Tameside & Glossop Care Together

STRATEGIC COMMISSIONING BOARD

Day: **Wednesday**
Date: **19 September 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 Board.	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of the Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 29 August 2018.	1 - 6
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance.	7 - 26
5.	**COMMISSIONING FOR REFORM**	
a)	**BANDING PAYMENT SYSTEM AND AGE POLICY CHANGE FOR SHARED LIVES PLACEMENTS** To consider the attached report of the Executive Leader and Director of Adult Services.	27 - 66
b)	**NHS ENGLAND CONSULTATION ON EVIDENCE BASED INTERVENTIONS: GM RESPONSE** To consider the attached report of the Interim Director of Commissioning.	67 - 112
6.	**URGENT ITEMS** To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	
7.	**DATE OF NEXT MEETING** To note that the next meeting of the Strategic Commissioning Board will be held on 24 October 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.

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TAMESIDE AND GLOSSOP
STRATEGIC COMMISSIONING BOARD

29 August 2018

Commenced: 1.00 pm **Terminated: 2.20 pm**

Present: Dr Alan Dow (Chair) – NHS Tameside and Glossop CCG
Steven Pleasant – Tameside MBC Chief Executive and Accountable Officer for NHS Tameside and Glossop CCG
Councillor Bill Fairfoull – Tameside MBC
Councillor Warren Bray – Tameside MBC
Councillor Gerald Cooney – Tameside MBC
Councillor Leanne Feeley – Tameside MBC
Councillor Allison Gwynne – Tameside MBC
Councillor Oliver Ryan – 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
Dr Ashwin Ramachandra – NHS Tameside and Glossop CCG

In Attendance: Sandra Stewart – Director of Governance and Pensions
Kathy Roe – Director of Finance
Stephanie Butterworth – Director of Adult Services
Jeanelle De Gruchy – Director of Population Health
Michelle Walsh – Deputy Director of Quality and Safeguarding
Sandra Whitehead – Assistant Director (Adult Services)
Sarah Dobson – Assistant Director (Policy, Performance and Communications)
Janna Rigby – Head of Primary Care

Apologies: Councillor Brenda Warrington – Tameside MBC
Carol Prowse – NHS Tameside and Glossop CCG
Councillor Jean Wharmby – Derbyshire CC

37. DECLARATIONS OF INTEREST

Declarations of interest were submitted as follows:

Members	Subject Matter	Type of Interest	Nature of Interest
Dr Alan Dow	Item 9(a) – Primary Care Access Service: Procurement	Personal	Potential perceived conflict of interest therefore did not take part to avoid challenge to process.
Dr Alison Lea	Item 9(a) – Primary Care Access Service: Procurement	Prejudicial	Assistant Medical Director (primary care) at Tameside and Glossop Integrated Care NHS Foundation Trust and GP Practice Partner Director of Orbit.
Dr Vinny Khunger	Item 9(a) – Primary Care Access Service: Procurement	Prejudicial	Salaried GP for Go-to-Doc Ltd and also clinical lead for primary care for Go-to-Doc Ltd.

* Drs Dow, Lea and Khunger left the room during consideration of this item and took no part in the decision thereon.

38. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held o 25 July 2018 were approved as a correct record.

39. TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST

The Chair welcomed Jane McCall, Chair of the Tameside and Glossop Integrated Care NHS Foundation Trust, who outlined who explained that she had joined the Trust in January 2018. The Trust's Corporate Objectives for 2018/19 were circulated and outlined which underpinned the key priority of ensuring that patients and service users received harm-free care by improving the quality and safety of services through the delivery of the organisation's Quality and Safety Programme.

A key challenge facing the Trust was recruitment and retention of staff across the workforce and particularly in specialist areas where there were national shortages and devising local strategies to achieve workforce sustainability would improve the experience of staff and patients. Work continued with the Trust's key partners to enable the five primary care neighbourhood hubs to deliver new integrated service models to improve the health and wellbeing outcomes for local communities.

The Members of the Board then viewed a short video of the Trust's successes and highlights over the past year.

In conclusion, Jane McCall stated that Tameside and Glossop Integrated Care NHS Foundation Trust had a clear plan to radically change and improve the healthcare provision for local people and she was delighted to play a part in reaching that goal.

RESOLVED
That thanks be extended to Jane McCall, Chair of the Tameside and Glossop Integrated Care NHS Foundation Trust for her attendance and presentation outlining the Trust's priorities for 218/19 and reflecting on progress and successes for the previous year.

40. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

Consideration was given to a report of the Director of Finance providing an overview on the financial position of the Tameside and Glossop economy in 2018/19 at the 30 June 2018 with a forecast projection to 31 March 2019 including the details of the Integrated Commissioning Fund for all Council services and he Clinical Commissioning Group with a total net revenue budget value for 2018/19 of £581 million. The report also included details of the financial position of the Tameside and Glossop Integrated Care NHS Foundation Trust.

The Strategic Commission was currently forecasting that expenditure for the Integrated Commissioning Fund would exceed budget by £5.848 million by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas, particularly in respect of Continuing Healthcare, Children's Social Care and Growth, and supporting details of the projected variances were explained in Appendix 1 to the report. Further detailed analysis for service areas was provided in Appendix 2. The Strategic Commission risk share arrangements remained in place for 2018/19 as outlined in the report.

