROACTIS website	25 th June 2018
Bidder event	Event to explain procurement process and documentation	w/c 2 nd July 2018
Tender deadline	Date by which bids need to be submitted	23 rd July 2018
Consensus scoring	Evaluator panel meeting to agree scores for bidders	1 st August 2018 – 3 rd August 2018
Presentation	Presentation from Bidders – Stage 4	7 th August 2018
Recommended bidder report	Report to CCG Strategic Commissioning Board to approve successful bidder	29 th August 2018
Standstill period	Notification to bidders of outcome, allowing 10 days for any challenges to be raised	31 st August 2018 – 10 th September 2018
Contract award	Official offer of contract sent to successful bidder	11 th September 2018
Contract signature and mobilisation	Mobilisation of contract	12 th September 2018 - 1 st October 2018
Service commencement	Service start date	1 st October 2018

8. Evaluation Strategy

- 8.1 The evaluation model proposed seeks to identify the Most Economically Advantageous Tender (MEAT), which is interpreted as the highest combined quality and price score, the evaluation criteria are outlined in Table 2, the full set of evaluation questions are attached within Appendix 3.

Table 2

Section		Question Ref.	Question Topic	Red Flag Question	Micro Weighting %	Macro Weighting %
Quality	Section 1 Clinical & Service Delivery	CSD01	Accessibility	Red Flag	6	25
		CSD02	Equity of Service & Equality		5	
		CSD03	Partnership working		6	
		CSD04	Referrals		3	
		CSD05	Estates	Red Flag	PASS/ FAIL	
		CSD06	Mobilisation	Red Flag	5	
	Section 2 Quality	QTY01	Performance		6	20
		QTY02	Continuous Improvement		3	
		QTY03	Patient Involvement		4	
		QTY04	Patient Experience		4	
		QTY05	Medicines Management		3	
	Section 3 IM&T	IMT01	IT Systems		5	10
		IMT02	Information Governance		5	
	Section 4 Workforce	WF01	Organisational Structure and Workforce	Red Flag	5	10
		WF02	Recruitment & Retention		3	
		WF03	Workforce Supervision & Training		2	
	Section 5	GOV01	Clinical Governance		6	10

	Governance					
		GOV02	Business Continuity		4	
	Presentation	PR01	Mobilisation Presentation		5	5
Finance	Finance	FMT01	Bid Price and Affordability		20	20
	Sub-total for Quality					75
	Presentation					5
	Finance					20
	Total					100

8.2 The evaluation process is made up of four stages as detailed below.

8.2.1 Stage 1 – Compliance

The information supplied in the bid response by each bidder will be checked for completeness and compliance with the requirements of the ITT before responses are evaluated. The preliminary compliance review will check that submissions:

- have answered all questions (or explained satisfactorily if considered not applicable);
- have included all documents as requested and those documents are presented in the format and named as requested; and
- have submitted a bid within the affordability limit of £2,389,000 per annum and £23,890,000 for the contract term.

Bids received in excess of the affordability envelope for any one year and/or for the contract duration will fail and the bidders submission will not be evaluated any further and the bidder will not be awarded a contract by the Contracting Authority.

8.2.2 Stage 2 – Capability and Capacity

To assess whether the potential bidder and its relevant organisations:

- are eligible to be awarded a public contract, as detailed in Regulation 57 of the Public Contracts Regulation 2015;
- are in a sound economic and financial position to participate in the procurement;
- have the necessary resources and core competencies available to them; and
- Evaluation of the Financial Model Template (FMT).

Bidders who fail any part of stage 2 will take no further part in the procurement process and will not be awarded a contract by the Contracting Authority.

8.2.3 Stage 3 – Technical Evaluation

This stage of the evaluation is to assess the detailed bidder solutions to the service-specific questions and must:

- achieve a minimum score of 50% or more on all Red Flag questions*;
- achieve a minimum of 50% from the 75% available for all non-finance related criteria (quality). This does not include the presentation element of the evaluation process.

* Red Flag questions are those that have been identified as crucial for all bidders to achieve a minimum score. If a bidder does not achieve a minimum score of 50% for the red flag questions further evaluation of the ITT will not be undertaken and the bidder will not be taken any further in the procurement of the service.

Bidders who fail stage 3 will take no further part in the procurement process and will not be awarded a contract by the contracting authority.

Following the evaluation process of stages 1, 2 and 3 which will be carried out by a team of subject matter experts, a consensus score will be agreed.

8.2.4 Stage 4 – Presentation

Bidders that have progressed to this stage of the process will be asked to give a presentation as an element of the evaluation. This element of the process will require bidders to present their mobilisation plans in further detail. This stage of the process has a maximum score of 5% available.

Following the evaluation of stage 4, which will be carried out by a team of subject matter experts, a consensus score will be agreed.

8.2.5 Finance - Threshold and Financial Evaluation

Bidders will be advised that the CCG has an affordability limit of £23,890,000 over the 10 year contract (5 year initial contract period + 5 years extension period). Bidders will also be informed that there is a maximum affordability limit per contract year which has been set at £2,389,000.

Bidders will be required to submit a bid within or at the affordability envelope for each year of the contract including the 5 year extension period (years 1 – 10). Bids received in excess of the affordability envelope will be deemed not viable and will fail, in this instance the bidder's submission will not be taken any further in the evaluation process.

The affordability envelope per annum for this procurement is outlined in table 3.

**Table
3**

Contract Year	Affordability Limit (AL)
Year 1	£2,389,000
Year 2	£2,389,000
Year 3	£2,389,000
Year 4	£2,389,000
Year 5	£2,389,000
Year 6	£2,389,000
Year 7	£2,389,000
Year 8	£2,389,000
Year 9	£2,389,000
Year 10	£2,389,000
Total Contract Value	£23,890,000

The financial evaluation will test value for money. Bidders that meet the affordability limit will be measured by distance from the affordability limit and scored on a sliding scale. The sliding scale will be determined by the distance of the bid price from the affordability limit. The sliding scale will be calculated using the scale within table 4.

**Table
4**

Classification	Sliding Scale
AL	Affordability Limit (AL) - £2,389,000
AL1	Within 2% of AL
AL2	Within 3% of AL
AL3	Within 4% of AL
AL4	Within 5% of AL

Bids will be scored as detailed table 5 below:

**Table
5**

Total Bid Price	Score
Greater than AL	Fail
Equal to AL	0%
< than AL but \geq to AL1	5%
< AL1 but \geq AL2	10%
< AL2 but \geq AL3	15%
< AL3 but \geq AL4	20%

- 8.3 Following the evaluation process, which is carried out by a team of clinical and subject matter experts, a consensus score is agreed and the bidder who has passed each stage of the process and scored the highest combined score for quality and finance will be reported to the Contracting Authority as the recommended bidder.

9. Recommended Bidder

- 9.1 The recommended bidder will be the bidder who has met the requirements of the evaluation criteria and has submitted the Most Economically Advantageous Tender (MEAT) by scoring the highest combined score. This will have been evaluated against the published evaluation criteria. The MEAT will include capacity and capability evaluation as well as consideration of how bidders have calculated their costings.
- 9.2 In the event that two or more bidders achieve the same score, the bidder with the highest overall score in the clinical and service delivery section of the quality evaluation will be awarded the contract. In the event that two or more bidders still score the same marks the rule will be applied in the following order:
- Quality
 - Finance
 - Governance
 - Workforce
 - IM&T
 - Presentation

10. Financial Threshold

- 10.1 The financial threshold for this procurement is £23,890,000. The contract is for an initial contract period of 5 years with the option to extend for an additional 5 year period at the discretion of the CCG.
- 10.2 The maximum agreed budget per annum is £2,389,000.
- 10.3 The financial threshold has been determined from existing contract values with a QIPP Programme (Quality, Innovation, Productivity and Prevention) saving applied.

11. Potential Procurement Risks and Mitigation

- 11.1 Bids submitted exceed the affordability thresholds:
- Bidders will be notified of affordability thresholds within the ITT documentation;
 - Bidders will be notified of the implications if they do exceed the affordability threshold (bid will not be evaluated further).
- 11.2 Limited interest from potential bidders:
- A Prior Information Notice (PIN) was advertised via OJEU and on Contracts Finder on the 23rd May to raise awareness of the forthcoming procurement opportunity.
- 11.3 Submissions received do not meet the minimum quality thresholds outlined in the evaluation criteria:
- The ITT documentation contains instructions on how to ensure bids are compliant with the quality thresholds; and

- A bidder event will be held to explain the tender documentation, systems and processes to those who have expressed an interest in the procurement opportunity.

11.4 Conflicts of Interest;

- NECS provides assurance that the procurement process is compliant with Managing Conflicts of Interest: Revised Statutory Guidance for CCGs (2017) and that all required standards are complied with for those parts of the procurement process which are undertaken on behalf of the CCGs/NHS; and
- All members of the project group and any subsequent evaluators will be required to complete and sign a Conflict of Interest declaration.

11.5 Mobilisation period is insufficient;

- Due to the extremely tight timescales within this procurement process the mobilisation period is only 2.5 weeks however it has been agreed by the Head of Primary Care that a staggered mobilisation period will be appropriate. 3 out of 5 sites are to be accessible from the contract start date with the other 2 sites are to be accessible by 1st November 2018;
- The service specification and ITT documents will ensure that bidders are aware of the extremely short mobilisation period.

11.6 No market engagement activity undertaken to assist the capability and capacity of the market to deliver against the specification;

- Consultation undertaken to develop the service model

11.7 Challenge received from bidders or non-bidders

- Ensure procurement documentation is accurate and thorough;
- Ensure that the procurement documentation reflects the reports approved by the appropriate committee; and
- Ensure that the procurement is carried out to reflect the procurement treaty principles and is transparent, proportionate, give equality of treatment and gives mutual recognition to reduce the risk of challenge.

11.8 Red Flag questions and justification for each;

- Accessibility – Bidders must demonstrate that they have understood the key accessibility themes within the procurement, for example the delivery sites are to be within the 5 neighbourhoods within Tameside and Glossop CCG;
- Estates – Bidders must agree to undertake the Service from the sites identified by the CCG;
- Mobilisation – Bidders must understand and work with the CCG to ensure service commencement within 2.5 weeks from final contract award.
- Organisational Structure and Workforce – It is key that bidders understand and demonstrate how they will overcome any possible TUPE implications and

demonstrate that are able to undertake the service with the correct skill mix of staff within the affordability envelope.

12. Contract Term

- 12.1 The initial contract term for this service is from 1st October 2018 until 30th September 2023 (5 years) with the option to extend for a further 5 year period subject to satisfactory performance and at the discretion of the contracting authority.

13. Recommendations

The Strategic Commissioning Board are asked to:

- 13.1 Give the approvals sought for the procurement and evaluation strategy, procurement timetable, financial envelope, contract term, evaluation questions, evaluation methodology, Official Journal of the European Union (OJEU) advert and to note any risks identified.
- 13.2 Approve the opening of the tenders by the authorised representative of NECS.
- 13.3 Note the date for the recommended bidder report and this item is added to the meeting agenda on the 29th August 2018.
- 13.4 Note the request for minute references for the approvals requested, and that these minutes are sent to the following email address: necsu.neprocurement@nhs.net.

Stephanie Cox
NECS Procurement Officer

Procurement and Evaluation Strategy Appendices

Appendix 1 – Market Engagement Tool Outcome

Project Market Engagement Decision Scorecard - Final Report

EXECUTIVE SUMMARY

Project: Primary Care Access Service

Final Project Score: 51 out of 100

1. Innovation / Improvement Factor

If time allows, it would be worthwhile to learn more about potential innovation within the market

2. Complexity Factor

If time allows, it would be worthwhile to engage and inform the market

3. Political Factor

High political influence may be a risk factor if no market engagement is undertaken as part of this project

4. Value Factor

As this is a high value contract with identified barriers to the market, it is important to ensure market engagement is undertaken as part of this project

5. Demographic Factor

Better understanding of the market would be an advantage and if time allows, it would be worthwhile to engage and inform the market

6. Contractual Performance Factor

There have been no historic issues around current or previous contracts which ensures a good understanding and relationship around this service requirement

7. QIPP Savings Factor

If time allows, it would be worthwhile to engage and inform the market

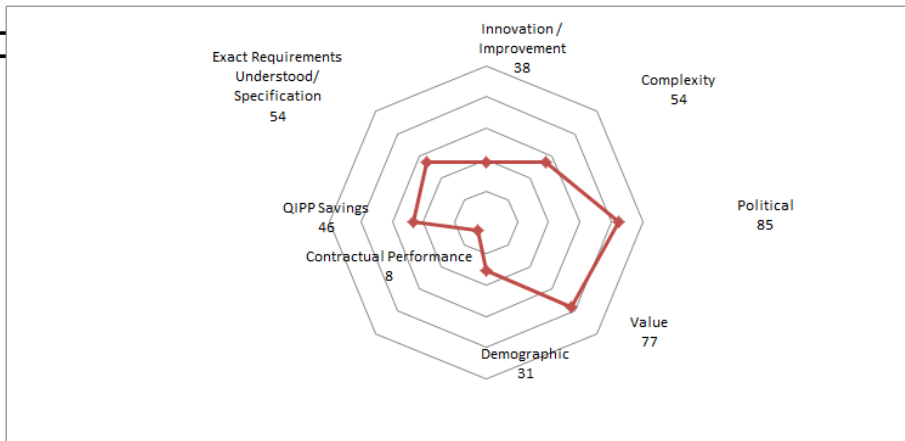
8. Exact Requirements Understood / Specification Factor

If time allows, it would be worthwhile to engage and inform the market

PROJECT FACTOR ANALYSIS

Project Factors	Score
Innovation / Improvement	5 out of 13
Complexity	7 out of 13
Political	11 out of 13
Value	10 out of 13
Demographic	4 out of 13
Contractual Performance	1 out of 13
QIPP Savings	6 out of 13
Exact Requirements Understood/ Specification	7 out of 13

The Relative Strengths & Weaknesses of the Project Factors (scale = 100 - lower % score is good. High peaks / high % score indicates factors of concern)



SUMMARY OF FINAL RECOMMENDATIONS

There is a fair to average understanding of the market and would recommend some market engagement such as request for information or a market engagement event.

Would be useful to utilise some category management market engagement tools to evidence understanding of market.

Appendix 2 – OJEU / Contracts Finder Advert Wording

North of England Commissioning Support (NECS) working, for and on behalf of NHS Tameside and Glossop Clinical Commissioning Group, wish to commission a Primary Care Access Service within Tameside and Glossop

The contract is for 5 years with the option to extend for a further 5 years. The initial contract term will commence on 1st October 2018, ending on 30th September 2023. The extension period, which will be awarded at the discretion of Tameside and Glossop CCG will commence on 1st October 2023 ending on 30th October 2028.

It is anticipated that the Tender documents will be made available to view on the Proactis portal on Monday 25th June 2018.

NECS is utilising an electronic tendering tool to manage this procurement and communicate with potential providers. There will be no hard copy documents issued to potential providers and all communications with NECS, including your submission, will be conducted via the portal:

<https://www.proactisplaza.com/SupplierPortal/?CID=NECS>

The portal is hosted by Proactis. It is free to register on the portal but if you have any problems registering on the portal, you should contact PROACTIS via either

Email: Suppliersupport@proactis.com or

Website: <http://proactis.kayako.com/suppliernetwork/Core/Default/Index> (Monday to Friday, 8:30 to 17:00).

The deadline for submission of all bids is 12 Noon on 23rd July 2018

Potential Bidders are to note: It is anticipated that the Transfer of Undertakings (Protection of Employment) Regulations 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment) Regulations 2014 (TUPE) will apply for this contract. Potential Bidders are advised to form their own view on whether TUPE applies, obtaining their own legal advice and carrying out due diligence.

Appendix 3 – Evaluation Questions

Section: Clinical & Service Delivery		Macro Weighting 25%
Question No: CSD01	Question: Accessibility	
<p>Please describe how you will deliver the service to ensure it is accessible and equitable to patients</p> <p>With reference to tender documentation, Bidders must describe how they will deliver the service to ensure it is accessible to patients as identified in the service specification.</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none">• Description of booking appointment system, including; face to face, telephone, e-mail, fax, text and options for on-line booking facilities• Consultation methods offered to patients including telephone triage• How will the service balance demand for urgent and routine appointments; including capacity for booking via NHS 111 and other providers including general practice• Compliance with service access requirements• Shared use of patient records and administration relating to patient appointments• How the provider will ensure effective engagement with relevant stakeholders including pharmacies and care homes• Processes for advising patients on services available to them; including the Urgent Treatment Centre (when available)• Description of how the service will offer home visiting and End of Life Care• Should reflect an appreciation of the diversity of T&G CCG communities and recognition that differentiated approaches are required to ensure equity of access and outcomes, including people powered change.• Actions to increase the use of digital technology to improve how people access care, including opportunities to improve access to advice, consultation and treatment through use of digital technology and how records are shared with the ambition of becoming paper free at the point of care. <p>The answer will contain specific, appropriate proposals - e.g. translation, building access, arrangements for sensory disabilities etc.</p>		
Micro Weighting: 6%		Character Limit: 11,400

Question No: CSD02	Question: Equity of Service and Equality
<p>How will you ensure equity of service and equality in delivery?</p> <p>The answer will reflect an appreciation of the diversity of T&G CCG communities and recognition that differentiated approaches are required to ensure equity in access and outcomes. The answer will make it clear how the provider will monitor access to ensure equity.</p> <p>Bidders must describe how they will deliver the service which will address the needs of the local population in respect of the individual practices taking into consideration the local varying demographics to ensure provision of a locally sensitive service.</p> <p>Response should make reference but not be limited to the following key areas:</p> <ul style="list-style-type: none"> • A consideration of the Equity of Access requirements as outlined in Part 1 of the Contract; • Compliance with the Public Sector Equality Duty Act 2010, describing your experience of working with a population of patients with diverse needs. • Elimination of unlawful discrimination, harassment, victimisation and other conduct prohibited by the Act; • Advancing equality of opportunity between people who share a protected characteristic and those who do not; • Fostering good relations between people who share a protected characteristic and those who do not; • Removing or minimising disadvantages suffered by people due to their protected characteristics; • Steps that should be taken to meet the needs of people with certain protected characteristics where these are different from the needs of other people; and • Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low. <p>The following links provide additional information on the Public Sector Equality Duty Act 2010: http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/introduction-to-the-equality-duty/ http://www.equalityhumanrights.com/uploaded_files/EqualityAct/PSED/essential_guide_update.doc</p>	
Micro Weighting: 5%	Character Limit: 10,000

Question No: CSD03	Question: Partnership Working
<p>Please describe how you will ensure effective and relevant partnership working with all stakeholders.</p> <p>Response should include the following groups:</p> <ul style="list-style-type: none"> • Patients/service users; • CCG and Local authority; recognising the establishment of the T&G Single Commissioning Function; • Local Practices at a neighbourhood and locality level • Integrated Neighbourhoods • NHS England Local Team; • LMC; • Orbit Healthcare, local GP Federation • CQC; • Third Sector Organisations; • Other primary care providers; and • Local hospitals and community health service providers, with particular reference to the newly established Tameside and Glossop Integrated Care NHS Foundation Trust 	
Micro Weighting: 6%	Character Limit: 11,400

Question No: CSD04	Question: Referrals
<p>Please describe the systems and processes you will have in place to ensure effective management of referrals.</p> <ul style="list-style-type: none"> • Monitor referrals in respect of clinical appropriateness; • Identify and manage referrer training and development needs; • Monitor and manage attendances at local emergency and urgent care services; and • Work in partnership with relevant stakeholders to reduce unnecessary admissions for patients with long-term conditions. • Review referral and activity data through practice visits and neighbourhood meetings, understanding of position in relation to peer practices, neighbourhood and locality. 	
Micro Weighting: 3%	Character Limit: 6,500

Question No: CSD05	Question: Premises and estates
<p>Please confirm that you will utilise the identified premises Y/N</p>	
Micro Weighting: PASS/ FAIL	Word Limit: N/A

Question No: CSD06	Question: Mobilisation
<p>With reference to tender documentation, Bidders are to provide a suitable and appropriate mobilisation/implementation plan. The plan should detail the key tasks and milestones on a week-by-week basis the bidder will complete pre, during and post mobilisation period to deliver the services in accordance with the contract.</p> <p>The plan should set out tasks, deadlines and implementation responsibilities and be segmented into the work-streams, including:</p> <ul style="list-style-type: none"> • Planning /implementation and Governance arrangements across pathway; • Workforce and capacity/demand planning; • Finance; • IM&T; • Facilities management arrangement for premises; • Equipment; • Communications and relationships; including how they will work with the current provider to ensure a smooth transition of services; • Stakeholder engagement; • Patient and Public communication and engagement; • Risk management and contingencies; • Identification of potential strengths and weaknesses of workforce to deliver service and proposed solution if required; • Process and service readiness tests; and • Outputs/outcomes monitoring <p>ATTACHMENTS ALLOWED</p>	
Micro Weighting: 5%	Character Limit: 10,000 plus attachments

Section: Quality		Macro Weighting 20%
Question No: QTY01	Question: Performance	
<p>Please describe your approach to monitoring performance</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none">• Key performance indicators (Including but not limited to referrals, access, prescribing and patient experience);• Delivery against quality and clinical outcomes as set out in the specification• Approach taken to determine and understand issues and indicated performance failure. <p>Bidders must outline how they will prepare for quarterly and annual monitoring requirements.</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none">• The mechanisms by which they will internally analyse performance to outline areas for improvement in order to meet the deadlines for submission of data to Commissioners;• How they will gather information i.e. incidents, complaints and concerns, for discussion at contract meetings; and• How they will feed back to Commissioners on lessons learned from incidents, complaints and concerns through the use of thematic analysis.		
Micro Weighting: 6%		Character Limit: 11,400

Question No: QTY02	Question: Continuous Improvement	
<p>Please describe the mechanisms that you will use to ensure continuous service improvement.</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none">• Clinical audit plans;• How you will evidence compliance with evidence-based guidelines (i.e. NICE);• How you will improve access to services		
Micro Weighting: 3%		Character Limit: 6,500

Question No: QTY03	Question: Patient Involvement and Engagement	
<p>Please describe the process of how you will engage and involve patients and carers in the development and delivery of this service.</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none">• Identify key patient groups;• Engagement with the local community to identify needs (including hard to reach groups);• Undertaking continuous service user engagement;• Utilisation of PPG to support delivery of effective patient involvement and engagement;• Implementing service development resulting from engagement and consultation exercises;• Sharing information and decisions;• Ensuring practice strategies dovetail with NHS England’s strategy for patient engagement².		
Micro Weighting: 4%		Character Limit: 8,100

2 <https://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf>

Question No: QTY04	Question: Patient Experience
<p>How will you ensure a positive patient experience?</p> <p>Responses should include but not be limited to the following aspects:</p> <ul style="list-style-type: none"> • Promotion of dignity, privacy, and independence of patients. Bidders should reflect developments in this area and show that they 'get' why this matters. The response should have concrete proposals for promoting dignity and make it clear how this will be measured and assured. • Promotion of shared decision making including the involvement of carers where appropriate. Bidder's responses should demonstrate enthusiasm for enabling patients and their families / carers to make informed decisions about their care. It will contain specific proposals for ensuring this happens consistently (training, decision making tools, patient education, assurance etc.) It will show a n understanding of the distinct needs and concerns of carers while ensuring cared-for patients are able to express their own views and preferences. • Communicating effectively with patients. The bidder should show an appreciation of the different types of communication required (appointment letters, patient education, self-care advice etc.) and contain proposals for recognising and responding to the needs of individuals with specific needs (e.g. Braille letters, languages other than English etc). • Ensuring patients are made comfortable, both physically and emotionally. Bidders will show recognition of the importance of physical and mental wellbeing in treatment, and the likely concerns of patients which may give rise to anxiety etc. The answer will contain specific proposals for promoting, measuring, and assuring wellbeing. • Measurement and reporting of the patient experience and acting on insights gained. Bidders will show an understanding of the importance of measurement and transparency and welcome the potential for feedback driving improved quality. The answer will contain specific, credible proposals for measuring experience in a systematic manner. The answer will make it clear how they will share data, and actions taken in response with both patients and the commissioner. • Recognition of the mandate in the 2017-2019 NHS Operational Planning Guidance to maintain and increase the number of people recommending services in the Friends and Family Test and ensure its effectiveness, alongside other sources of feedback to improve services. • Understanding of the practice's scores around patient experience in the GP Survey and actions taken to act on and drive improvements. 	
Micro Weighting: 4%	Character Limit: 8,100

Question No: QTY05	Question: Medicines Management
<p>Please describe the systems and processes that you will have in place to ensure safe and effective prescribing and medicines management.</p> <p>Response should include but not be limited to an explanation of:</p> <ul style="list-style-type: none"> • Monitoring of prescribing, including; accuracy, output and prescriber development needs; • Review of repeat prescriptions; • How the bidder will ensure systems and processes are compliant with legislation and national and local guidelines and best practice including reporting mechanisms for medication errors, safe and secure handling of medicines, controlled drugs legislative requirements; and • Approach to electronic prescribing 	
Micro Weighting: 3%	Character Limit: 6,500

Section: IM&T	Macro Weighting 10%
Question No: IMT01	Question: IT Systems and booking
<p>Please identify the IT systems you will use to deliver and manage the service (clinical and administrative). You should also describe how these systems will support management of Primary Care as detailed in the Service Specification.</p> <p>The response should include but not be limited to the details of:</p> <ul style="list-style-type: none"> • Identify Clinical and Administration IT systems and software you propose to use to deliver and manage the service and particularly how you will integrate with GP practice and 111 direct booking capability. <p>General</p> <ul style="list-style-type: none"> • System security; • System backups; • Disaster recovery and business continuity plans; • Expected system availability; • Service level agreements to meet availability; and • Desktop and laptop data loss prevention. <p>Clinical</p> <ul style="list-style-type: none"> • Use of the NHS Number as the key identifier for patients; • Appointment bookings/scheduling etc.; • Clinical coding; • System integration with SCR, PDS and Directory of Services; • Access to clinical records; • Onward and processing of referrals; and • Activity reports. • Care planning <p>Increasing the use of technology as described in the 2017-2019 NHS Operational Planning Guidance.</p>	
Micro Weighting: 5%	Character Limit: 10,000 plus attachments

Question No: IMT02	Question: Information Governance
<p>Please describe your approach to Information Governance, confidentiality and data protection assurance.</p> <p>Response should include (but not be limited to) the details of: IG Toolkit score or level expected to achieve with plans and timescales to achieve:</p> <ul style="list-style-type: none"> • Policies and procedures; • Strategic development; • Operational management; • Standards and good practice; • Statutory obligations; • Confidentiality and Data Protection Assurance; • Information Security; • Information Risk Management; • Records Management; and • Information Incident Management. • Information Governance specific roles and responsibilities <p>Please provide evidence of at least IG Toolkit Level 2 status Please refer to https://nww.igt.hscic.gov.uk/ for more information regarding IG Toolkit. Please provide evidence of the following:</p> <ul style="list-style-type: none"> • Confirmation and evidence of IG Toolkit Level 2 status; or • An action plan which clearly describes how your organisation will attain IG Toolkit Level 2 prior to the service commencement date to include any gaps against requirements which do not meet level 2 and how these gaps will be addressed. <p>Please refer to https://nww.igt.hscic.gov.uk/ for more information regarding IG Toolkit Character Count: 4500 ATTACHMENTS ALLOWED: Evidence of IG Toolkit Level 2 or Action Plan only</p>	
Micro Weighting: 5%	Character Limit: 10,000 plus attachments

Section: Workforce	Macro Weighting 10%
Question No: WF01	Question: Organisational Structure and workforce
<p>Please outline your proposed full organisational structure for delivery of this service.</p> <p>Considering the five measures reportable to the CQC (safe, effective, caring, responsive, well-led), Bidders must describe their experience of developing an organisational structure for the delivery of a safe service for each centre.</p> <p>Weighting: 10%</p> <p>Response should include as a minimum but not be limited to:</p> <ul style="list-style-type: none"> • Organisation chart with clear lines of accountability and leadership; • Skill set profile and how this will be maintained / reviewed; • Planned working patterns to ensure full staff complement during contract hours and to support a system wide partnership approach to service provision; • Staff ratio to manage demand how this will be reviewed / adapted; • Use of agency staff if applicable; • Consideration of skills and competencies of the entire workforce / succession planning / talent management; • Clear rationale for the selected skill mix to be used for the service; and professional indemnity • Evidence of linking service delivery with the service requirements and staffing allocation. <p>Responses in this section will be cross referenced with the staffing model submitted in the FMT to ensure consistency.</p>	
Micro Weighting: 5%	Character Limit: 10,000 plus attachments

Question No: WF02	Question: Recruitment and Retention
<p>Please outline your approach to recruitment and retention and sustainability of the workforce requirements for this service.</p> <p>Response should include as a minimum but not be limited to:</p> <ul style="list-style-type: none"> • Recruitment strategy / workforce plan; • Induction process; • Locums and agency staffing utilisation plans; • Development of leadership capability/attributes; • Monitoring of professional credibility / clinical skills development of individuals and the service; and • Compliance with current legislation / DBS checks / HR support mechanisms / staff management policy • Consideration of ways, building of the 10 high impact actions to release capacity outlined in the GP Forward View, to be innovative and progressive in the use of a varied skill mix to get the most from what different health and care professionals can bring. • Workforce development plans 	
Micro Weighting: 3%	Character Limit: 6,500

Question No: WF03	Question: Workforce Supervision and Training
<p>Please outline your approach to clinical and non-clinical supervision and training for delivery of this service.</p> <p>Response should include but not be limited to:</p> <ul style="list-style-type: none"> • Demonstration of clear appropriate professional leadership and supervision • Checks in place for professional registration / revalidation • Mechanisms and checks for mandatory training; • Continuous development/training and support requirements for the primary care team; • Supervision training; • Staff appraisal; and personal development planning – performance management • Supervision of locum/agency staffing. 	
Micro Weighting: 2%	Character Limit: 5,000

Section: Governance		Macro Weighting 10%
Question No: GOV01	Question: Clinical Governance	
<p>Please provide your description of Clinical Governance at the core of service delivery.</p> <p>Response should include but not be limited to an explanation and evidence* of:</p> <ul style="list-style-type: none">• Management of clinical risk including treating patients at home and medical emergencies;• Patient safety and staff safety (e.g. incident reporting, significant event reporting etc.);• Reporting of adverse incidents;• Management of patient complaints;• System that facilitates learning from experience and action planning, including improvement of quality of care to patients;• Safeguarding Adults/Children procedures;• Implementation of evidence based guidelines; and• Implementation of patient safety alerts. <p>*Evidence should be in the form of policies and protocols available listed as an appendix. <u>Note:</u> NOT the policy / protocol documents.</p>		
Micro Weighting: 6%		Character Limit: 11,400

Question No: GOV02	Question: Business Continuity
<p>Please describe your approach to disaster recovery and business continuity as a provider and part of the whole pathway.</p> <p>Bidders may evidence some of this with business continuity plans. A copy of the business continuity plan should be submitted as evidence; however policies should not be submitted as supporting documents for this question.</p> <p>Response should include as a minimum but not be limited to:</p> <ul style="list-style-type: none"> • Fire or theft; • Severe weather; • Staff shortage (including each staff group); • Peaks in demand of service; • Surge preparedness (peaks in service); • Major Incidents; and • Power failure. • Recognition of need to response and support the overall health economy in periods of escalation/enacting of business continuity plans. 	
Micro Weighting: 4%	Character Limit: 8,100

Section: Presentation	Macro Weighting 5%
Presentation – 5%	
<p>Presentation to be delivered to enhance a bidders response to CSD06 regarding the mobilisation of the service.</p> <p>The presentation to be delivered should verify the response submitted at stage 3 referring to but not being limited to how key priorities and milestones will be deliver within the timescales. For example</p> <ul style="list-style-type: none"> • Mitigation factors to reduce risks during the mobilisation period • Service readiness as at 1st October 2018. 	

Section: Financial Model Template	Macro Weighting 20%
Evaluation of Financial Model Template (FMT) – 20%	
<p><u>Please note that your response to question WF01 will be cross referenced against the staffing costs submitted in the FMT and clarification will be sought for any discrepancies.</u></p>	

Agenda Item 7

Report to:	STRATEGIC COMMISSIONING BOARD								
Date:	20 June 2018								
Officer of Strategic Commissioning Board	Councillor Brenda Warrington – Executive Leader Stephanie Butterworth – Director of Adult Services								
Subject:	PRESENTATION OF THE DRAFT OUTLINE BUSINESS CASE THAT PRESENTS THE CASE FOR THE TRANSACTION OF A NUMBER OF ADULT SOCIAL CARE FUNCTIONS AND STAFF INTO TAMESIDE & GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST								
Report Summary:	<p>The attached report presents the draft Outline Business Case (OBC) for the transaction of a proportion of Adult Social Care services and staff into the ICFT. The OBC combines a high level Strategic Outline Case (SOC) and the OBC within one document as agreed with NHS Improvement.</p> <p>The Council, ICFT, and CCG considered a number of integration options at the SOC stage and concluded that the options distilled in the OBC were the most effective ones to take at this time.</p> <p>Details of the teams and functions that are included in the preferred option are detailed, including the benefits, dis-benefits and risks to both the Council and the ICFT.</p> <p>The report describes the economic, business, financial, commercial and management cases for the transaction of the services and functions identified in the preferred option.</p>								
Recommendations:	That Strategic Commissioning Board note the content of the report and support the content of the report and the proposal contained in Option 2.								
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	<table><tr><td>ICF Funding Stream</td><td>Section 75</td></tr><tr><td>Decision Required By</td><td>Strategic Commissioning Board</td></tr><tr><td>Organisation and Directorate</td><td>Tameside MBC – Adult Services</td></tr><tr><td colspan="2">Comments The Outline Business Case (OBC) includes assumptions on the level of Council resources that will support the transfer of the respective services to the ICFT for the five year period to 2023/24 (Section 2 of the OBC). Section 6.4 of the OBC includes the proposed details of the risk share arrangements for the transfer. The arrangements for the Council support functions related to the transfer are yet to be confirmed. Members should consider the related risks to the Council associated with the transfer alongside the share of the proposed financial risk share arrangements stated in 6.4. The financial implications of the OBC will continue to be reviewed and updated, with further updates included within the Full Business Case should the OBC be approved by NHS Improvement.</td></tr></table>	ICF Funding Stream	Section 75	Decision Required By	Strategic Commissioning Board	Organisation and Directorate	Tameside MBC – Adult Services	Comments The Outline Business Case (OBC) includes assumptions on the level of Council resources that will support the transfer of the respective services to the ICFT for the five year period to 2023/24 (Section 2 of the OBC). Section 6.4 of the OBC includes the proposed details of the risk share arrangements for the transfer. The arrangements for the Council support functions related to the transfer are yet to be confirmed. Members should consider the related risks to the Council associated with the transfer alongside the share of the proposed financial risk share arrangements stated in 6.4. The financial implications of the OBC will continue to be reviewed and updated, with further updates included within the Full Business Case should the OBC be approved by NHS Improvement.	
ICF Funding Stream	Section 75								
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Legal Implications: (Authorised by the Borough Solicitor)	It should be noted that he approach to risk transfer set out in the report states that: “ <i>It will be based on the best practice principle of allocating risk to the party, or parties, best placed to manage that</i>								

risk. Therefore, an optimum allocation of risk rather than a maximum risk transfer will be taken.