In particular, the Director of Finance made reference to the economy wide savings target for 2018/19 of £35.721 million. Against this target, £10.906 million of savings had been realised in the first quarter, 30% of the required savings. Expected savings by the end of the year were £30.292 million, a shortfall of £5.429 million against target. It was noted that there was a risk of under achievement of this efficiency sum across the economy at this reporting period. It was therefore essential that additional proposals were considered and implemented urgently to address this gap on a recurrent basis thereafter.

RESOLVED

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

(ii) That the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks which were contributing to the overall adverse forecast be acknowledged.

(iii) That the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Growth be acknowledged.

41. QUALITY ASSURANCE

Consideration was given to a report of the Director of Quality and Safeguarding providing the Strategic Commissioning Board with assurance that robust quality assurance mechanisms were in place to monitor the quality of the services commissioned and covered data and issues of concern / remedy, good practice including patient stories and surveys and horizon scanning.

Reference was made to commissioners working on issues relating to high prescribing costs and high admissions for people with diabetes, chronic obstructive pulmonary disease and asthma. Frequent attenders had been identified and work was ongoing with the appropriate practices and would also be progressed through the Diabetes Improvement Group and Respiratory Programme Board.

There were currently four residential homes rated inadequate within the Tameside and Glossop locality and a short summary of key issues and the support being provided by the Quality Improvement Team was provided.

RESOLVED

That the content of the update report be noted.

42. PERFORMANCE UPDATE

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

Health and Care Dashboard

Exceptions (areas of concern):

- A&E 24 hour waits total time with 4 hours at Tameside and Glossop Integrated Care Foundation Trust;
- Referral to treatment – 18 weeks;
- Cancer 62 day wait from referral to treatment;
- Proportion of people using social care who receive self-directed support and those receiving Direct Payments;
- Learning Disability service users in paid employment

On watch (monitoring):

- Cancer 31 day wait;
- 65+ at home 91 days.

Other Intelligence / Horizon Scanning

- NHS 111;
- 52 week waiters;
- GP referrals trend.

In addition, it was reported that NHS England had recently published assessments for cancer and maternity for each Clinical Commissioning Group in the country. Tameside and Glossop Clinical

Commissioning Group had been assessed as 'Good' for concern and 'Requires Improvement' for maternity.

It was explained that in relation to cancer, Tameside and Glossop Clinical Commissioning Group was one of six areas in Greater Manchester to get a rating of 'Good' or better for cancer. Although the Clinical Commissioning Group had received a 'Good' rating, more recent data – since the end of 2017/18 – indicated a slight dip in performance. While not significant nor a major cause for concern, it was important to keep a close eye on ongoing changes in performance detailed in section 2.5 and Appendix 2 of the report.

The Chief Executive and Accountable Officer was pleased to advise that the Clinical Commissioning Group had been presented with a certificate by the All Party Parliamentary Group for being one of the most improved Clinical Commissioning Groups as measured by annual one-year cancer survival rates. Thanks to medical advances and the hard work of health staff, survival rates continued to improve which was great news.

For maternity, Tameside and Glossop Clinical Commissioning Group was one of eight areas in Grater Manchester to get a rating of 'Requires Improvement'. A key measure of the effectiveness and quality of maternity services was performance regarding neonatal mortality and stillbirths. Tameside and Glossop Clinical Commissioning Group had the second lowest rate (best) in Greater Manchester and the third lowest (best) amongst peer areas. Improving the quality and effectiveness of maternity services in Tameside and Glossop remained a priority for the Clinical Commissioning Group, the Integrated Care Foundation Trust and other partners. A summary of the key actions relating to the following were outlined:

- Stillbirth and neonatal mortality rate;
- Women's experience of maternity services;
- Choices in maternity services;
- Rate of maternal smoking at time of delivery.

In Focus – Adult Social Care

The Director of Adult Services gave a presentation focusing on the overall performance in adult social care services in Tameside including customer satisfaction and experience with services. It also provided details on initiatives and interventions to enable people to remain in their homes and reduce admission to residential care including:

- Community Response Service – providing different types of alarms depending on customer needs and health;
- Re-ablement Service – supporting people to maximise their level of independence, improve their health and enhance their quality of life.

Data on the quality of care homes in Tameside was also provided and discussed and although there had been improved performance since November 2017 it was recognised that there was a need for further improvement, particularly in two key areas – the safety and well led elements. It was noted that it was the medium sized care homes where the most help was required.

The Chair commented that there had been extensive developments over the last 24 months in moving forward with the integration agenda and was pleased to see that the Quality and Performance reporting now looked at Tameside and Glossop, Primary and Secondary care and health and social care which was a tremendous achievement.

RESOLVED

That the content of the performance report and Adult Social Care In Focus progress report be noted.

43. RISK REGISTER

Consideration was given to a report of the Director of Finance which explained that the Clinical Commissioning Group's Audit Committee had requested that Risk 32 be reviewed which specifically related to the Strategic Commissioning Board to ensure it did not negatively impact on the Clinical Commissioning Group.