The risk sharing agreement (which protects the ICFT from undue financial hardship until it can start to realise benefits) will be defined and agreed during the project process. After this TMBC will not cover any funding shortfalls as the ICFT will have had the opportunity to transform the service in a manner that releases savings. Risks associated with the delivery of the solution (i.e. post contract award) will be maintained in a jointly held risk register with clear assignment to the responsible party.

Hempsons Solicitors have provided an initial review of the legal feasibility and likely risks involved in this transfer.

Going forward we need to be clear that there is an appropriate risk transfer and the Council/CCG are not left exposed with an increasing demand for resources set against a lack of control whilst retaining the liability for the service. This will need to be carefully understood before any final decision is made.

How do proposals align with Health & Wellbeing Strategy?

The proposals and strategic direction are consistent and aligned.

How do proposals align with Locality Plan?

The proposals and strategic direction are consistent and aligned.

The service is consistent with the following priority transformation programmes:

- Healthy Lives (early intervention and prevention)
- Enabling self-care
- Locality-based services
- Urgent Integrated Care Services
- Planned care services

How do proposals align with the Commissioning Strategy?

The service contributes to the Commissioning Strategy by:

- Empowering citizens and communities
- Commission for the 'whole person'
- Target commissioning resources effectively

Recommendations / views of the Health and Care Advisory Group:

This document has not been presented at HCAG.

Public and Patient Implications:

It is anticipated that this proposal will improve the service offer to people living within the borough.

Quality Implications:

A Quality Impact Assessment will be completed as part of the development of the FBC and the programme of transfer to ensure quality is maintained.

A robust quality assurance framework will be developed to assure the DASS that the ICFT is delivering the Council's statutory duties.

How do the proposals help to reduce health

A primary objective of the Care Together Programme and the development of the Integrated Care Organisation (ICO) – Tameside and Glossop Integrated Care NHS Foundation Trust –

inequalities?	<p>is to reduce health inequalities.</p> <p>Bringing together the health and social care functions, working in an asset based, place based way, will improve the offer to local people, with a focus on those whose health is placing them at most risk.</p>
What are the Equality and Diversity implications?	<p>It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act.</p> <p>An Equality Impact assessment will be completed as part of the FBC.</p>
What are the safeguarding implications?	<p>Safeguarding assurance is integral and essential to the service model. All safeguarding implications will be considered as part of the FBC.</p>
What are the Information Governance implications? Has a privacy impact assessment been conducted?	<p>As part of the development of the FBC, 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. A work stream is already considering the implications.</p> <p>A Privacy Impact Assessment has not been conducted at this stage in the process.</p>
Risk Management:	<p>The OBC details the anticipated risks to the three options proposed in the report. Further risk analysis and mitigation will be considered as part of the development of the Full Business Case.</p>
Access to Information :	<p>The background papers relating to this report can be inspected by contacting Stephanie Butterworth, Director of Adult Services</p>



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1. INTRODUCTION

- 1.1 The purpose of this report is to provide a progress update to the Strategic Commissioning Board (SCB) regarding the progress made on the transaction of transferring a sub-set of Adult Social Care (ASC) services from Tameside Metropolitan Borough Council (TMBC) into Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT). This builds on the report that was received by the Health and Wellbeing Board in January 2018.

2. CONTEXT

- 2.1 During 2015 analysis conducted through the Contingency Planning Team's report concluded that in order to achieve the most improved outcomes for our local people and to be a sustainable economy the formation of an Integrated Care Organisation was required. This new organisation would be inclusive of Social Care and the principle was accepted by the locality partners.
- 2.2 Consequently the locality established a programme of work to define, design, and implement the transactional process to deliver Adult Social Care into the ICFT, and within agreed timescales.

3. OUTLINE BUSINESS CASE

- 3.1 The recent activity undertaken in support of this transaction has been focused upon the production of the Outline Business Case (OBC). Before the transaction can be effected it needs to receive the support of the ICFT's Board, of Council's Cabinet, and of NHS Improvement (one of the ICFT's regulators). Therefore the OBC aims to set out the locality's rationale for the transaction and a compelling case for change.
- 3.2 There is appended to this report the current draft of the OBC (version 12.2). There has been a significant focus over the last two months to produce a business case that will set out for NHS Improvement the benefits to the local health and care system of delivering this transaction whilst also setting out the risks and how these can be mitigated.
- 3.3 SCB are advised that this version of the OBC has been shared with the Board members of the ICFT who were supportive of the report, with a preference for Option 2, subject to a more detailed Full Business Case.

Strategic Outline Case

- 3.4 This current version of the OBC (version 12.2) opens with the Strategic Outline Case and sets out a long list of options that have been considered with regards to the services under consideration for the transaction and also the options for any new contractual basis including the implications for staff. From this long list of eight potential options there is the rationale provided as to how the OBC arrived at a short list of three options.
- 3.5 These three options are:
- Option One – Do nothing
 - Option Seven - Integration of a subset of in house ASC delivered services from TMBC into the ICFT, through TUPE arrangements
 - Option Eight - Integration of a subset of in house ASC delivered services from TMBC into the ICFT, as detailed in Appendix B, with the LA staff seconded into the ICFT.

ASC services for the transaction

- 3.6 The draft OBC is proposing that only a subset of ASC services would transfer at this time. Although it remains the intent to progress the integration in the future to include the wider scope of ASC services it has been decided to transact a smaller sub-set of services in the first instance both to prove the concept and to limit the financial and operational risk. It is considered that this stepped approach would be more amenable to NHS Improvement. It remains the intent that in future further services would still look to be transferred.
- 3.7 The following table sets out the services proposed for transfer at this time:

Service Area – Adult Social Care	Service Description
TMBC Urgent Care	
Service Unit Manager	
Integrated Urgent Care Team (IUCT) - staff and Management team	The ASC resource in IUCT is made up of Social Workers, Assessors Assistant Practitioners, Customer Care Officers. Community Care Officers and therapists, including Physios and OTs. The function of the team is to aid a speedy discharge from hospital, prevent hospital admission, deal with a wide range of situations which present within the community, the referrals that are received by the Team come from a range of sources, such as GP's, Emergency Services, other professionals, families and carers. The function of the Team is to assess a persons' needs and requirements, provide a 72 hour wrap around service establishing on-going support requirements going forward. At present the team also carry out rehabilitation for a period of time, which should be no longer than 6 weeks.
Integrated Community Equipment Service (ICES) - Service co-ordination staff member	Integrated Community Equipment Services provides a vast range of equipment to support people either in their own homes or the establishments they live in. ICES contract has three partners – TMBC, CCG and Derbyshire County Council. It is currently a section 75 pooled budget with TMBC as the lead Commissioner. The contract is currently being reviewed to determine future commissioning arrangements. A Co-ordinator is employed to ensure appropriate ordering and prescribing by health and social care staff, and to monitor the performance of the contract.
TMBC – Localities	
Assessment / Care Co-ordination (18+) Inc Locality teams and management	<p>The Care Act 2014 provides a statutory duty on the Council to carry out an assessment of need for anyone requesting it. Once an assessment has taken place, the application of the national eligibility criteria is made and a suitable support plan is determined. People receiving a package of care must be reviewed/reassessed annually as a minimum and those with complex care packages will be care managed/care co-ordinated throughout their time with the service.</p> <p>Assessment and Care Management staff undertake assessments and annual re-assessments. They hold a caseload, and will support individuals on an on-going basis, working proactively with individuals to enable them to live well in their own homes. Where an individual experiences a crisis or experiences a change in need the Social Worker/Assessor will work with the individual, carrying out a re-assessment where appropriate, and amending/changing the support</p>

	<p>plan where appropriate.</p> <p>The staff have a commissioning function in that they put in place care home placements or refer to the Home Care Commissioning Team to set up a home care package. Referrals to other appropriate professionals are also made, as is support to access community resources.</p> <p>A key function involves safeguarding adults, including undertaken and supporting safeguarding investigations. Investigation of complaints is also a function of managers in this function.</p>
Direct Payment – staff resource	<p>Direct Payments (DP) are the Governments' preferred delivery vehicle for service users to have greater choice and control. Once a package of care has been identified, a personal budget is set against it and this can be taken as a direct cash payment to the user. This allows the individual to determine how best to meet their needs. A small team support individuals who have chosen a DP to ensure they are confident to manage the DP.</p>
Review function in care homes – staff resource	<p>The Council has a statutory duty to carry out at least an annual review of all packages of care. Reviews and reassessments can be carried out more frequently should the need arise. Two staff - Operational Performance Officers (OPOs) carry out this function with people who live in residential homes. The OPOs are responsible for organising the reviews, chairing the meetings and circulating copies of review minutes. The OPOs will also follow up on any actions identified during the reviews.</p>
Health & wellbeing and Carers Service – staff resource	<p>Whilst not everyone will meet the eligibility criteria to receive ASC it is important that help and advice is offered to everyone so that they are able to make informed decisions about their lifestyle and options for support within communities. The Health and Wellbeing Advisors work closely with people to support them in accessing the correct support and the correct connections with community and third sector groups in neighbourhoods. Within the Neighbourhood teams there are specific staff who work directly with carers to identify their care and support needs. The Council has a statutory duty to assess carers' needs and to provide suitable services to help support carers to continue to carry out their caring role.</p>
Occupational therapy / Manual Handling Team	<p>Adult services carry out assessments to determine whether appropriate community equipment and or adaptations are required. It also provides assessment for people with manual handling needs particularly if they are returning from hospital or are in crisis in their own homes.</p>
TMBC Long Term Support	
Reablement Service (CQC Registered) (Inc Homecare through the night)	<p>The Reablement service is a CQC registered service that provides reablement support to individuals whose needs may have changed or have experienced a period of crisis. This service currently provides support for up to 6 weeks and supports the urgent care system in terms of 'step-up' and 'step down' support and provides support in the provision of community care assessments. The service is usually delivered in the individual's home.</p> <p>Individuals are referred into the service either from IUCT or from the</p>

	<p>Neighbourhood teams and is part of the Intermediate Tier function. The service is usually established within 2 working days. Individuals are reviewed weekly and their care package modified as an individual's skills and confidence improve.</p> <p>The service is delivered free as it is identified as a rehabilitation function. The service will usually support between 100 and 120 people at any one time. Individuals may require on-going longer term support, though for many this service builds confidence and skills that results in no further interventions being required.</p> <p>Social Workers in IUCT carry out reviews to close cases. There are usually about 30 people awaiting closure reviews – an individual cannot be charged for this service while awaiting this review. In exceptional circumstances Reablement will provide 'long term' home care support to individuals where a home care package cannot be commissioned – individuals are financially assessed for these services.</p>
Through the Night Service (CQC Registered in reablement registration)	This service offers planned care visits during the hours of 10pm and 7am to enable individuals who require care and support through the night to remain at home. The main functions are support with turning people and to support people with using the toilet.
TMBC Crisis & Response	
Community Response Service – warden/response element (Not Control/Operator function)	<p>CRS provides support to enable people to remain in their own homes through the installation of assistive technology. A system linked to an individual's telephone is installed which gives connection to the Control/Operator function (it is proposed that the telephone response function remains with the Council). Devices include falls pendant, wander alert, pill dispensers, as well as a range of environmental alerts (gas, flood, etc). The service also supports hospital discharge, by installing equipment within 2 hours of referral, to facilitate a speedier discharge. The service also has a range of lifting equipment which can be utilised to lift someone who has fallen, where they are not injured, thereby reducing transfers to hospital or hospital admission.</p> <p>The service is available to anyone aged 18+, whether they live in their own home, sheltered housing, or social housing. There is a weekly charge, which is currently £6.17. The service provides a 24 hour response, 365 days per year.</p> <p>The service offers a physical response, usually within 20 minutes, through a team of Wardens. A minimum of 2 Wardens are on duty at any one time, on a shift basis. A further 2 members of staff are utilised to install equipment and devices. The service also provides technical triage for Telehealth, Digital Health services.</p> <p>This service is not means tested and there is no eligibility criteria – this is a universal offer to anyone living in the borough.</p>
Sensory Service – (inc interpreting services)	This service provides an assessment and support function to adults aged 18+ who are blind, partially sighted or deaf, or dual sensory. Support includes rehabilitation, cane training, guide communicator, travel training, mail reading, provision of sensory aids and an interpreter service.

4. NEXT STEPS

- 4.1 If the OBC then receives support from the leadership at both organisations it will then be submitted to NHS Improvement for their consideration. It is expected that NHS Improvement would provide a response by September 2018.
- 4.2 Should the appropriate approval be given to transfer staff into the ICFT full and formal consultation will be undertaken with all affected staff.

5. RECOMMENDATIONS

- 5.1 As set out on the front of the report.

Tameside and Glossop Integrated Care NHS Foundation Trust

Adult Social Care Transaction OUTLINE BUSINESS CASE

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Glossary

Term or abbreviation	Description
SOC	Strategic Outline Case
OBC	Outline Business Case
FBC	Full Business Case
ASC	Adult Social Care
ICFT	Integrated Care Foundation Trust
TMBC	Tameside Metropolitan Borough Council
CCG	Clinical Commissioning Group
LA	Local Authority
SCF	Strategic Commissioning Function
DASS	Director Adult Social Services
POPPI	Projecting Older People Population Information

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Appendices

Appendix A: SOC – Long List of Options

Appendix B: Option Analysis of Gross Expenditure & Associated Funding Gap

Appendix C: Public Health Joint Needs Assessment

Appendix D: Adult Social Care Budget Analysis

Appendix E: Hempsons' Due Diligence Report & Questionnaire

DRAFT

Executive Summary

This is the Business Case for the transfer of in house Adult Social Care (ASC) services into Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) from Tameside Metropolitan Borough Council (TMBC). For the purposes of this document this transaction refers to:

- The transfer of the provision of in house ASC services from TMBC into the ICFT
- The transfer of ASC staff from TMBC into the ICFT

TO BE COMPLETED ONCE ALL OF THE OPTIONS HAVE BEEN WORKED THROUGH AND A RECOMMENDATION MADE

DRAFT

1. Introduction

The Tameside and Glossop Economy consists of Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT), NHS Tameside and Glossop Clinical Commissioning Group (CCG) and Tameside Metropolitan Borough Council (TMBC). TMBC provides Social Services within the Tameside area, but does not provide these services to the residents of Glossop who receive Social Services from Derbyshire County Council (DCC). Under the future models of care Glossop residents would continue to receive Social Services from DCC who will not be integrating their services into the ICFT.

The Tameside and Glossop economy has experienced significant clinical and financial sustainability challenges for a number of years. Over a number of years three external reviews have been conducted (Ernst & Young 2012, McKinsey 2013/4, and PwC via Monitor's Contingency Planning Team process in 2015) and all concluded that improved population outcomes at reduced cost could be achieved through the integration of health and social care services. As the financial challenge continues, we have continued to develop and implement plans to maintain (and in some cases to increase) service provision but at reduced cost.

Monitor appointed Price Waterhouse Cooper (PwC) in November 2014 as a Contingency Planning Team (CPT) to test the financial and clinical sustainability of the then Tameside Hospital NHS Foundation Trust (THFT) following a number of critical reports. The CPT report was supported and published by Monitor in September 2015 and fed directly into the on-going transformation work across the economy. The CPT process provided considerable assurance on our plans as it concluded that THFT should become an Integrated Care Foundation Trust (ICFT) as the delivery vehicle for providing an integrated health and social care system.

The CPT report proposed the full integration of Community Services, Adult Social Care, Mental Health Services and Commissioning into the ICFT in order to support ongoing financial sustainability of the ICFT. The ICFT has already integrated Community Services into the Trust in April 2016 as the first stage of the integration process. This OBC intends to further progress the process with the integration of Adult Social Care Services which are currently provided by TMBC directly employed Social workers and other associated staff.

2. Strategic Outline Case

This Outline Business Case (OBC) integrates a high level Strategic Outline Case (SOC) and the OBC within one document as agreed with NHSI.

The ICFT, TMBC and CCG considered a number of various integration options at the SOC stage and concluded that the options distilled in the OBC were the most effective options at this time.

The long list of options considered within the SOC are detailed below:-

- Option One – Do nothing

- Option Two – Full integration of all Adult Social Care Services, and CCG Commissioned Services.
- Option Three – Full integration of all Adult Social Care Services, and a subset of CCG Commissioned Services.
- Option Four – Full integration of all Adult Social Care Services (including staff and funding).
- Option Five – Integration of in house ASC delivered services from TMBC into the ICFT through TUPE arrangements
- Option Six - Integration of in house ASC delivered services from TMBC into the ICFT with TMBC staff being seconded into the ICFT
- Option Seven - Integration of a subset of in house ASC delivered services from TMBC into the ICFT, through TUPE arrangements
- Option Eight: Integration of a subset of in house ASC delivered services from TMBC into the ICFT, as detailed in Appendix B, with the LA staff seconded into the ICFT.

The high level reason for excluding each of the options not taken forward are detailed below.

Option Two – Full integration of all Adult Social Care Services, and CCG Commissioned Services.

The Trust engaged Hempsons Solicitors in July 2017 to undertake a review of the integration of all Adult Social Care and CCG Commissioned Services. As a result of this review it was determined that including the integration of CCG Commissioned services would slow the process down due to the proposal not being sufficiently developed and the legal issues that would need resolving in order to transfer CCG Commissioned Services, as it is not lawful for the CCG to delegate its functions to an NHS Foundation Trust. This option also transferred significant financial risk to the ICFT and under the Single Oversight Framework this may have resulted in the failure to secure an acceptable NHS Improvement risk rating

Option Three – Full integration of all Adult Social Care Services, and a subset of CCG Commissioned Services.

The reasons for discounting this option were the same as option two but the financial risk had reduced but only marginally. The largest financial risk remained associated with all of adult social services transferring. There also remained potential legal issues with the sub-set of CCG Commissioned services.

Option Four – Full integration of all Adult Social Care Services (including staff and funding).

This option was discounted on the level of financial risk to the ICFT. The transfer of all Adult Social Care Services had the potential to have transferred a financial gap of £x by 22/23 to the ICFT with no clear financial or operational plans to mitigate this.

Option Five – Integration of in house ASC delivered services from TMBC into the ICFT through TUPE arrangements

This option was also discounted on the level of financial risk to the ICFT.

Option Six - Integration of in house ASC delivered services from TMBC into the ICFT with TMBC staff being seconded into the ICFT

This option was also discounted on the level of financial risk to the ICFT.

A matrix of the services considered as part of each of the options can be found at Appendix A. Appendix B details the financial gap details and values of the services within each option.

The table below details for the Adult Social Service options transferring (excludes back office support functions), the 2023/24 projected financial gap associated with each option, and supports the option being discounted on the basis of financial risk.

Table:- Adult Social Care Financial Gap Associated with each of the Options

2023/2024 Projected Gap	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
TMBC ASC Financial gap £m	17,318	17,318	17,318	17,318	4,312	4,312	2,264	2,264

Only options one, seven and eight have been taken forward as the shortlist of options into the OBC, as such the later parts of this OBC will be limited to the remaining three options. Section 4 details the OBC options and the services covered within the case.

3. OBC - Strategic Case

3.1 Strategic Vision

Care Together is our transformational approach to improving significantly the health and wellbeing of the 250,000 residents of Tameside and Glossop. The programme comprises three key elements:

- The establishment of a Strategic Commissioning Function to ensure resources are aligned and distributed in a way which facilitates integration and most effectively meets need
- The development of an Integrated Care Organisation to eliminate traditional organisational silos and boundaries
- A new model of care to drive forward at pace and scale the changes required in order to achieve our ambitions of improved outcomes for our population and a financially and clinically sustainable health and care system.

We aim to develop a sustainable economy by improving the healthy life expectancy (HLE) of our population. In doing this, our programme has three key ambitions which are wholly in line with both Greater Manchester and national policy:

1. To support local people to remain well by tackling the causes of ill health, supporting behaviour and lifestyle change, and maximising the role played by local communities
2. To ensure that those receiving support are equipped with the knowledge, skills, and confidence to enable them to take greater control over their own care needs and the services they receive
3. When illness or crisis occurs, to provide high quality and integrated services designed around the needs of the individual and, where appropriate, provided as close to home as possible.

We have the economy-wide leadership in place to deliver our integration agenda. We have a coherent, ambitious strategy and comprehensive governance arrangements and have already delivered a Strategic Commissioning function. Implementation is underway to transform to our new models of care. We have one health economy with all partners equally sharing the risk and burden of deficit. This Outline Business Case sets out the opportunity for delivering at pace the three key ambitions above by bringing together health and adult social care services and, in the process, transforming the local hospital into an Integrated Care Foundation Trust. This ambitious programme firmly establishes the confidence held by the Strategic Commissioners regarding the Foundation Trust's ability to develop into a fully-fledged Integrated Care Foundation Trust by taking responsibility for the provision of Adult Social Care and integrating these services with community and acute medicine. As evidence of this confidence and in order to support the transaction the Strategic Commission has agreed to underwrite the financial risk in full for a number of years and then for a proportion for a further period of time.

We are confident that the aims of this transaction are achievable; we have taken learning from colleagues elsewhere in Greater Manchester and note for example the progress made by the Salford locality to bring together Adult Social Care and health services.

We are fully cognisant of the context within which we are operating; we know that by progressing this transaction at pace we have the opportunity to deliver Adult Social Care services to the ICFT without the requirement of undergoing a largescale procurement process.

We recognise our locality's uniqueness both within Greater Manchester and nationally. We are rightly acknowledged as being at the forefront of integration and this transaction will further cement our reputation as visionary system leaders.

3.2 Strategic Context

The way in which the NHS and care partners provide health and care services has been the subject of review for a number of years as the UK population and its needs change. Demand for services is increasing as people live for longer with more complex health and care needs. Consequently, the current model of care which we offer is under pressure.

In 2014 the NHS published a Five Year Forward View (FYFV), which recognised the scale of the challenges facing the health and care system in England and projected a funding gap of up to £30bn by 2020 if the NHS did not radically change the way it delivered services. This called for changes to the way in which health and care is provided, to better meet the needs of individuals, whilst meeting the financial and sustainability challenge. This recognised the need for a wholesale shift towards care that is; focussed on prevention as much as cure, that empowers people to manage their health and care, and is organised around the needs of the individual as well as the assets of the community.

The Greater Manchester Health and Social Care Partnership (GMH&SCP) has developed its five year plan 'Taking Charge of our Health and Social Care in Greater Manchester'. This describes the vision for Greater Manchester (GM) 'to deliver the fastest and greatest improvement in health and wellbeing of the 2.8 million population of GM, creating a strong, safe and sustainable health and care system that is fit for the future'.

Locally the Public Health Joint Strategic Needs Assessment (Appendix C) highlights that people in Tameside and Glossop experience particularly high levels of ill health, and shorter life expectancy, than the national average. Additionally projections indicate that the population of Tameside and Glossop will increase by 10% by 2035 to 280,000 with a greater growth in the number of older people.

The locality has some significant social issues including continuing high levels of relative deprivation as well as the impact of a reducing resource base.

The health of people in Tameside is generally worse than the England average. Tameside is one of the 20% most deprived districts/unitary authorities in England and about 24% (10,600) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy locally is about 7 years lower for men and 8 years lower for women in the most deprived areas of Tameside compared to the least deprived in the borough (as at 2014/16).

In adults the recorded diabetes prevalence, excess weight, and drug and alcohol misuse is significantly worse than the England average. Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average. 70% of all preventable disease in Tameside is linked to four conditions (Liver disease, Heart disease, Respiratory disease, and Cancer).

Compared with England as a whole, Tameside and Glossop has a slightly lower proportion of people aged 20-39 and a slightly higher proportion of people aged 40-69. In addition, an ageing population is likely to increase the overall prevalence of life limiting long term illness or disability and increase demand for health services and social service interventions. The burden on and need for efficient Adult Social Care services is likely to increase over the next few years.

The table below indicates elements of Tameside population projections to 2035¹. The data source is POPPI (Projecting Older People Population Information), and specifically relates to Tameside, and excludes Glossop's population.

Table: TMBC POPPI Data

	2018	2020	2025	2030	2035	Percentage Increase
People aged 65 and over	40,400	41,400	45,600	51,300	56,200	39%
People aged 85 and over	4,600	4,800	6,000	7,400	9,600	109%
People living with dementia	2,603	2,745	3,183	3,750	4,307	65%
People living with a limiting long term illness	22,362	23,038	25,737	28,896	31,890	43%
People 65 and over unable to manage at least one personal care task	15,842	16,423	18,511	21,038	23,477	48%

As can be seen from the table above over the next seventeen years there is projected to be a thirty nine percent increase in people over the age of 65 within the Tameside area, and a forty eight percent increase in people unable to manage at least one personal care task, and a forty three percent increase in people living with a limiting long term illness.

All of these projections will put increasing pressure on the local health and social care economy, thereby emphasising the need for transformation of the way in which services are provided.

Changes in the ageing population are already contributing to an increased demand on health and social care services. The demands on these services will continue as people live longer and the dynamics of the ageing population changes. The number of carers will also increase as more people live longer and therefore it is important to have responsive, flexible arrangements in place to support those people caring for others and to support people who want to live independently; this will create a health and social care culture where the need for secondary hospital services are a last resort.

3.3 The Tameside and Glossop Case for Change

Traditionally, the provision of ASC services within Tameside and Glossop rested with TMBC for the residents of Tameside. With the increased collaboration between TMBC, the CCG and the ICFT it was recognised that there was an opportunity to transfer the provision of in house ASC services to the ICFT. It was felt that this gave an opportunity to rationalise the service within the local health and care economy without negatively impacting patient care.

The vehicle for implementing the Care Together vision is the ICFT. The ICFT would bring together under the controlling auspices of one organization the provision of:-

- In house Adult Social Care services currently provided by TMBC
- Community health services which are already integrated into the ICFT

- Hospital services.

This proposal supports that intention by moving a defined set of ASC services into the ICFT and is in alignment with recommendations contained within the Contingency Planning Report (2015).

Through strong leadership, pooling our resources, and redesigning how our health and social care provision works collectively we aim to improve financial sustainability. This will be achieved by a continued focus on:

- Reducing growth in health and social care demand
- Avoiding unplanned admissions
- Preventing ill health
- Use of the Voluntary sector and communities
- Efficiency and unlocking the potential of enabling work streams.

Our transformation plans describe how health and social care services will contribute towards our whole system ambition of improving health, wellbeing and prosperity.

The local health and social care economy has delivered significant transformation over the last two years culminating in the formation of the Strategic Commissioning Function and the continued development of the Integrated Care Organisation to deliver the economy vision. TMBC, Tameside and Glossop ICFT, and the CCG have a significant track record in the delivery of substantial strategic change programmes. We are therefore in a strong position to drive ahead at both pace and scale with the programme identified in this Outline Business Case.

3.4 Rationale for the Transaction of ASC moving into the ICFT

The Tameside and Glossop locality has created a compelling case for the development of the local health and care economy (social care, health, primary care, mental health, voluntary and community sector and others) to deliver a significantly improved offer and outcomes for local people. The vision is predicated on a fully integrated model that promotes good health, great outcomes for local people and manages the demographic challenges faced by the locality. The locality has received external assurance (from the CPT report commissioned by then Monitor) that this is the appropriate strategy.

The model of care that is currently being implemented through our local transformation programme is fundamentally about an offer:

- to activate and empower local people and communities to look after their own health
- to do so in the context of wider determinants of health reaching across to leisure, housing, education, employment and training, and local economic development
- to deliver care in or as close to people's homes as possible developing five neighbourhood community care teams bringing together professional expertise, including primary care, offering a range of services for preventative and proactive care interventions and support for people living with long term conditions. Hospital based services would only be provided where there is no other suitable setting of care.

In order to maximise the benefits of this model and to deliver against the transformation programme, it is crucial that health and social care services are delivered in a fully integrated manner. This will ensure maximum flexibility in the movement of funding and resources across the whole system to support and enable people to remain in good health and to delay the need for more intensive interventions. It is only by bringing health and social care services into an integrated system that the opportunities to transform services can be maximised.

Our vision for Adult Social Care is as an integral element of a system that delivers our ambitions for local people, maximises the opportunities to maintain and develop people to live well in their own homes, supports and promotes independence, minimises social isolation and develops a local offer where people expect to self-care when appropriate and to engage with local community assets to ensure personal resilience and self-determination.

Other ASC services and functions are integral to the delivery of the model, and being part of a single economic entity ensure maximum flexibility in how these resources are deployed to impact positively on system priorities. An example of this is the Community Response Service that delivers a physical response to individuals via a pendant alarm system. This service works collaboratively with Digital Health Service and forms an integral part of the falls prevention agenda, the frailty programme across Integrated Neighbourhoods and the Support at Home model.

The creation of an ICO requires a higher level of service integration that cannot be delivered through collaboration alone. Bringing the full range of care within a unified, aligned management structure and contractual arrangement enables more efficient, effective and person-centred services.

Although care can be integrated without transfer to the ICFT the advantage of this approach is that a unified organisation with one funding envelope, an agreed set of objectives and a shared vision of integration for the future of Tameside and Glossop's health and social care economy is better able to avoid the problems of fragmentation and duplication. An ICFT should be able to more effectively ensure:

- Consistency in applying operational policies and procedures
- Consistency in applying risk, governance and performance principles
- The spread and sustaining of improvements to practice across the whole economy
- The improvement of communication, information and reporting systems
- Faster reaction to changes in demand and times of pressure
- More innovation in developing new services
- Provide more assurance to staff and improve sickness and retention rates
- Collectively deliver improved outcomes for local people it serves
- Efficient and effective use of resources

3.5 Strategic Alignment of Adult Social Care into ICFT's Strategic Plan

The integration of ASC forms an integral element of the ICFT's five year strategic plan. The table below demonstrates how the Trust's five year strategic plan is aligned to and enables the

delivery of the triple aims of the national five year forward view and the Greater Manchester plan, Taking Charge and Locality plans. (* denotes locality plans)

DRAFT

Adult Social Care Transaction - Business Case

<p>NATIONAL Five Year Forward View</p> <p>1: Improved Health & Wellbeing A radical upgrade in prevention and public health</p>	<p>GREATER MANCHESTER Taking Charge</p> <p>Radical upgrade in population health Changing our relationship with people through,</p> <ul style="list-style-type: none"> • People looking after themselves other. • Increased early intervention at scale • Starting well, living well and ageing well 	<p>TAMESIDE AND GLOSSOP ICFT (Underpinned by the Locality plan 'Care Together*')</p> <p>Tackling the causes of ill health</p> <ul style="list-style-type: none"> • Establishment of a single commissioning function for Tameside and Glossop, bringing together the resources of the Clinical Commissioning Group and the Local Authority.* • Development of the Integrated Care Foundation Trust to be the primary provider of health and social care services to provide joined up care. • Integration of primary care and mental health services with the ICFT • Develop strong partnerships with our population, voluntary sector and health and social care organisations. • Use population insight data and risk stratification to inform decision making.
<p>NATIONAL Five Year Forward View</p> <p>2: Better Value and Sustainable Finances NHS will take decisive steps to break down the barriers in how care is provided</p>	<p>Standardising clinical support and back office services Redesign back office support to create the most efficient services we can at a GM level.</p>	<p>Collaboration across clinical support and back office services The Trust and Tameside and Glossop Health and Care economy is developing organisational collaborations to maximise the efficiencies from shared or collaborative back office services in IM&T.</p> <p>The Trust will work with our GM partners across Procurement, HR and finance as well as Clinical Support Services for Pharmacy and Pathology.</p>
	<p>Enabling Better Care Create systems once, at GM level which incentivise our new models of care and support</p>	<p>Alignment with GM on Specialist Provision The ICFT has embedded the GM led cross cutting projects on Specialist Provision and Standardisation of clinical services within its transformational programme to deliver improved outcomes in;</p> <ul style="list-style-type: none"> • Cancer Services • Mental Health provision • Digital Technologies
		<p>Enabling Delivery The Trust recognises that there are some key enablers to deliver integrated services, including; Workforce, Estates and Informatics. Each of these enabling functions have developed five year strategies that align to the deliver the ambitions of the Trusts five year plan.</p> <p>Outcomes The Single Commissioner has taken the initial steps of removing the financial barriers to innovate transformation through the introduction of an outcomes based contract for Tameside and Glossop Health and Social Care services. The next step is the development of an outcomes framework for the Tameside & Glossop Health and Social care economy that will inform the strategic commissioning of services and drive delivery of the integrated care system ambitions.*</p>

3: Transformed Quality of Care Delivery

When people do need health services, patients will gain far greater control of their own care.