RESOLVED
That having reviewed Risk 32 it was agreed that the risk of negative impact of the Strategic Commission on the Clinical Commissioning Group remained very low.

(At this juncture Drs Dow, Lea and Khunger left the room for consideration of the following item of business.)

(Councillor Bill Fairfoull in the Chair)

44. 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.

45. PRIMARY CARE ACCESS SERVICE PROCUREMENT: EVALUATION OUTCOME

RESOLVED
(i) That the item be deferred to a future meeting of the Strategic Commissioning Board to provide Members of the Board with assurances that the procurement process had been carried out with due process and how it delivered the outcomes in the Procurement and Evaluation Strategy approved by the Board on 20 June 2018 as there was insufficient information in the report to form a view.
(ii) That the existing contract for Primary Access Services be extended with the current providers to ensure continuous service provision until the procurement process had been completed.

46. URGENT ITEMS

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

47. DATE OF NEXT MEETING

It was noted that the next meeting of the Strategic Commissioning Board would take place on Wednesday 19 September 2018.

CHAIR

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Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	19 September 2018
Officer of Strategic Commissioning Board	Kathy Roe – Director Of Finance – Tameside & Glossop CCG and Tameside MBC
Subject:	**STRATEGIC COMMISSION AND NHS TAMESIDE AND GLOSSOP INTEGRATED CARE FOUNDATION TRUST – CONSOLIDATED 2018/19 REVENUE MONITORING STATEMENT AT 31 JULY 2018 AND FORECAST TO 31 MARCH 2019**
Report Summary:	This report has been prepared jointly by officers of Tameside Council, NHS Tameside and Glossop Clinical Commissioning Group and NHS Tameside and Glossop Integrated Care Foundation Trust (ICFT). The report provides a consolidated forecast for the Strategic Commission and ICFT for the current financial year. Supporting details for the whole economy are provided in **Appendix 1.** The Strategic Commission is currently forecasting that expenditure for the Integrated Commissioning Fund will exceed budget by £4.061 million by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas.
Recommendations:	Strategic Commissioning Board Members are recommended : 1. To acknowledge the significant level of savings required during 2018/19 to deliver a balanced recurrent economy budget together with the related risks which are contributing to the overall adverse forecast. 2. To acknowledge the significant cost pressures facing the Strategic Commission, particularly in respect of Continuing Healthcare, Children's Social Care and Growth. 3. To authorise use of headroom in the ICF risk share to increase the CCG surplus in 2018/19. This will enable drawdown of cumulative surplus in 2019/20 and improve the future financial position.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report provides the 2018/19 consolidated financial position statement at 31 July 2018 for the Strategic Commission and ICFT partner organisations. For the year to 31 March 2019 the report forecasts that service expenditure will exceed the approved budget in a number of areas, due to a combination of cost pressures and non-delivery of savings. These pressures are being partially offset by additional income in corporate and contingency which may not be available in future years. The report emphasises that there is a clear urgency to implement associated strategies to ensure the projected funding gap in the current financial year is addressed and closed on a recurrent basis across the whole economy. The Medium Term Financial Plan for the period 2019/20 to 2023/24 identifies significant savings requirements for future years. If budget pressures in service areas in 2018/19 are sustained, this will inevitably lead to an increase in the level of savings required in future years to balance the budget.

	It should be noted that the Integrated Commissioning Fund (ICF) for the Strategic Commission is bound by the terms within the Section 75 and associated Financial Framework agreements.
Legal Implications: **(Authorised by the Borough Solicitor)**	Given the implications for each of the constituent organisations this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Strategic Commissioning Strategy
Recommendations / views of the Health and Care Advisory Group:	A summary of this report is presented to the Health and Care Advisory Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.
Risk Management:	Associated details are specified within the presentation
Access to Information :	Background papers relating to this report can be inspected by contacting : Tom Wilkinson, Assistant Director of Finance, Tameside Metropolitan Borough Council Telephone:0161 342 5609 e-mail: tom.wilkinson@tameside.gov.uk

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

Telephone:0161 342 5626

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

Telephone:0161 922 4624

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

1. INTRODUCTION

1.1 This report aims to provide an overview on the financial position of the Tameside and Glossop economy in 2018/19 at the 31 July 2018 with a forecast projection to 31 March 2019. Supporting details for the whole economy are provided in **Appendix 1.**

1.2 The report includes the details of the Integrated Commissioning Fund (ICF) for all Council services and the Clinical Commissioning Group. The total net revenue budget value of the ICF for 2018/19 is currently £581.888 million.

1.3 It should be noted that the report also includes details of the financial position of the Tameside and Glossop Integrated Care NHS Foundation Trust. This is to ensure members have an awareness of the overall Tameside and Glossop economy position. Reference to Glossop solely relates to health service expenditure as Council services for Glossop are the responsibility of Derbyshire County Council.

1.4 Please note that any reference throughout this report to the Tameside and Glossop economy refers to the three partner organisations namely:

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

2. FINANCIAL SUMMARY

2.1 Table 1 provides details of the summary 2018/19 budgets and net expenditure for the ICF and Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) projected to 31 March 2019. The Strategic Commission is currently forecasting that expenditure for the Integrated Commissioning Fund will exceed budget by £5.848m by the end of 2018/19 due to a combination of non-delivery savings and cost pressures in some areas. Supporting details of the projected variances are explained in **Appendix 1**.

Table 1: Summary of the ICF and ICFT – 2018/19

Organisation	Net Budget £000s	Forecast £000s	Variance £000s
Strategic Commission (ICF)	581,888	585,949	(4,061)
ICFT	(19,149)	(19,149)	0
Total	**562,739**	**566,800**	**(4,061)**

2.2 The Strategic Commission risk share arrangements remain in place for 2018/19. Under this arrangement the Council has agreed to increase its contribution to the ICF by up to £5.0m in 2018/19 in support of the CCG's Quality, Innovation, Productivity and Prevention (QIPP) savings target. There is a reciprocal arrangement where the CCG will increase its contribution to the ICF in 2020/21.

2.3 Any variation beyond is shared in the ratio 68 : 32 for CCG : Council. A cap is placed on the shared financial exposure for each organisation (after the use of £5.0m) in 2018/19 which is a maximum £0.5m contribution from the CCG towards the Council year end position and a maximum of £2.0m contribution from the Council towards the CCG year end position. The CCG year end position is adjusted prior to this contribution for costs relating to the residents of Glossop (13% of the total CCG variance) as the Council has no legal powers to contribute to such expenditure.

2.4 A summary of the financial position of the ICF analysed by service is provided in Table 2. The projected variances arise due to both savings that are projected not to be realised and emerging cost pressures in 2018/19. Further narrative on key variances is summarised in sections 3 and 4 below with further detail in **Appendix 1**.

Table 2: 2018/19 ICF Financial Position

Service	Net Budget £000s	Forecast £000s	Variance £000s
Acute	205,071	205,308	(238)
Mental Health	32,758	32,861	(103)
Primary Care	84,487	84,412	75
Continuing Care	14,504	17,441	(2,937)
Community	30,040	30,045	(4)
Other CCG	23,338	20,131	3,207
CCG TEP Shortfall (QIPP)	0	1,546	(1,546)
CCG Running Costs	5,175	5,175	(0)
Adults	40,492	40,507	(15)
Children's Services	49,100	52,174	(3,074)
Population Health	16,232	16,197	35
Operations and Neighbourhoods	50,379	50,924	(545)
Growth	7,858	10,106	(2,247)
Governance	9,049	9,049	0
Finance & IT	4,488	4,602	(113)
Quality and Safeguarding	67	73	(6)
Capital and Financing	9,638	8,236	1,402
Contingency	(2,660)	(3,388)	728
Corporate Costs	1,870	550	1,320
Integrated Commissioning Fund	**581,888**	**585,949**	**(4,061)**
CCG Expenditure	395,374	396,920	(1,546)
TMBC Expenditure	186,514	189,029	(2,515)
Integrated Commissioning Fund	**581,888**	**585,949**	**(4,061)**
A: Section 75 Services	266,713	269,235	(2,522)
B: Aligned Services	241,487	242,468	(981)
C: In Collaboration Services	73,687	74,246	(558)
Integrated Commissioning Fund	**581,888**	**585,949**	**(4,061)**

3. BUDGET VARIATIONS

3.1 The forecast variances set out in Table 2 includes a number of variances driven by cost pressures arising in the year and risks or non-delivery of savings. The key variances by service area are summarised below.

Continuing Care (£2.937m)

3.2 Growth in the cost and volume of individualised packages of care is the amongst the biggest financial risks facing the Strategic Commission. Expenditure growth in this area was 14% in 2017/18, with similar double digit growth rates seen over the previous two years. When benchmarked against other CCGs in GM on a per capita basis spend in Tameside and Glossop spends significantly more than average in this area. A continuation

of historic growth rates is not financially sustainable and should not be inevitable that the CCG is an outlier against our peers across GM in the cost of individualised commissioning. Therefore budgets which are reflective of this and assume efficiency savings have been set for 2018/19.

3.3 A financial recovery plan is now in place and progress against this is reported to the Finance and QIPP Assurance Group on a regular basis. A summary of progress against this recovery plan is included in **Appendix 1.**

3.4 Further work is required to develop and realise the savings associated with these schemes. However there is clear evidence that progress is being made on fast track placements where marked reductions in both the number of active packages and the duration of each package can be seen.

CCG Other £3.207m

3.5 Services within this directorate such as BCF, estates, safeguarding and patient transport are spending broadly in line with budget and do not present a risk to the CCG position. We have received £1.6m of the approved £6.3m transformation funding so far this year. Allocations for the remainder will be transacted later in the year and we have plans in place to spend.

3.6 The significant favourable variance has been calculated in order to balance the CCG position and can only be delivered if the CCG is able to fully achieve the £19.8m Targeted Efficiency Plan (TEP) target. As reported in **Appendix 1**, there is a £1.5m risk attached to fully closing this gap.