GREATER MANCHESTER Taking Charge

Transforming community based care and support

Transform care in localities by integrating primary, community, acute, social and third sector care through the development of new local Care Organisations (LCO's) focussing on;

- Managing care at home and in the community
- Providing alternatives to A&E when crisis occurs
- Supporting effective discharge from Hospital
- Helping people return home and stay well

Standardising acute and specialist care

Standardise and create consistent evidence based hospital services so that;

- Care that does not require a hospital stay will be provided locally
- In-patient emergency care and all in-patient surgery would be organised at a cluster or group level.
- Highly specialised services requiring specialist skills and infrastructure will be organised at a GM level.

TAMESIDE AND GLOSSOP ICFT (Underpinned by the Locality plan 'Care Together*')

Supporting People with Greater Control

The support people need to stay healthy and well is not always medical or based on treatments. It can be practical help with tasks of daily living, emotional support, or information so that people can better manage their own health. This will be delivered through System-Wide Self-Care, which includes;

- Social Prescribing
- Asset Based Approaches
- Self-management education
- Person-centred care and support

Integrated services closer to home

The ICFT has committed to bringing together health and social care services within Tameside and Glossop, to provide seamless care to meet all of an individual's needs rather than treating each condition or need as an isolated episode and where possible to delivering services within the communities or in people's homes. Our approach will be to;

- Adopt a Home First principle to support effective and timely discharge from hospital and avoid unnecessary admissions.
- Create integrated neighbourhood teams (INTs) made up of a range of health and social care professionals to provide co-ordinated care and support to people who live in their neighbourhood. INT multi-disciplinary team will work closely with community, including carers, the local voluntary sector, and wider statutory services.
- Provide specialised health or social care services through the Intermediate Tier services
- Develop innovative and integrated end of life and frailty care pathways.
- *Develop the home care service in Tameside and Glossop to provide individualised patient centred care that gives individuals greater control.*

Developing Local Hospital Services

The Integrated Care Trust will continue to provide and develop seamless and joined-up Local Hospital Services to the population of Tameside and Glossop. Including:

- *Development of an Urgent Care Treatment Centre on the Hospital site to provide alternatives to A&E**
- *Collaboration with Mental Health Partners to simplify and improve mental health provision for our populations.**
- Development of Maternity Services and network arrangements with other organisations to deliver high quality maternity services for a wider geographical population.
- Development of collaborative and network arrangements with other organisations to provide high quality specialist care for our population.
- Enhance the Trusts Research and Development programme and participation in clinical trials.
- Contributing to wider work on the standardisation of clinical services across Greater Manchester to look at how services in key clinical areas can be provided in a more standardised way across GM.

4.0 OBC - Options considered

The three partner organisations considered various options at the SOC stage as discussed in section two. Although it remains the intent to progress the integration in the future to include the wider scope of Adult Social Care services it was decided to transact of smaller sub-set of Adult social care in the first instance to both prove the concept and limit the financial and operational risk. It remains the intent that in future further services would still look to be transferred. The following short list of options taken forward therefore reflects a staged approach and an agreed initial configuration of the ICFT.

This Outline Business Case considers the following five options for the transaction of Adult Social Care services into the ICFT.

Option One: Do Nothing

Option Two: Transfer the provision of a subset of ASC delivered services from TMBC into the ICFT, as detailed in Appendix B, through TUPE arrangements

Option Three: Transfer the provision of a subset of ASC delivered services from TMBC into the ICFT, as detailed in Appendix B, with the LA staff seconded into the ICFT.

For clarity, the definition of 'ASC delivered services' is staff and services that are delivered directly by the Council (that is, TMBC employed staff) not services that are commissioned by TMBC to meet need (such as residential and nursing care beds, home care services). These have not been considered for transaction at this time but will be considered for a separate transaction at a later date.

Both options two and three would see the same services transferring across to the ICFT but just under differing operational models.

The services that would transfer under both options two and three are detailed below with a brief service description in order to aid understanding of the options.

Service Area – Adult Social Care	Service Description
TMBC Urgent Care	
Service Unit Manager	
Integrated Urgent Care Team (IUCT) - staff and Management team	The ASC resource in IUCT is made up of Social Workers, Assessors Assistant Practitioners, Customer Care Officers. Community Care Officers and therapists, including Physios and OTs. The function of the team is to aid a speedy discharge from hospital, prevent hospital admission, deal with a wide range of situations which present within the community, the referrals that are received by the Team come from a range of sources, such as GP's, Emergency Services, other professionals, families and carers. The function of the Team is to assess a persons' needs and requirements, provide a 72 hour wrap around service establishing on-going support requirements going forward. At present the team also carry out rehabilitation for a period of time, which should be no longer than 6 weeks.
Integrated Community	Integrated Community Equipment Services provides a vast range of equipment

Equipment Service (ICES) - Service co-ordination staff member	to support people either in their own homes or the establishments they live in. ICES contract has three partners – TMBC, CCG and Derbyshire County Council. It is currently a section 75 pooled budget with TMBC as the lead Commissioner. The contract is currently being reviewed to determine future commissioning arrangements. A Co-ordinator is employed to ensure appropriate ordering and prescribing by health and social care staff, and to monitor the performance of the contract.
TMBC – Localities	
Assessment / Care Co-ordination (18+) Inc Locality teams and management	<p>The Care Act 2014 provides a statutory duty on the Council to carry out an assessment of need for anyone requesting it. Once an assessment has taken place, the application of the national eligibility criteria is made and a suitable support plan is determined. People receiving a package of care must be reviewed/reassessed annually as a minimum and those with complex care packages will be care managed/care co-ordinated throughout their time with the service.</p> <p>Assessment and Care Management staff undertake assessments and annual re-assessments. They hold a caseload, and will support individuals on an on-going basis, working proactively with individuals to enable them to live well in their own homes. Where an individual experiences a crisis or experiences a change in need the Social Worker/Assessor will work with the individual, carrying out a re-assessment where appropriate, and amending/changing the support plan where appropriate.</p> <p>The staff have a commissioning function in that they put in place care home placements or refer to the Home Care Commissioning Team to set up a home care package. Referrals to other appropriate professionals are also made, as is support to access community resources.</p> <p>A key function involves safeguarding adults, including undertaken and supporting safeguarding investigations. Investigation of complaints is also a function of managers in this function.</p>
Direct Payment Function – staff resource	Direct Payments (DP) are the Governments' preferred delivery vehicle for service users to have greater choice and control. Once a package of care has been identified, a personal budget is set against it and this can be taken as a direct cash payment to the user. This allows the individual to determine how best to meet their needs. A small team support individuals who have chosen a DP to ensure they are confident to manage the DP.
Review function in care homes – staff resource	The Council has a statutory duty to carry out at least an annual review of all packages of care. Reviews and reassessments can be carried out more frequently should the need arise. Two staff - Operational Performance Officers (OPOs) carry out this function with people who live in residential homes. The OPOs are responsible for organising the reviews, chairing the meetings and circulating copies of review minutes. The OPOs will also follow up on any actions identified during the reviews.
Health & wellbeing and Carers Service – staff resource	Whilst not everyone will meet the eligibility criteria to receive ASC it is important that help and advice is offered to everyone so that they are able to

	make informed decisions about their lifestyle and options for support within communities. The Health and Wellbeing Advisors work closely with people to support them in accessing the correct support and the correct connections with community and third sector groups in neighbourhoods. Within the Neighbourhood teams there are specific staff who work directly with carers to identify their care and support needs. The Council has a statutory duty to assess carers' needs and to provide suitable services to help support carers to continue to carry out their caring role.
Occupational therapy / Manual Handling Team	Adult services carry out assessments to determine whether appropriate community equipment and or adaptations are required. It also provides assessment for people with manual handling needs particularly if they are returning from hospital or are in crisis in their own homes.
TMBC Long Term Support	
Reablement Service (CQC Registered) (Inc Homecare through the night)	<p>The Reablement service is a CQC registered service that provides reablement support to individuals whose needs may have changed or have experienced a period of crisis. This service currently provides support for up to 6 weeks and supports the urgent care system in terms of 'step-up' and 'step down' support and provides support in the provision of community care assessments. The service is usually delivered in the individual's home.</p> <p>Individuals are referred into the service either from IUCT or from the Neighbourhood teams and is part of the Intermediate Tier function. The service is usually established within 2 working days. Individuals are reviewed weekly and their care package modified as an individual's skills and confidence improve.</p> <p>The service is delivered free as it is identified as a rehabilitation function. The service will usually support between 100 and 120 people at any one time. Individuals may require on-going longer term support, though for many this service builds confidence and skills that results in no further interventions being required.</p> <p>Social Workers in IUCT carry out reviews to close cases. There are usually about 30 people awaiting closure reviews – an individual cannot be charged for this service while awaiting this review. In exceptional circumstances Reablement will provide 'long term' home care support to individuals where a home care package cannot be commissioned – individuals are financially assessed for these services.</p>
Through the Night Service (CQC Registered in reablement registration)	This service offers planned care visits during the hours of 10pm and 7am to enable individuals who require care and support through the night to remain at home. The main functions are support with turning people and to support people with using the toilet.
TMBC Crisis & Response	
Community Response Service – warden/response element (Not Control/Operator function)	CRS provides support to enable people to remain in their own homes through the installation of assistive technology. A system linked to an individual's telephone is installed which gives connection to the Control/Operator function (it is proposed that the telephone response function remains with the Council). Devices include falls pendant, wander alert, pill dispensers, as well as a range of environmental alerts (gas, flood, etc). The service also supports hospital discharge, by installing equipment within 2 hours of referral, to facilitate a

	<p>speedier discharge. The service also has a range of lifting equipment which can be utilised to lift someone who has fallen, where they are not injured, thereby reducing transfers to hospital or hospital admission.</p> <p>The service is available to anyone aged 18+, whether they live in their own home, sheltered housing, or social housing. There is a weekly charge, which is currently £6.17. The service provides a 24 hour response, 365 days per year.</p> <p>The service offers a physical response, usually within 20 minutes, through a team of Wardens. A minimum of 2 Wardens are on duty at any one time, on a shift basis. A further 2 members of staff are utilised to install equipment and devices. The service also provides technical triage for Telehealth, Digital Health services.</p> <p>This service is not means tested and there is no eligibility criteria – this is a universal offer to anyone living in the borough.</p>
Sensory Service – (inc interpreting services)	This service provides an assessment and support function to adults aged 18+ who are blind, partially sighted or deaf, or dual sensory. Support includes rehabilitation, cane training, guide communicator, travel training, mail reading, provision of sensory aids and an interpreter service.

The table below details both the number of staff employed in each of these services, and where appropriate, details the activity levels associated with the service.

Table :- Transferring Staff Numbers and Service Activity

SERVICE/FUNCTION	NUMBER OF STAFFING POSTS	ACTIVITY
Integrated Urgent Care Staff & Management Team	47	
ICES Service co-ordination	1	
Assessment / Care Co-ordination (18+)	48	2,515
Direct Payment Function - staff resource	2	315 service users
Review function in care homes - staff resource	2	386 residents
Health & Wellbeing and Carers Service (Inc Management)	9	929 includes carers and wellbeing
Community Occupational Therapy / Manual Handling Team	19	1,321
Reablement Service	131	115
Through the Night Service	11	43
Community Response Service	50	3,425 18,000 in-bound calls on CRS per month 1,300 in-bound calls on Control per month (approximately 342 relating to ASC)

Sensory Service including Interpreter Services	8	136 541 Interpreting sessions 182 Mail Reading
Total Staff	328	

In addition to the service departments transferring it will be necessary to transfer either function or funding to support back office functions. If operationally it is better to retain the function with TMBC in order to maintain economies of scale funding will transfer and a service level agreement will be put in place for the ICFT to purchase the service from TMBC. Alternatively funding and staff will transfer and the service will be integrated into the ICFT. The table below identifies the functions:-

Function	Service description
Assistant Director Adults	
Head of Service Assessment and Care Management	
Finance	
Human Resources	
Legal	
Information	
Payroll	
IT & Systems	
Performance Management	
Quality Governance	

Further work will be required between approval of the OBC and FBC to develop the options and values associated with back office functions, as it is only proposed to transfer a sub-set of ASC which will mean that it is more difficult to disaggregate roles and responsibilities as most staff will support the whole of ASC services. Any agreements will need to ensure value for money and aim to avoid any increases in economy costs.

TMBC will still maintain legal responsibility for the provision of ASC services (although they will choose to discharge this responsibility through using the ICFT as their provider). This responsibility will be protected by the introduction of a Service Level Agreement. There will need to be appropriate additional controls around safeguarding, and assurance to TMBC that the ICFT is delivering social care effectively, ensuring TMBC duties are being delivered in accordance with the law.

Further detail on the options and the benefits and dis-benefits of each of the options taken forward in the OBC are included in the economic case below.

5.0 Economic Case

5.1 Option One – Do Nothing

The three partners (CCG, ICFT and TMBC) could do nothing. This would leave the responsibility for providing Adult Social Care with TMBC. Nothing would be changed.

5.1.1 Benefits

- Lowest risk option in the short term

- No additional risk of disruption to patients/clients
- No additional risk of disruption to the hospital or staff – at the moment the ICFT and ASC is undergoing considerable change and transformation. This would be an additional significant change

5.1.2 Dis-benefits

- No opportunity to change and improve the service (financial)
- Ignores the wider integration agenda
- Fragmentation of services
- Duplication of service provision
- Whole economy gap will remain and money will not flow through the system
- Less scope to improve the quality of services, as organisations work in silos.
- Less opportunity to improve user experience
- Lose opportunity to develop organisational development activities
- Reputational damage in terms of money already spent on forming partnerships.
- Opportunities to maximise early intervention, prevention and community based interventions will be lost
- Limited opportunities to develop a 'think family' and place based approach to meet people's needs
- Lose opportunity to access and share skills and knowledge across the organisation

5.1.3 Risks of this option

The significant drawback of the 'Do nothing' option is that it does not help the partners to address the whole economy financial gap. Under this option none of the three statutory partners to the Tameside and Glossop Locality Plan will be in financial balance by the end of the time period. Also there will be no significant progress made to deliver the required improvements in healthy life expectancy.

5.2 Option 2 – Transfer the provision of a subset of ASC delivered services from TMBC into the ICFT, as detailed in appendix A, through TUPE arrangements.

5.2.1 Rationale

There are a range of services that have a close interface between the ICFT and social care. These services identified as transferring as a subset of ASC are those that are more easily recognised as supporting the individual's journey through the health and social care system, since they impact more directly on the transition of care between the acute sector and neighbourhood provision. Several operate to support people to remain at home through an admission avoidance function or ensure that an individual's care is supported on discharge from hospital care.

The transformational work already commenced as part of the Care Together Programme has demonstrated the synergies/co-dependencies between these services and the benefits to the system and individuals that can be gained when pathways are streamlined and care better co-ordinated. It becomes more difficult to articulate a rationale for managing all

services under the current ASC remit the further along a continuum that those services are away from that health/social care interface.

It is therefore proposed that a subset of ASC services are transferred (as listed in Section four and in appendix A) along with the funds/staff required to perform them. It has been established that operationally the majority of these services are already closely aligned and that further integration would be beneficial to ensuring that standardisation of policies and working practices could be completed. Services that are partially aligned rather than fully integrated do present some issues as this alignment leads in some instances to clear lines of responsibility and accountability becoming more blurred. Whilst this is not necessarily a disadvantage for service users it can become complex for staff operating in the service and attempting to respond to the different organisational requirements.

Whilst it is unlikely that full integration of these services would result in significant cash releasing benefits in the short term, it would assist in supporting workforce redesign within health and social care in the medium to long term. The opportunities for exploiting the potential for developing apprenticeships and new roles and career paths is unlikely to occur in the absence of fully integrated services but would be an advantage given the predicted future shortfall in workforce across these sectors.

The need for data sharing presents further rationale for the transfer of these services. The interventions with the client group served by these services currently requires complex data sharing arrangements and access to and recording on multiple information systems. This would be more streamlined within a fully integrated service having the potential for the development of single assessment documentation between professional disciplines. This would enhance quality, potentially reduce risk and avoid duplication.

A number of considerations relating to governance issues could also be addressed and simplified with one organisation having a single line of sight on incidents and opportunities for improvement in the quality of services. This may present some risks, if not regulatory then reputational, as the ICFT develops a more in-depth understanding of service delivery and the potential risks inherent within them. To some extent this could be covered in part by a risk-sharing agreement though any public perception of a poor quality of service would be unlikely to be resolved even if this were in place. Given the high degree of regulation of health services, there may be some differences in the risk appetite between organisations. That said, the services recently reviewed by the CQC have been positively rated.

The services not included in this option are the longer term provision of care and mental health services. Whilst there is some risks that the flexibility gained by the transfer of ASC to the ICFT would be at the expense of the loss of the same flexibility between those ASC services remaining and those transferring, it is likely that greater benefits would be gained from the transfer.

Further information is available in the detailed benefit profiles below.

5.2.2 Benefits

This option in part mitigates the risk deriving from a transaction the size of the whole of Adult Social Care; it is more likely that both organisations would more easily be able to continue to meet their statutory duties.

The scale of change would be less likely to distract from the transformational programme and would enhance the work undertaken to date.

Operational teams are currently working in a partially integrated manner and there are further operational benefits that would be realised with the standardisation of policies and procedures. It is likely that staff would have more clarity on lines of reporting, responsibility and accountability.