CCG TEP Shortfall (£1.546m)

3.7 The CCG has a TEP target (also known as the QIPP), of £19.8m for 2018/19. Against this target, £8.682m (44%) of the required savings have been achieved in the first four months of the year. A further £6.853m is rated green and will be realised in future months. After the application of optimism bias, anticipated further savings of £2.719m from schemes currently rated as amber or red, reducing the net gap to £1.546m.

Children's Services (£3.074m)

3.8 Position has improved slightly due to staff vacancies but this remains a significant pressure. The Council continues to experience extraordinary increases in demand for Children's Social Care Services, placing significant pressures on staff and resources. The number of Looked after Children has gradually increased from 612 at 31 March 2018 to 636 at 31 July 2018. Despite the additional financial investment in the service in 2017/18 and 2018/19, the service is projecting to exceed the approved budget by £3m; due to the additional placement costs. It should be noted that the 2018/19 placements budget was based on the level of Looked After Children at December 2017 (585); the current level at 31 July 2018 is 636; a resulting increase of 51 (8.7%). This should also be considered alongside the current average weekly cost of placements in the independent sector with residential at £3,681 and foster care £761.

Operations and Neighbourhoods (£0.545m)

3.9 The service continues to face pressures due to non-delivery of savings and additional cost pressures. The new Car parking provision around the hospital on Darnton Road was expected to generate additional income of £500k per annum. Delays in the construction of the spaces has resulted in the non-delivery of the saving in 2018/19 of £275k. There have been additional pressures of £207k due to waste disposal levy and construction costs. There are also growing budget pressures in this area due to more proactive gully cleansing (to prevent flooding) and increased maintenance costs associated with Children's playgrounds as a result of capital investment being delayed.

Growth (£2.247m)

3.10 The service continues to face pressures due to non-delivery of savings and additional cost pressures.

3.11 Following the liquidation of Carillion the appointed liquidator PwC has been managing the contracts to enable the smooth transfer to other providers. This transfer took place on 31 July 2017 but significant costs were incurred up to this date which were not included in the budget.

3.12 Significant pressures are also being experienced in relation to loss of income due to the sale of assets and utilisation of assets for Council purposes, income from advertising and income from Building Control and Development Control is currently forecast to be less than budget.

3.13 Non delivery of savings is also creating further pressures. The additional Services contract with the Local Education Partnership (LEP) was due to end at the end of October 2018, it was anticipated that savings as a result of a new provision would be achievable. As a result of the collapse of Carillion the existing contract with the LEP has been extended until July 2019 to enable a full review of the Service. Savings anticipated will therefore not materialise in 2018/19. In addition, the purchase of the Plantation Industrial Estate is no longer proceeding and the anticipated additional income will not be realised.

3.14 The movement from the prior period is due to the forecast surplus on the Ecology Unit being included in the period 3 forecast. This is a hosted service and any surplus or deficit on the service is not held within the Council budget.

4. TARGETED EFFICIENT PLAN (TEP)

4.1 The economy wide savings target for 2018/19 is £35.720m. This consists of:

- CCG £19.800m
- TMBC £3.119m
- ICFT £12.801m

Table 3: 2018/19 Targeted Efficiency Plan (TEP)

Savings	Opening Target £'000	RED £'000	AMBER £'000	GREEN £'000	Savings Posted £'000	Forecast £'000	Variance £'000
CCG	19,800	1,456	5,147	6,853	8,682	18,254	(1,546)
TMBC	3,119	313	552	990	456	1,753	(1,366)
Strategic Commission	**22,919**	**1,769**	**5,699**	**7,843**	**9,138**	**20,007**	**(2,912)**
ICFT	12,801	1,793	1,559	5,962	3,586	11,107	(1,695)
Total	**35,720**	**3,562**	**7,258**	**13,804**	**12,724**	**31,114**	**(4,606)**

4.2 Against this target, £12.724m of savings have been realised in the four months, 36% of the required savings. Expected savings by the end of the year are £31.114m, a shortfall of £4.606m against target. Slides 8 and 9 of **Appendix 1** provide a summary of the associated risks relating to the delivery of these savings for the Strategic Commission. It is worth noting that there is a risk of under achievement against this efficiency target across the economy at this reporting period.

4.3 More work is required to identify new schemes and turn red and amber schemes green. As things stand we would need to fully deliver all of the amber rated schemes and half of the

red rated schemes to fully close the gap. It is therefore essential that additional proposals are considered and implemented urgently to address this gap on a recurrent basis thereafter.

4.4 There are high risk savings proposals of £ 3.562m which are currently at risk of non-delivery in 2018/19. **Appendix 1** summarises risks by service area, which for the Strategic Commission includes:

- £1.026m CCG Emerging Pipeline Schemes have not yet been sufficiently developed. More work is required to develop these schemes and assess viability.
- Growth Savings of £0.533m will not be delivered in 2018/19. These included forecast savings from the re-provision of the Additional Services contract with the Local Education Partnership (LEP) which has been extended as a result of the collapse of Carillion, and additional income from the purchase of the Plantation Industrial Estate which is no longer proceeding.
- Operations and Neighbourhoods £0.275m - Most of this savings target relates to the new Car parking provision at Darnton Road which was expected to generate additional income of £0.500m per annum. A delay in the construction of the spaces has resulted in the forecast additional income for this financial year being reduced to £0.225m.