Data sharing would be less complex and there is potential for streamlining assessment processes and avoidance of duplication.

Governance arrangements could be more easily determined and opportunities for learning and improvement accelerated and risk reduced.

Workforce planning could be completed in an integrated manner creating the potential for new roles which would be unlikely to occur if services remained separate. This is important given the future reductions in workforce across both health and social care sector.

5.2.3 Dis-benefits

There would be a separation in ASC services which does not currently exist and a potential loss of flexibility in TMBCs ability to flex resources as it does at present.

The ICFT may have a different risk appetite than TMBC and determine risks to be greater than is currently perceived.

5.2.4 Risks of this option

However leading from this specific option is the risk that the functions identified for transfer will either not be sufficient to address the locality's financial challenge and / or be unable to enable the delivery of significant service transformation to deliver the Locality Plan's objectives.

This option also carries the risk of failing to agree an appropriate financial value of the transaction as only a subset of services is to transfer. Under this option the ICFT holds the risk for the transfer of the identified staff.

5.3 Option 3 – Transfer the provision of a subset of ASC delivered services from TMBC into the ICFT, as detailed in Appendix A, with the LA staff seconded into the ICFT.

5.3.1 Rationale

The rationale for this option are the same as those discussed in section 5.2.1.

5.3.2 Risks of this option

This option contains the same risk profile as Option Two above but without the ICFT taking on the same degree of staffing risk. There continues to be the risk of having two cohorts of

staff on different terms and conditions.

5.4 Adult Social Care - Support Functions

In terms of the back office functions that support the new organisational form there are three key options to be considered.

- No back office functions transfer from TMBC to the ICFT and instead there is a range of Service level agreements put in place to cover the requirements.
- Transfer all of the back office functions from TMBC into the ICFT
- Transfer a subset of back office functions dependent on which option is recommended.

6.0 Finance Case

6.1 Financial Position within the Economy

In 2015 the ICFT, CCG and TMBC worked together to develop their locality plan. As part of that locality plan the three organisations developed a projected financial gap by 2020/21. At that time the projected gap was £70 million assuming that the ICFT could deliver £30 million pounds of cash releasing savings across that period. As such the economy do nothing gap was circa £100m. It should be noted that TMBC's financial gap included Children's services which no longer forms part of the integration plans.

The table below identifies the latest projected economy gap (still incorporating TMBC's Children's Services).

Economy Financial Gap	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000
CCG	21,877	21,036	21,232	21,232	
Council – Social Care & Population Health	12,131	12,944	17,926	18,251	
Strategic Commissioner	34,008	33,980	39,158	39,483	
ICFT	29,500	28,666	31,655	31,349	
Health; Social Care & Population Health Gap	63,508	62,646	70,813	70,833	

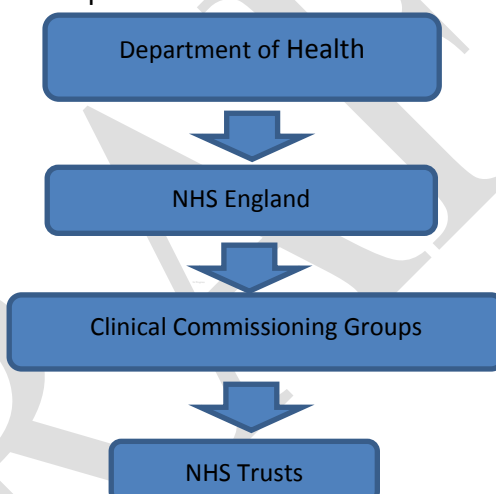
ICFT TEP savings required					
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Other Council Services Savings	5,115	7,477	14,820	18,717	
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Strategic Commissioning Total Gap	39,123	41,456	53,978	58,200	
Total Commissioner & Provider Gap – assuming ICFT TEP achieved	68,623	70,122	85,633	89,549	
Total Commissioner & Provider Gap – assuming ICFT TEP not achieved	77,123	78,224	91,799	93,756	

6.2 Funding Regimes

Funding and accounting mechanisms vary between the Local Authorities and the NHS. The funding flows within the NHS are depicted below.

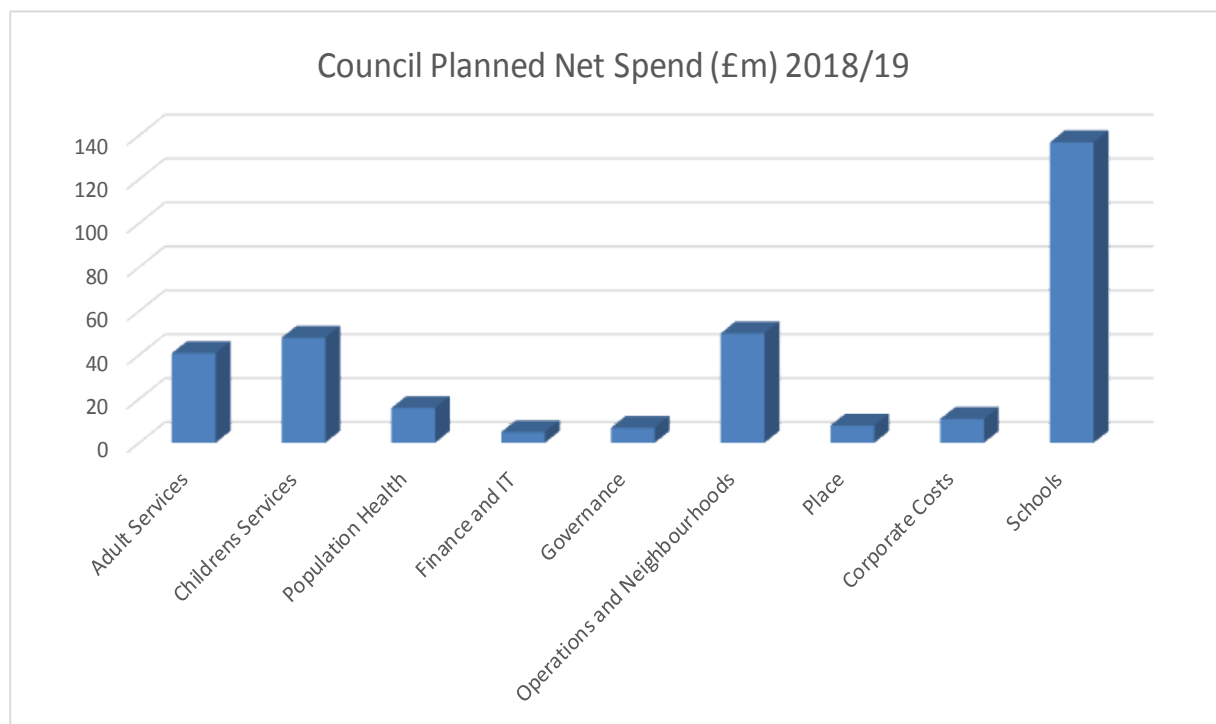


CCG's purchase activity from hospitals and, in the main, pay for it using a set of nationally set tariffs. As such funding follows the patients who receive the services free of charge. NHS Trusts are performance managed by NHSI, and are required to deliver against nationally set performance targets, and quality standards set by inspection regimes (Care Quality Commission – CQC). NHS Trusts account for income and expenditure on a gross basis.

Local Authorities receive their funding from four main sources; funding from central government, business rates, local council tax and fees and charges levied for Council Services. Councils which provide Social Care to Adults have been allowed to increase their share of Council tax by a maximum of an extra 6% between 2017/18 and 19/20, if it is all used to fund the increasing costs of Adult Social Care services. This is referred to as the 'Adult Social Care precept'. The extent of total Council expenditure is dictated by the amount of income or funding received, as the Council has to balance income and expenditure on an annual basis. They cannot have a deficit, as such if income falls for any reason the Council has to cut back on its planned levels of expenditure. As such the Council has to align its limited resources with key Council priorities, which are influenced by local priorities, input from public consultation, consultation with local businesses, Government

policies, performance information and external inspections. Councils are able to charge for Adult Social Services, based upon means testing, in accordance with the Care Act 2014. Councils report income and expenditure on a net basis, and also operate under different sections of the VAT Act to the NHS.

TMBC spends its money on the services depicted below.



It is only elements of Adult services that would be integrated into the ICFT in the first instance, and TMBC would continue to collect any client charges.

6.3 Section 75 Agreement

The funding for Adult Social Care services is held within the integrated Commissioning Fund (ICF) which is a pooled arrangement between the CCG and TMBC. Within the Tameside and Glossop ICF there are three pooling mechanisms; a section 75 pooling arrangement, 'aligned' funds, and 'in collaboration' funds. It is anticipated that the Adult Social Care transfer will be funded from the section 75 element of the ICF but there may be a small minority of services which may be funded from the 'aligned' funds due to the limitation of the section 75 legislation. This will be fully identified prior to the transaction being undertaken. The ICFT contract is funded from the ICF in which it is proposed that this Adult Social Care transfer will be included.

The transfer of this sub-section of adult Social Care services to the ICFT will be funded from the local authority contributions into the ICF. The ICF is underpinned by a robust Financial Framework which incorporates a mechanism for sharing financial risk between the two Strategic Commissioners and this will be separate from the risk share arrangement proposed for Adult Social Care between the Strategic Commission and the ICFT. This flow of funds in

respect of the transferred services will be managed, monitored, and reported in line with the governance set out within the ICF's Financial Framework.

The risk share arrangement between the Strategic Commission and the ICFT is proposed in section 6.4 below.

6.4 Financial Risk Management

To ensure greater confidence in the ongoing sustainability of both the ICFT and the provision of ASC services, there will need to be a risk sharing agreement with TMBC that guarantees the ICFT will not endure a further deficit on it in the first three years of implementation (starting in 19/20); additionally there will need to be detailed plans that identify how and when benefits can be released which will make the service more financially sustainable.

The following Risk Sharing Agreement has been proposed:

Financial Year	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24
TMBC contribution to funding shortfall	100%	100%	100%	50%	25%

Funding would commence from the point of implementation in the Finance Year 19/20 and cover the remainder of that year. As part of the risk share agreement it will be necessary to identify any proposed caps on the risk share taking account of the projected activity risks.

6.5 Benefits Realisation

6.6 Financial Option Appraisal

The tables below detail the finances associated with each of the three options proposed. In all cases it is the intention to transfer the gross expenditure budgets for the services, and TMBC will continue to recover and retain all client chargeable income. The detail supporting the expenditure budgets can be found in Appendix D.

It should be noted that at this time the figures reflected in the tables below have been provided by TMBC, and as yet there has been no agreement as to the methodology proposed to determine the allocation of the Adult Social Care financial gap down to the sub-set of transferring services. As such the financial gap could reduce pending discussions between now and production of the full business case.

Option One

Option 1 - Do Nothing	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Income	10,668	10,289	10,147	9,978	9,803
Expenditure	10,851	11,146	11,441	11,743	12,067
(Surplus) / Deficit	183	857	1,294	1,765	2,264
Risk Sharing Agreement	0	0	0	0	0
Trust Efficiency Requirement	0	0	0	0	0

Under option 1 the Council would retain the services and any projected financial gap would remain the responsibility of TMBC to resolve. This option does not support the economy vision of integration and would not support the benefits of integration. The economy financial gap would also remain static.

Option Two

Option 2 –Subset ASC Services - TUPE ASC Staff	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Income	10,668	10,289	10,147	9,978	9,803
Expenditure	10,851	11,146	11,441	11,743	12,067
(Surplus) / Deficit	183	857	1,294	1,765	2,264
Risk Sharing Agreement	183	857	1,294	882.5	566
Trust Efficiency Requirement	0	0	0	882.5	1,698

Under option 2 social workers and other staff included within the transfer would retain their terms and conditions. This would require the ICFT to be admitted to the Local Authorities pension fund, which may have associated risks and liabilities. It would also be necessary to agree which organisations terms and conditions any future staff recruitments would follow, as this too could have pension fund implications. Additional due diligence would highlight any associated risks of this during the development of the FBC.

The NHS scheme is a defined benefit scheme but because it is unfunded and (in theory) the future liabilities associated with each member body cannot be identified, it is accounted for as

if it were a defined contribution scheme, with employer pension costs being charged to expenditure as and when they become due. Effectively the only cost in the Trust's accounts will be the employer contributions payable for the financial year in question.

The Local Authority pension scheme charges the discounted present value of future benefits to expenditure each year, but then reverse this out through the statutory override so the charge to expenditure is just the employer cost in year. The Local Authority also reflect the future liabilities and share of the fund assets on their balance sheet (the NHS doesn't recognise anything on the balance sheet). This means that Local Authorities have a charge to expenditure that is generally greater than the actual cash cost in year, and depending on the valuation point, generally a significant net pensions liability on the balance sheet. The ICFT needs to understand how if they are admitted to the Local Authority pension fund they will be required to account for these pensions and its potential impact on the charges to expenditure being in excess of the budgets transferred, and any impact of the Trust's balance sheet.

The Local Authorities also maintain a reserve in relation to any future shortfalls in the local authority pension scheme. The ICFT would need to understand if this would be a requirement for the ICFT, or if TMBC would retain this in relation to the staff transferred.

If staff are TUPE across to the ICFT, this will result in staff being employed within the ICFT on differing terms and conditions. Any potential integration of staff onto NHS terms and conditions could increase the costs to the system, as the two organisations have differing staff and employer pension contributions and differing levels of sickness pay. The impact of any such proposal would need to be financially assessed to determine the impact on the economy and staff.

If staff are transferred this will result in staff following the same organisational policies and procedures, and will help to develop a single cultural and organisational identity. I should also support the streamlining of management processes and ensure equity. It should also enable the reduction in duplication of processes, allowing more time for direct care.

The transfer of staff to the ICFT would also potentially impact adversely on TMBC in relation to their Civil Contingency duties. Currently all staff employed by TMBC can be called on to support any local civil contingency. If the staff are TUPE, TMBC would lose this potential resource, unless this was covered within any future contract arrangements. If not it could have a potential cost to TMBC.

The transfer of staff has the potential to impact on adherence to the Care Act in that pressures within the ICFT could result in social workers priorities being shifted to the hospital which may impact on the delivery of TMBC's statutory responsibilities such as re-assessments being undertaken within twelve months, or safeguarding duties being completed within the set timescales.

Both options two and three, by the nature of only a sub-set of adult social care services transferring, have the potential to risk management fragmentation, as current service managers will support or manage both ASC services transferred and ASC services retained by TMBC. This will need to be resolved as part of the management and back office support discussions which will be resolved as part of the FBC.

Another potential risk which applies to both options two and three, is the fact that the staff which would form part of this transfer will be commissioning services against budgets and contracts retained by TMBC such as residential home placements, nursing homes, and home care, and as such these costs could increase due to differing management priorities. This could result in cost shunting between organisations, but this could be resolved as part of the future financial principles and risk share arrangements.

Option Three

Option 3 – Subset ASC services - Seconded ASC Staff	2019/20 £000's	2020/21 £000's	2021/22 £000's	2022/23 £000's	2023/24 £000's
Income	10,668	10,289	10,147	9,978	9,803
Expenditure	10,851	11,146	11,441	11,743	12,067
(Surplus) / Deficit	183	857	1,294	1,765	2,264
Risk Sharing Agreement	183	857	1,294	882.5	566
Trust Efficiency Requirement	0	0	0	882.5	1,698

Under option 3 staff would remain employed and paid by TMBC, but would be seconded to the ICFT who would then pay TMBC for the staff. This would negate any pension fund issues, but could potentially have VAT issues, although initial VAT advice is that this would be recoverable by the ICFT. As part of stage two due diligence any VAT issues would need to be further explored, and resolved such there are no increases in costs to the economy of this option. If VAT were to be an issue in respect of this option it could increase costs across the economy by circa £2m.

The secondment option arrangement is easier to withdraw from if the 'proof of concept' does not materialise. If the 'proof of concept' does work this would support future TUPE of staff and the future transfer of further services.

Secondment of staff may not support the creation of an organisational identity, as staff will be on differing terms and conditions, which could not be changed if staff were seconded. It also could make transformation of services more difficult if any staff related proposals have to go through governance at both the ICFT and TMBC. If staff are seconded it would be necessary to clarify whose policies and procedures they would follow, which could result in a team manager having to follow differing policies and procedures for different staff in their team.

This option may also make it more difficult to re-align budgets and services in the future as part of the integration and transformation process.

Both options two and three have the same financial impact on the ICFT, subject to further due diligence work at FBC.

The tapering risk share agreement would mean that the ICFT would need to find integration benefits starting in 2022/23 of 7.5% of Adult Social Care expenditure, rising to 14%

cumulatively in 2023/24. This level of benefits exceeds that normally expected and delivered within the NHS, and is the same for both options two and three.

6.7 Financial Principles

As part of any transaction the partners would need to agree some financial principles such as:-

- Financial transparency and co-operation between organisations.
- Fair and proportionate transfer of resources to support back office functions, while maintaining services at no additional costs where ever possible.
- No transfer of historic liabilities these will be retained by the transferring organisation
- No increase in service requirements either in terms of activity levels, or specification without agreement of all parties.
- No in year reductions in funding without prior agreement, and agreement to corresponding reductions or efficiencies in service provision.
- Any national changes to terms and conditions over and above those in the financial modelling to be funded by the Single Commissioners.
- No cost shunting between partners in the economy unless fully discussed and agreed as it reduces the economy financial gap.