5. CCG SURPLUS

5.1 In 2018/19 the CCG is planning to deliver a surplus of £9,347k. This overall surplus is broken down into two parts:

- **£3,668k** Mandated 1% surplus;
- **£5,679k** Cumulative surplus brought forward from previous years.

5.2 The 1% in year surplus is a requirement of the business rules. It is calculated on the basis of 1% of opening allocations, excluding the allocation for delegated co-commissioned primary care.

5.3 The cumulative surplus brought forward was built up in 2016/17 and 2017/18, when CCGs had to contribute into a national risk reserve offsetting overspend in the provider sector. While the cumulative surplus brought forward remains on the CCG balance sheet, there is currently no mechanism through which T&G are able to drawdown or use any of this resource.

5.4 There is no national risk reserve in 2018/19. However there is still a significant financial gap nationally, which needs to be addressed.

5.5 The Greater Manchester Health and Social Care Partnership are involved in ongoing discussions with national bodies to address this gap. Nothing has been formally agreed at this stage. However there are emerging proposals which would potentially allow CCGs who are able to increase their 2018/19 surplus, to drawdown some of their cumulative surplus in 2019/20. The following draft proposal has been circulated to CCG's across Greater Manchester:

For CCGs with a cumulative surplus

Where the CCG agrees to underspend its allocation this year, the CCG will receive guaranteed surplus drawdown next year, on a 2 for 1 basis, subject to the cumulative surplus being available. For example a CCG that underspends by £5m this year will be allowed to drawdown £10m next year. The drawdown could be spread over the next two years if preferable

5.6 An additional benefit from this proposal would be an improvement in the aggregate GM financial position in 2018/19. Any underspend against the GM system control total would attract 48p of additional Provider Sustainability Funding for every £1 of underspend.

5.7 There was a detailed discussion about a potential Tameside and Glossop response to this proposal at Finance and QIPP Assurance Group in August.

5.8 In 2017/18 the CCG entered into a risk share with the local authority. Under the terms of our arrangement, the council were able to increase their contribution to the Section 75 pooled budget by up to £5m per year in both 2017/18 and 2018/19. In return the CCG will need to increase its contribution to the Section 75 pool in 2019/20 and 2020/21.

5.9 Approval is already in place for the council to increase 2018/19 contribution to the ICF by up to £5m, but the requirement to balance the CCG position will be less than this. Finance and QIPP Assurance Group discussed the potential of using headroom in the ICF risk share to increase the CCGs 2018/19 surplus by up to £3m.

5.10 Under the terms of the GM proposal, increasing the 18/19 surplus by £3m would enable drawdown of £6m in 2019/20, reducing the cumulative surplus to £6.3m. The money drawn down would be paid back into the ICF through increased CCG contributions to the pool.

5.11 5 year financial plans have been built on the assumption that there will be no mechanism to access the CCGs cumulative surplus. If we are able to drawdown some of our surplus in 2019/20 through the GM proposal, the financial position of the integrated commissioner will improve on a recurrent basis and the reported gap will reduce.