6.8 Sensitivity Analysis

Full sensitivity analysis will be completed as part of the full business case.

7.0 Commercial Case

7.1 Commissioners' Procurement Strategy

The Contingency Planning Team report of 2015 (the Monitor-sponsored review by PwC) proposed the creation of an Integrated Care Organisation as the best opportunity for the locality to deliver the most significant improvements to the health and outcomes of our population.

The Strategic Commission is, therefore, convinced that the best way to achieve our vision and to deliver our priorities is by delivering via the ICO a new service model of which adult social care is a key component. It is therefore critical that the procurement strategy facilitates the development of the ICO and enables it to deliver a system of care that effectively responds to and impacts on population health outcomes whilst reducing costs.

It is therefore the intention of the Strategic Commission to transfer this subset of Adult Social Care services to Tameside and Glossop Integrated Care NHS Foundation Trust.

This approach has been formed through discussions with a colleague at NHS Improvement.

7.2. Due Diligence Summary

The ICFT and the Strategic Commissioners agreed to undertake due diligence in two phases. The first phase has been undertaken to support the completion of the OBC, and was commissioned on behalf of all parties. This work was undertaken by Hempsons. The second phase of due diligence will be required to support the FBC and will require the parties to the agreement to seek independent due diligence to provide the required assurance to the parties Boards.

The creation of a fully integrated Health and Social Care system is a complex undertaking that carries significant risks potentially to both TMBC who retain the statutory responsibility, and to the ICFT in terms of financial and delivery risks. As such the economy engaged Hempsons, as legal advisors in July 2017 to undertake due diligence into the integration of Adult social Care and some Commissioning functions. Hempsons were engaged to act on behalf of all partners to identify any areas of risk in expanding the ICFT services.

Due diligence has been identified as the basis of identifying both the risks and the available mitigation of those risks in expanding the ICFT. Formal due diligence will need to be performed to cover:

- Legal
- Financial
- Operational
- Quality

At the current time the first stage of external due diligence has only been undertaken by Hempsons in respect of legal issues, as it was assessed as being the areas with the highest areas of risk. The first stages of due diligence for the other areas has been undertaken internally for the first stage. At the FBC stage the ICFT will undertake formal external due diligence on the proposed option as the receiving organisation, which will comprise of legal, financial and operational due diligence.

7.2.1 Hempsons Due Diligence Report

Hempsons were engaged by the partner organisations in May 2017 and provided their findings in July 2017. Hempsons were engaged to cover the following areas:-

- Corporate, commercial, governance and contracts
- Employment and pensions
- Estates and Equipment
- Health and Safety / Environmental

- IM&T and intellectual property
- Disputes, clinical governance and indemnity
- Information governance

Hempsons review process aimed to highlight the main areas of risk including those requiring the need for greater clarity. As such the following areas were covered.

- System wide governance and accountability arrangements, including statutory powers of TMBC to transfer ASC and SCT functions to TGICFT, and the role of TMBC following completion of the arrangements
- Commissioned contracts with third parties, assuming these will transfer to TGICFT
- Procurement law compliance by TMBC and TGCCG as commissioners, and by TGICFT in respect of commissioned contracts with third parties
- Governance issues including role of Boards of Directors and Council of Governors
- Regulatory issues including NHS Improvement compliance requirements for transactions and the ISAP process, and CQC requirements
- Pensions liabilities in relation to TMBC staff transferring to TGICFT
- TUPE implications including employment liabilities of transferring staff
- Estates implications where there will be a change of use of existing estate
- IM&T implications where partners intend to integrate IM&T systems
- Disputes/claims – existing material disputes, civil and criminal claims of the partners and regulatory concerns (with CQC, NHS Improvement, Information Commissioners' Office, Health and Safety Executive)
- Indemnity arrangements for transferring services.

The final report was based on information provided by the three partner organisations and can be found within Appendix E. The report highlights the risks and recommends actions / mitigations that should be instigated. It should be noted that the report was produced to reflect the SOC longlist option two, where all Adult Social Services and an element of Commissioning functions would transfer.

7.2.2 Hempsons Phase One – Key Findings Report

Hempsons first phase due diligence report for inclusion within the OBC was produced based on information received from the partner organisations. The due diligence questionnaire is attached at Appendix C along with the full final report.

The key findings of the report were:-

- There are no legal showstoppers which will prevent the transfer of functions/services and the award of contract.

- There are a number of legal, commercial and practical steps that need to be undertaken to allow the proposed transfer to happen.
- There are some material risks of which 7 are red risks and 29 amber for which actions and mitigations have been identified.
- Most risks affect the ICFT, as the organisation which will acquire responsibility to Commissioners for the services.
- All risks can be rated 'green' or in a few cases 'amber' following the next stage of the project if actions and mitigations are followed.
- Recommended that partners carry out further due diligence on the matters identified and implement suggested actions and mitigations.

7.2.3 Partnership Response

As part of the ongoing partnership working each risk has been allocated to an individual or working group to address. The output should then support the stage two formal due diligence in order to mitigate the red and amber rated risks.

7.3 Contractual Arrangements

7.3.1 Statutory Responsibility

Tameside Metropolitan Borough Council will continue to retain legal responsibility for the provision of all Adult Social Care services. For the subset of services transferring under this Outline Business Case the local authority is choosing to discharge this responsibility through the ICFT as the provider.

The Council is required to appoint a Director of Adult Social Services under section 6 of the Local Authority Social Services Act 1970 (as amended) who is accountable for the delivery of TMBC's social services functions (except those the responsibility of the Director of Children's Services) listed in Schedule 1 of the Local Authority Social Services Act 1970 (as amended). The Director of Adult Social Services is directly accountable to the Chief Executive of the Council, appointed by the Council to a politically restricted Statutory Chief Officer post under section 2 of the Local Government Act 1989 (as amended), and from where they are required to deliver a key leadership role on behalf of the Council. This is not a role capable of novation or delegation to another organisation. It must remain part of the statutory chief officer team employed by the Council.

The position of Director of Adult Social Services is a leadership role to deliver the local authority's part in:

- improving preventative services and delivering earlier intervention
- managing the necessary cultural change to give people greater choice and control over services
- tackling inequalities and improving access to services
- increasing support for people with the highest levels of need.

One of the key aspects of the Director of Adult Social Services role is to deliver an integrated 'whole systems' approach to supporting communities. This is at the very heart of our locality's approach to neighbourhood working and for bringing together and transforming services.

The Director of Adult Social Services will seek assurances from the ICFT regarding the quality and timeliness of service delivery, regarding the application of the agreed eligibility criteria, and for the arrangements for the safeguarding of vulnerable adults. It is expected that these will be monitored through the existing contract review meetings.

TMBC will maintain the legal obligation to fulfil these services but will enter a contractual arrangement with the ICFT to be the provider.

7.3.2 Contract Form

The NHSE Contracting Team has verbally advised the ICFT that the standard NHS contract, as currently used by the Trust in its contract with the Single Commissioning Function, may not be the most suitable contract form in which to incorporate the provision of ASC. Instead, the NHS Standard Contract for Accountable Care Organisations (ACO) may be more appropriate.

The ICFT has raised a series of additional queries with the NHSE Contracts team. Without pre-empting any subsequent advice there is likelihood that the ICFT will continue to use the NHS standard form contract and adapt this to include the provision of ASC; this is for several reasons including:

- the model contract for Accountable Care Organisations is still not finalised and appears to be essentially for the provision of primary medical services with the addition of selected local authority services such as social care and/or public health
- At least one other GM NHS acute provider that also provides social care has continued to use the standard form contract without any issues
- The vast majority of the ICFT's income will continue to relate to the provision of acute and community healthcare

Regardless of the type of contract, any agreement will have a defined lifespan with the usual exit clauses which will be identified during the project process. Additionally, the provision of ASC will be fully specified in the contract, including the performance and quality requirements necessary to ensure that TMBC meets its legal obligations.

Required Services

The exact list of services that need to be performed, the volume and associated Service Level Agreements along with associated costs will be detailed in greater depth within any Full Business Case and later contractual documentation that will be agreed by the three partner organisations.

7.3.3 Risk Mitigation

This NHS contract will also include a risk sharing agreement which will ensure that TMBC is responsible for funding shortfalls within the first three years of the ICFT operating the ASC

services starting 19/20 and a decreasing percentage after the initial three years. The percentage available to the ICFT is covered in the table in Section 6.4.

The risk mitigation strategy outlined in section 6.4 may need to be reconsidered if the final arrangements for the TMBC ASC staff affected by the transfer changes the balance of risk. For example, if TMBC retains the employment of ASC staff, and their services are provided to the ICFT under a service level agreement or secondment arrangement then it this potentially creates a conflict as the ICFT:

- takes on increasing responsibility for any funding shortfalls from TMBC, and
- is dependent on TMBC for the supply of staff

In other words TMBC would have control over both the ICFT's ASC income and costs potentially creating a significant financial risk

7.3.4 Risk Transfer

The approach to risk transfer will be based on the best practice principle of allocating risk to the party, or parties, best placed to manage that risk. Therefore, an optimum allocation of risk rather than a maximum risk transfer will be taken.

The risk sharing agreement (which protects the ICFT from undue financial hardship until it can start to realise benefits) will be defined and agreed during the project process. After this TMBC will not cover any funding shortfalls as the ICFT will have had the opportunity to transform the service in a manner that releases savings.

Risks associated with the delivery of the solution (i.e. post contract award) will be maintained in a jointly held risk register with clear assignment to the responsible party.

Hempsons have provided an initial review of the legal feasibility and likely risks involved in this transfer. These issues are being captured within the Project Risk Register and will be documented in greater detail in the Project Initiation Document (PID).

8. Management Case

8.1 Introduction

This section addresses how the expansion of services within the ICO sits within the broader transformation programme within the ICFT. The integration transaction in its own right will not deliver financial or operational benefits. It will be the subsequent ability to integrate and transform services to provide a more streamlined end to end service that will provide efficiencies and a better patient experience.

To support the integration vision the Locality partners bid for and were successful in securing £23.2m of non-recurrent transformation monies from Greater Manchester Health and Social Care Partnership over a three year period from 2016. This funding will be used to transform services to better support people in their own homes, reducing the likelihood of hospital attendance and admissions, and to ensure that people are as well supported as possible to live healthy and independent lives.

All of the schemes aim to change behaviours or services within the Tameside & Glossop health and social care system, to contribute to delivery of the proposed system benefits, and impact on the successful delivery of the locality ambitions of financial sustainability and healthy life expectancy. The integration of Adult Social Care supports this ambition as reflected in the ICFT strategy as detailed in section 3.5. The aim is to fully integrate Social Service staff into the developing Neighbourhood structure which is aimed at reducing secondary care activity, and integrate them into the Hospital structure to support effective patient discharge.



8.2 Integration Principles

Further work required (Stephanie, Sandra W, Trish, Suzanne to discuss)

- E.g. secure vfm for the economy
- Transparency
- Co-operation and commitment

- Effective integrated working between the partners
- Positive health and social care outcomes
- Positive communication, integration and engagement of Social Care staff

8.3 Management Structure

The operational structure would require to be reviewed in order to ensure that this transaction resulted in integration of services rather than the development of a silo within the ICFT in which social care operates. This was the approach adopted with the transfer of community services in April 2016 and there are benefits in replicating this. It should be noted that the transfer of services from one health provider to another, in which expertise in the receiving organisation already exists, differs from the transfer of functions from social care to a health care provider who is inexperienced in this. The statutory responsibility of the DASS also requires consideration in this context.

It is envisaged that a senior management team with the capability to operationally lead the delivery of services and contribute to the on-going transformational work would be required to supplement the existing management structure within the ICFT. It is proposed that this team would sit alongside the existing operational teams reporting to the Executive Director of Operations. In the first instance it is unlikely that structures within services which are already integrated would change significantly but rather that this would be an iterative process as the workforce model develops.

There would also need to be further support provided by corporate services e.g IM&T, finance, human resources, Governance to support the expanded functions of operations.

8.4 Organisational Development

The workforce within the locality has been working collaboratively for a number of years in order to transform the delivery of health and social care services to enable improvement and seamless services to our residents.

Whole workforce engagement, including trade union colleagues has been undertaken to raise awareness of our transformation plans and to ensure that all colleagues are sighted on our vision and priorities and how they will contribute to this.

A detailed development programme has been commissioned and delivered by Rothwell Douglas. The focus of this has enabled us to drive forward our vision and transformation plans:

- strategic leadership and management
- whole workforce engagement
- neighbourhood and localities.

Neighbourhood teams are already co-located with colleagues from the Council and ICFT and plans are in place for this to be further developed to include primary care, voluntary sector and other wider public services.

To further support workforce transformation, a detailed workforce plan has been developed and dedicated resource put in place to ensure that the transformation is delivered. It is envisaged that the transaction of the Council workforce to the ICFT will provide significant

opportunities to accelerate transformation and new ways of working. Such benefits may include:

- ability for colleagues in NHS/Council to work even more closely together to reduce duplication
- develop improved ways of working
- enhance health and social care roles and to ensure improved outcomes for our residents are achieved
- colleagues are better equipped, able and expected to work and operate on a whole system approach
- improve understanding of whole system and enable priority and resource to be directed to areas of greatest transformation/improvement
- support and develop improved working/collaboration with primary care and voluntary sector
- enable improved career pathways to health and social care roles – improving recruitment and retention etc.
- improved user experience as workforce are better connected with our priorities and able to navigate the system better.

8.5 Governance Arrangements

Governance arrangements will be further developed as part of the full business case but will be required to cover arrangements at the ICFT, and how it sits within the economy wider governance structure, and continues to fulfil Statutory organisational requirements.

8.6 Project Management Arrangements

The SRO for the project is the Director of Adult Social Services at TMBC, whilst within the ICFT the Executive Lead for the project is the Director of Operations supported by the Executive management team, with the Director of Finance being the Executive lead for the transaction. The size and complexity of the project warrants significant management resource and oversight. The overall progress of the project will be overseen by the Care Together Programme Board.

The Care Together Programme Board will be collectively responsible for ensuring that:

- the project is adequately resourced
- the project achieves its objectives
- that risks are well managed
- that partner organisations undertake their responsibility to identify and release benefits
- the project is managed within budget, time and quality tolerances

8.7 Summary of Next Steps

To progress the OBC the economy partners would need to:-

- Undertake individual phase two due diligence work to satisfy Boards/Cabinet as to the benefits of the transaction
- Develop formal staff communication and TUPE consultation with affected staff (dependant on the preferred option)
- Agree either staff transfers or develop SLA's for back office functions, with associated finances and KPI's.
- Identify any additional costs to the ICFT resulting from the transaction (e.g. IM&T)
- Develop a long term strategic workforce plan
- Develop service and contractual obligations and KPI's
- Develop heads of terms
- Commence work on the Business transfer agreement
- Produce a detailed integration plan

Work to be completed to take the OBC up to a FBC – all

9. Conclusion and recommendations

Appendix A

Strategic Outline Case Long List of Options

Service Area – Adult Social Care	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
TMBC Urgent Care								

Service Unit Manager	x	√	√	√	√	√	√	√
Integrated Urgent Care staff and Management team	x	√	√	√	√	√	√	√
ICES Service co-ordination staff member	x	√	√	√	√	√	√	√
TMBC – Localities								
Assessment / Care Co-ordination (18+) Inc Locality teams and management	x	√	√	√	√	√	√	√
Direct Payment Function – staff resource	x	√	√	√	√	√	√	√
Review function in care homes – staff resource	x	√	√	√	√	√	√	√
Health & wellbeing and Carers Service – staff resource	x	√	√	√	√	√	√	√
Occupational therapy / Manual Handling Team	x	√	√	√	√	√	√	√
Home Care Commissioning Team	x	√	√	√	√	√	√	√
Property Management Function – staff resource	x	√	√	√	x	x	x	x
TMBC Long Term Support								
Service Unit Manager	x	√	√	√	√	√	x	x
Homemakers staff and management (24 hour Long term supported housing - LD) CQC Registered	x	√	√	√	√	√	x	x
LDS Support Clerks	x	√	√	√	√	√	x	x
Shared Lives (Carer Approval, training & support) CQC Registered	x	√	√	√	√	√	x	x
Learning Disability Day Services (including transport)	x	√	√	√	√	√	x	x
Reablement Service (CQC Registered) (Inc Homecare through the night)	x	√	√	√	√	√	√	√
Through the Night Service (CQC Registered in reablement registration)	x	√	√	√	√	√	√	√
Loxley House – Day service for people with physical disabilities / Development Trust	x	√	√	√	√	√	x	x
TMBC Crisis & Response								
Service Unit Manager	x	√	√	√	√	√	x	x
Community Response Service – warden/response element (Not Control/Operator function)	x	√	√	√	√	√	√	√

Sensory Service – (inc interpreting services)	x	√	√	√	√	√	√	√
Out of Hours Social work function inc statutory MH duty	x	√	√	√	√	√	x	x
Mental Health Service - TMBC Provision (social workers in Pennine Care) CMHT	x	√	√	√	√	√	x	x
Opt-In Service	x	√	√	√	√	√	x	x
MCA and AMHP co-ordination inc Deprivation of Liberty Safeguards	x	√	√	√	√	√	x	x
TMBC Contracts								
Age UK Core Funding	x	√	√	√	x	x	x	x
Community Support Service / Buddying (Age UK)	x	√	√	√	x	x	x	x
Advocacy (Cloverleaf)	x	√	√	√	x	x	x	x
Individual Service Fund (Tameside Link)	x	√	√	√	x	x	x	x
Mind Core Funding (Mind)	x	√	√	√	x	x	x	x
Willow Wood Hospice	x	√	√	√	x	x	x	x
Integrated Community Equipment Service (RossCare)	x	√	√	√	x	x	x	x
Minor Adaptations and Handy Person Service (Age UK / NCHT)	x	√	√	√	x	x	x	x
Garden Maintenance and Daytime Support (Greenscape)	x	√	√	√	x	x	x	x
Home Care Pre-Placement "Framework" Contract (Comfort Call; Mears Group; MRL Healthcare; Allied)	x	√	√	√	x	x	x	x
Home Care Pre-Placement Approved list (Able Care; Direct Care; Person Centred Care; CRG; Laurel Bank + Others)	x	√	√	√	x	x	x	x
Mencap	x	√	√	√	x	x	x	x
Older People Day Support - List of Approved Services	x	√	√	√	x	x	x	x
Learning Disability Day Support - List of Approved Services	x	√	√	√	x	x	x	x
Physical Disability Day Support - List of Approved Services								
Mental Health Alternative Accommodation	x	√	√	√	x	x	x	x
Mental Health Community Recovery Service (Turning Point)	x	√	√	√	x	x	x	x
Specialist Day Service for people with a Dementia (Creative Support - Wilshaw House)	x	√	√	√	x	x	x	x

Adult Social Care Transaction - Business Case

Supported Accommodation for Adults with a Learning Disability (24 hour Support) (Alternative Futures Group)	x	√	√	√	x	x	x	x
Provision of short-term and respite care to people with a learning disability plus alternative respite (Community Integrated Care)	x	√	√	√	x	x	x	x
Supported Accommodation for people with Mental Health Needs (Bendix Court, Mottram Road, Lyne View) (Creative Support)	x	√	√	√	x	x	x	x
Support with Independent Living – Lomas Court (Alternative Futures Group)	x	√	√	√	x	x	x	x
Supported Accommodation for young adults with a learning disability (Alternative Futures Group)	x	√	√	√	x	x	x	x
IMCA	x	√	√	√	x	x	x	x
Residential & Nursing Care Home “On Framework” Contract (26 Care homes)	x	√	√	√	x	x	x	x
Stroke Care Delivery	x	√	√	√	x	x	x	x
Senior Management Team								
Assistant Director Adults	x	√	√	√	√	√	√	√
Head of Service - Operations	x	√	√	√	√	√	x	x
Head of Service – Assessment and Care Management	x	√	√	√	√	√	√	√
Back Office Functions	x	√	√	√	√	√	√	√

Service Area – CCG Commissioned Services	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Public Health	x	√	x	x	x	x	x	x
Prescribing	x	√	√	x	x	x	x	x
Primary Care - PCQS, OOH, central drugs, LES, home oxygen, GPIT, Broomwell	x	√	x	x	x	x	x	x
Urgent Primary Care	x	√	√	x	x	x	x	x
Individualised Commissioning – CHC etc	x	√	x	x	x	x	x	x
3 rd Sector Grants & Services	x	√	x	x	x	x	x	x
Mental Health	x	√	x	x	x	x	x	x
Patient Transport	x	√	x	x	x	x	x	x

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Option Analysis of Gross Expenditure and Associated Funding Gap

Service Area - Adult Social Care	Option 1 - Do Nothing	Option 2 - Full integration of all Adult Social Care Services, and CCG Commissioned Services.	Option 3 - Full integration of all Adult Social Care Services, and a subset of CCG Commissioned Services.	Option 4 - Full integration of all Adult Social Care Services (including staff and funding).	Option 5 - Integration of in house ASC delivered services from TMBC into the ICFT through TUPE arrangements	Option 6 - Integration of in house ASC delivered services from TMBC into the ICFT with TMBC staff being seconded into the ICFT	Option 7 - Integration of a subset of in house ASC delivered services from TMBC into the ICFT, through TUPE arrangements	Option 8 - Integration of a subset of in house ASC delivered services from TMBC into the ICFT, as detailed in Appendix B, with the LA staff seconded into the ICFT.
Total Expenditure	73,979	73,979	73,979	73,979	17,976	17,976	10,556	10,556
2023-24 Financial Gap relating to ASC transfer (£'000)	17,318	17,318	17,318	17,318	4,312	4,312	2,264	2,264
Financial Gap as a % of Expenditure	23%	23%	23%	23%	24%	24%	21%	21%

Appendix C

Public Health Joint Needs Assessment

Summary of Tameside Joint Strategic Needs Analysis 2015/16

Key statistics for Tameside (compared to the England average);

- Highest premature death rate for heart disease in England
- For premature deaths from heart disease and stroke, Tameside is ranked 148th out of 150 Local Authorities in England
- For overall premature deaths, Tameside is ranked 142nd out of 150 Local Authorities in England (<75 years)
- For premature deaths from cancer, Tameside is ranked 133rd out of 150 Local Authorities in England
- Life expectancy at birth for both males and females is lower than the England average (76.9 years males, 80.3 years females)
- Life expectancy locally is 8.7 years lower for men and 7.4 years lower for women in the most deprived areas of Tameside compared to the least deprived areas.
- Healthy life expectancy at birth is currently 57.9 years for males in Tameside and 58.6 years for females in Tameside. This is significantly lower than the England averages.
- In year 6, 33.3% of children are classified as being overweight or obese, under 18 alcohol specific hospital admissions, breast feeding initiation and at 6 to 8 weeks and smoking in pregnancy are all worse than the England average.
- In adults the recorded diabetes prevalence, excess weight and drug and alcohol misuse are significantly worse than the England average
- Rates of smoking related deaths and hospital admissions for alcohol harm are significantly higher than the England average and many of our statistical neighbours
- Life expectancy with Males in Tameside living 3 years less than the England average and nearly 7 years less than the England best.
- Females live on average just over 2 years less than the England average and 6 years less than the England best.
- Healthy life expectancy for women is nearly a year less than for men, and close to the worst in England.
- Premature mortality for women has not improved as fast as the NW and England.
- Circulatory diseases including heart disease are the commonest cause of early death and rates are 55% higher than the national average.
- Disability free life expectancy at 65 years is significantly worse than the England average (6.8 years compared to 10.2 years in England (males)) and 7.1 years compared to 10.9 years (females))
- Nearly 20% of Tameside residents are living in fuel poverty compared to the 16% England average
- Significantly higher emergency admissions for both males and females
- People returning to their own homes after a stroke is significantly worse than the England average, 28% less people return to their own homes after a stroke compared to the England average.

Summary of Glossop Socio-economic status 2014

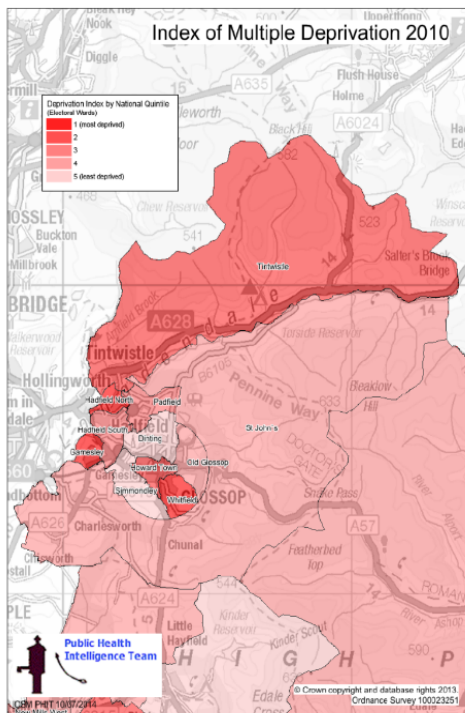


Fig. 2.2: Map of Glossop wards showing local area deprivation (see key)

Key term: Social deprivation

Deprivation is a lack of resources of all kinds, not just financial.¹ The English Indices of Deprivation 2010 (IMD) combine measures of employment, income, health and disability, education skills and training, barriers to housing and services, crime and disorder, and living environment—weighted to produce an overall area-based score.

In Fig. 2.2 each geographic area (Lower Level Super Output Area, or LSOA) is associated with an Index of Multiple Deprivation score. These scores are then ranked nationally and divided into five equal parts to create bands (each band thus equating to 20% of the total population, known as a quintile). The scores for each LSOA in Glossop are then mapped to the corresponding national band by colour coding. Thus those areas of Glossop that are the lightest shade (e.g. Dinting) are among the most affluent 20% of the population nationally. Conversely, those areas that are the darkest shade (e.g. Gamesley) are among the most disadvantaged 20% of the national population.

Table 2.4 shows more detail about each quintile in Glossop. It is notable that two LSOAs are in the most deprived national quintile, corresponding to 8% of the population of Glossop and to 2,560 residents.

Table 2.4: Social deprivation in Glossop LSOAs, by national quintile

LSOA IMD 2010 quintile	Number of LSOAs	Percentage of population	Number of residents
1 (Most deprived)	2	7.6	2,560
2	3	16.2	5,500
3	6	27.2	9,210
4	4	20.9	7,092
5 (Least deprived)	6	28.1	9,540
		100	33,902

Source: IMD 2010 and ONS mid-2012 estimates of population, via Public Health Intelligence, DCC

Table 2.5 shows that Glossop has a higher proportion of people living in the most deprived areas of England than the High Peak overall (two of the High Peak's three 'most deprived' LSOAs are in Glossop). However, Glossop overall is relatively affluent compared to Bolsover and Chesterfield, both of which have over three times the proportion of their population living in the 'most deprived' quintile.

Table 2.5: People living in the 20% most deprived areas in England, % (IMD 2010)	% in most deprived quintile
Glossop (11 wards combined)	7.6
Amber Valley	8.9
Bolsover	27.3
Chesterfield	25.8
Derbyshire Dales	2.2
Erewash	16.3
High Peak	4.6
North East Derbyshire	10.3
South Derbyshire	1.7
Derbyshire CC	12.2
England	20.4

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made
----------------------------	----------------------------	-----------------------------	--------------------------------

Source: Public Health England, via www.healthprofiles.info

Table 2.6 compares the sub-type of deprivation within Glossop by ward, revealing that Dinting, Simmondley and St John's are comparatively affluent whereas Gamesley, Hadfield North and Hadfield South are comparatively deprived.

Table 2.6: Index of Deprivation 2010, % (est. from MSOA level data)	Income deprivation	Child poverty	Older people in deprivation
Dinting	4.4	5.1	8.0
Whitfield	14.5	18.5	24.8
Old Glossop	11.8	15.2	20.1
Howard Town	14.5	18.5	24.8
Gamesley	22.0	30.8	28.6
Simmondley	4.4	5.1	8.0
Hadfield North	22.0	30.8	28.6
Hadfield South	18.2	25.6	24.7
Tintwistle	11.4	15.1	19.3
Padfield	11.4	15.1	19.3
St. Johns	4.4	5.1	8.0
Glossop (11 wards combined)	12.5	17.2	19.0
High Peak BC	10.2	13.7	14.4
Derbyshire CC	12.2	16.6	16.2
England	14.7	21.8	18.1

Quilt key:

Worse than England average	Similar to England average	Better than England average	No statistical comparison made
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Source: Public Health England, via www.localhealth.org.uk

For the full report see;

https://observatory.derbyshire.gov.uk/IAS/Custom/resources/HealthandWellbeing/Health_Needs_Assessments/Needs_and_assets_in_Glossop.pdf

Appendix D

Adult Social Care Budget Analysis

Adult Social Care Transaction - Business Case

Sum of Budget 2018/19			
Cost Centre	Cost Centre(T)	Subcipfa(T)	Total
SB500303	Assistant Executive Director - Adults	Employees	123,100
		Premises Related Expenditure	1,420
		Supplies and Services	3,370
		Transport Related Expenditure	1,100
SB500303 Total			128,990
SD710000	Home Care Through the Night	Employees	216,320
		Supplies and Services	2,160
		Transport Related Expenditure	4,500
SD710000 Total			222,980
SD711600	Reablement	Employees	1,551,930
		Premises Related Expenditure	730
		Recharge Expenses	600
		Supplies and Services	38,410
		Transport Related Expenditure	64,820
SD711600 Total			1,656,490
SI433900	Mental Capacity Act (MCA) Training - Deprivation	Employees	173,330
		Premises Related Expenditure	500
		Supplies and Services	157,810
		Transport Related Expenditure	900
SI433900 Total			332,540
SM090301	Team Clerks	Employees	89,340
		Supplies and Services	340
SM090301 Total			89,680
SM100000	Long Term Support Management Function	Employees	492,500
		Recharge Expenses	240
		Supplies and Services	15,020
		Transport Related Expenditure	560
SM100000 Total			508,320
SP420500	Occupational Therapy and Manual Handling	Employees	735,890
		Recharge Expenses	150
		Supplies and Services	8,410
		Transport Related Expenditure	3,330
SP420500 Total			747,780
SP420700	Sensory Services	Employees	292,290
		Premises Related Expenditure	-
		Recharge Expenses	-
		Supplies and Services	4,850
		Transport Related Expenditure	5,500
SP420700 Total			302,640
SP421300	Interpreter Services/Access to Work	Supplies and Services	20,000
		Transfer Payments	-
		Transport Related Expenditure	-
SP421300 Total			20,000
SP917100	Integrated Community Equip Servi Aids / Equipm	Employees	22,680
		Supplies and Services	-
SP917100 Total			22,680
SP917201	Telephones For Disabled	Supplies and Services	2,000
SP917201 Total			2,000
SQ760000	Carers Centre Main	Employees	-
		Premises Related Expenditure	-
		Supplies and Services	105,000
		Third Party Payments	25,000
SQ760000 Total			130,000

Appendix D

Sum of Budget 2018/19			
Cost Centre	Cost Centre(T)	Subcipfa(T)	Total
SQ760200	Health and Wellbeing Staff	Employees	215,870
		Premises Related Expenditure	-
		Recharge Expenses	300
		Supplies and Services	16,180
		Transport Related Expenditure	1,000
SQ760200 Total			233,350
SW500300	HOS - Head of Transformation	Employees	101,390
		Recharge Expenses	-
		Supplies and Services	45,310
SW500300 Total			146,700
SW752000	Localities Management Function	Employees	655,280
		Premises Related Expenditure	-
		Recharge Expenses	150
		Supplies and Services	3,220
		Transport Related Expenditure	500
SW752000 Total			659,150
SW752300	Adult Social Care Locality Teams	Employees	1,881,250
		Premises Related Expenditure	3,000
		Recharge Expenses	1,000
		Supplies and Services	32,100
		Third Party Payments	123,680
		Transfer Payments	-
		Transport Related Expenditure	18,050
SW752300 Total			2,059,080
SW752500	Urgent Integrated Care Team	Employees	1,623,140
		Premises Related Expenditure	2,000
		Recharge Expenses	-
		Supplies and Services	17,850
		Transfer Payments	-
Transport Related Expenditure	8,420		
SW752500 Total			1,651,410
SW752600	Urgent Intergrated Care Service Management Tea	Employees	308,890
		Supplies and Services	1,800
		Transport Related Expenditure	-
SW752600 Total			310,690
SW752700	Reablement Operational	Employees	502,510
		Recharge Expenses	100
		Supplies and Services	4,770
		Transport Related Expenditure	2,900
SW752700 Total			510,280
SW754200	Community Response and Emergency Control Ser	Employees	821,250
		Premises Related Expenditure	-
		Recharge Expenses	-
		Supplies and Services	-
		Transport Related Expenditure	-
SW754200 Total			821,250
Grand Total			10,556,010

Appendix E

Hempsons Legal Due Diligence Report – Stage One



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DD Questionnaire.docx

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Finance case

Economy Financial Gap	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000
CCG	21,877	21,036	21,232	21,232
Council - Social Care & Pop Health	12,131	12,944	17,926	18,251
Strategic Commissioner	34,008	33,980	39,158	39,483
ICFT	29,500	28,666	31,655	31,349
Health & Social Care & Pop Health Gap	63,508	62,646	70,813	70,833

ICFT TEP savings required	8,500	8,102	6,166	4,207
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Other Council Services Savings	5,115	7,477	14,820	18,717
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Strategic Commissioning Total Gap	39,123	41,456	53,978	58,200
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Total Gap Commissioner & Provider - assuming ICFT TEP achieved	68,623	70,122	85,633	89,549
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Total Gap Commissioner & Provider - assuming ICFT TEP not achieved	77,123	78,224	91,799	93,756
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APPENDIX E: INDIVIDUAL SERVICE BENEFIT TEMPLATES

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By virtue of paragraph(s) 3 of Part 1 of Schedule 12A
of the Local Government Act 1972.

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