6. RECOMMENDATIONS

6.1 As detailed on the front of the report.

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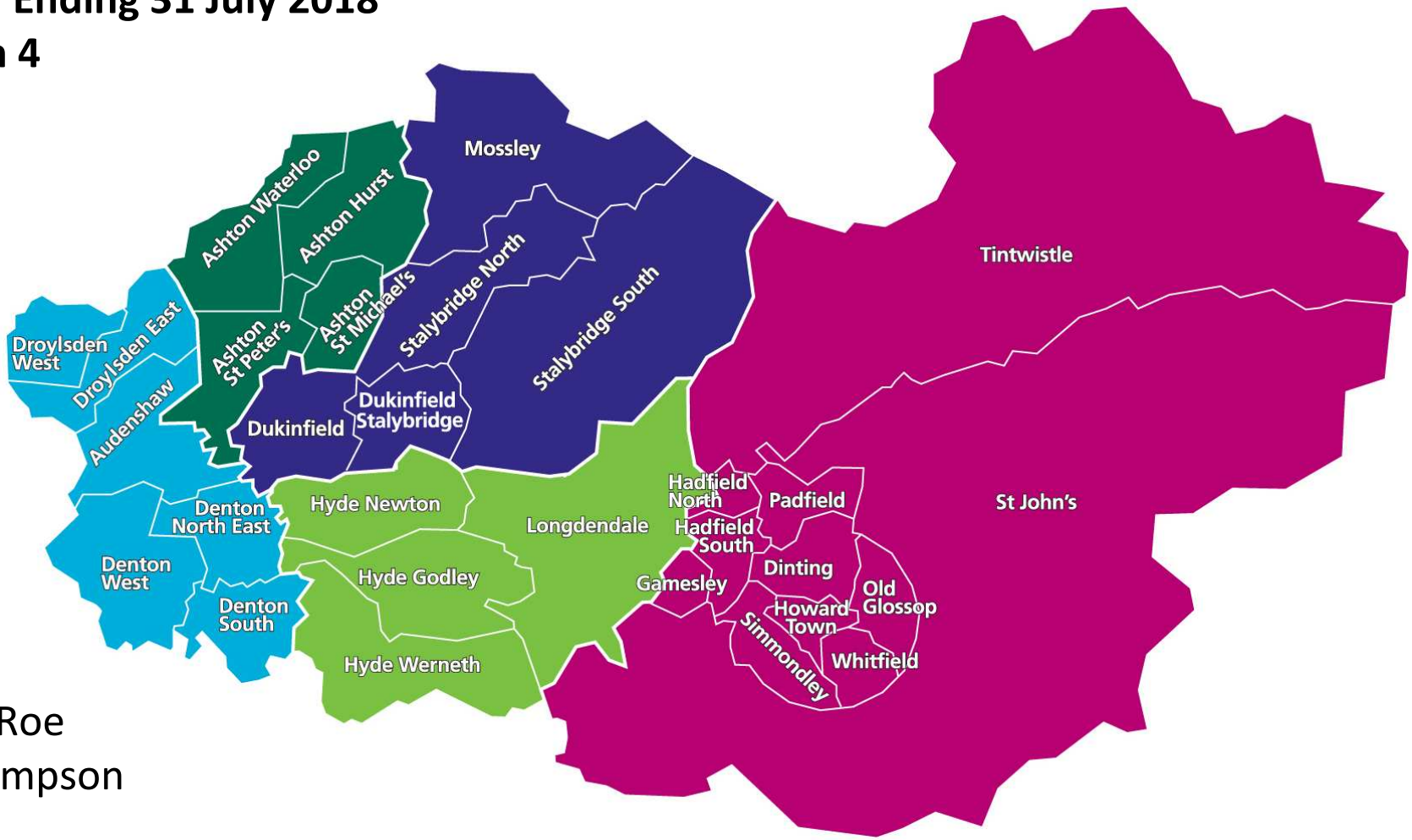
Tameside and Glossop Integrated Financial Position

financial monitoring statements

APPENDIX 1

Period Ending 31 July 2018
Month 4

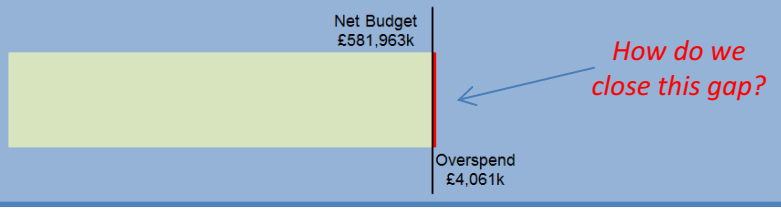


Kathy Roe
Sam Simpson

Appendix 1

Tameside & Glossop Integrated Economy Wide Financial Position

In 2018/19 the Tameside & Glossop economy still has a £4m financial gap to close



£3.0m

Children's Social Care

Expected in year pressure on Children's Social Care

£4.6m

Healthier Together

Significant emerging risk from 2020 onwards relating to the cost of implementing Healthier Together

£1.5m

CCG Net Risk

Reported control total will be met and £9.3m surplus will be delivered. But risk of £1.5m against delivery of target

£1.9m

ICFT TEP

The Trust is forecasting an underachievement of TEP. Failure to achieve TEP will result in the Trust not achieving its plan

Message from the DOF

In this July report we would like to expand on our message last month regarding the relaunch of the Targeted Efficiency Programme across the strategic commissioner as one of our key priorities to complement the programme in the ICFT.

Across the strategic commissioner we are facing a 'do nothing' financial gap of £29m next year, which is set to grow to £62m by 2022/23. Plans are in place which will deliver expected savings of £20m, but even in this 'do something' scenario there is still a financial gap of £42m to close.

We already have a focus on TEP delivery across the economy, including financial recovery plans for CHC and children's services. But it is important that measures are introduced to increase the pace and scale of planned savings in order to balance budgets for 2019/20 and beyond. The challenge is to think big, think transformationally and remember that nothing is off the table when looking at new savings initiatives:

- What should we start/stop doing?
- What can we do more/less of?
- What can we do differently or cheaper?
- What can we outsource or do in partnership with others?
- Can we revisit old ideas or best practice from elsewhere?

Over the Autumn all new and emerging savings schemes (76 at time of writing) will be presented at a 'Star Chamber'. These will be intense scrutiny panels made up of executive directors, clinicians and council members to review and challenge schemes. Savings, outcomes, quality and value for money will be the focus.

The Star Chamber process will result in a list of prioritised schemes which our organisation will pursue and use as the basis for setting a robust balanced budget for 2019/20 and beyond.

Tameside & Glossop Integrated Commissioning Fund - Forecast

- At the start of the year the opening ICF was £911m.
- Budget movements since this (including transformation funding and PFI budget adjustments) have seen the gross value of the ICF increase to £941m.
- This is £9m lower than the Gross budgets reported last month as a result of Housing Benefit claimants moving onto Universal Credit (which is not administered by the Council). As both expenditure and subsidy income are reduced, this change is nil effect on the net budget.
- After council income is taken into account the net value of the ICF is £582m.
- Detailed monitoring is done against this net position.
- At present a £4m overspend is currently forecast against this net budget.

	Forecast Position					Net Variance	
Forecast Position £000's	Expenditure Budget	Income Budget	Net Budget	Net Forecast	Net Variance	Previous Month	Movement in Month
Acute	205,388	0	205,071	205,308	-238	-48	-189
Mental Health	32,827	0	32,758	32,861	-103	-1	-103
Primary Care	84,534	0	84,487	84,412	75	173	-97
Continuing Care	14,569	0	14,504	17,441	-2,937	-2,982	45
Community	30,040	0	30,040	30,045	-4	-0	-4
Other CCG	22,915	0	23,338	20,131	3,207	2,859	349
CCG TEP Shortfall (QIPP)	0	0	0	1,546	-1,546	-2,537	991
CCG Running Costs	5,175	0	5,175	5,175	-0	0	-0
Adults	82,590	-42,098	40,492	40,507	-15	-56	41
Children's Services	78,326	-29,225	49,100	52,174	-3,074	-3,242	168
Individual Schools Budgets	127,944	-127,944	0	0	0	0	0
Population Health	16,353	-121	16,232	16,197	35	35	0
Operations and Neighbourhoods	76,386	-26,007	50,379	50,924	-545	-482	-63
Growth	45,146	-37,287	7,858	10,106	-2,247	-2,103	-145
Governance	88,931	-79,882	9,049	9,049	0	0	0
Finance & IT	5,839	-1,351	4,488	4,602	-113	-101	-12
Quality and Safeguarding	355	-288	67	73	-6	-6	0
Capital and Financing	10,998	-1,360	9,638	8,236	1,402	413	989
Contingency	4,163	-6,823	-2,660	-3,388	728	728	0
Corporate Costs	8,726	-6,857	1,870	550	1,320	1,502	-182
Integrated Commissioning Fund	**941,206**	**-359,244**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**
CCG Expenditure	395,449	0	395,374	396,920	-1,546	-2,537	991
TMBC Expenditure	545,757	-359,244	186,514	189,029	-2,515	-3,311	796
Integrated Commissioning Fund	**941,206**	**-359,244**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**
A: Section 75 Services	307,329	-41,144	266,713	269,235	-2,522	-3,354	832
B: Aligned Services	337,686	-96,822	241,487	242,468	-981	-1,708	727
C: In Collaboration Services	296,117	-221,278	73,687	74,246	-558	-786	228
Integrated Commissioning Fund	**941,131**	**-359,244**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**

Note that while this report talks about the integrated economy wide position, it does not capture any Local Authority spend for residents of Glossop. All spend at Tameside & Glossop Clinical Commissioning Group, Tameside Metropolitan Borough Council and Tameside & Glossop Integrated Care Foundation Trust is captured. But no spend from Derbyshire County Council is included.

Tameside & Glossop Integrated Economy Financial Position

- Using the net ICF, the strategic commissioner is £389k overspent at M4.
- This is a £13,509k improvement on the YTD overspend at M3. It relates to changes in the reported council position due to re-profiling of budgets to reflect the advanced payments of the community contract
- By year end we are forecasting an overspend of £4,061k, an improvement of £1,787k linked to CCG TEP and Council Capital & Financing.
- In order to meet financial control totals , this needs to reduced to zero. More work is required to progress schemes to deliver savings.
- The ICFT have an agreed a control total with NHSI. This means that an authorised deficit is in place. Current forecasts show this will be achieved.
- Further savings of £4,061k are required to meet the economy wide target.

	YTD Position			Forecast Position			Variance	
Forecast Position £000's	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	67,321	67,702	-381	205,071	205,308	-238	-48	-189
Mental Health	10,697	10,746	-49	32,758	32,861	-103	-1	-103
Primary Care	25,982	25,853	129	84,487	84,412	75	173	-97
Continuing Care	4,465	5,456	-991	14,504	17,441	-2,937	-2,982	45
Community	10,013	9,950	63	30,040	30,045	-4	-0	-4
Other CCG	10,917	9,694	1,223	23,338	20,131	3,207	2,859	349
CCG TEP Shortfall (QIPP)	0	0	0	0	1,546	-1,546	-2,537	991
CCG Running Costs	1,331	1,325	6	5,175	5,175	-0	0	-0
Adults	13,497	13,714	-216	40,492	40,507	-15	-56	41
Children's Services	18,570	19,595	-1,025	49,100	52,174	-3,074	-3,242	168
Population Health	10,496	10,496	0	16,232	16,197	35	35	0
Operations and Neighbourhoods	16,793	16,822	-29	50,379	50,924	-545	-482	-63
Growth	2,619	3,608	-989	7,858	10,106	-2,247	-2,103	-145
Governance	1,971	1,045	926	9,049	9,049	0	0	0
Finance & IT	1,496	1,291	205	4,488	4,602	-113	-101	-12
Quality and Safeguarding	22	81	-59	67	73	-6	-6	0
Capital and Financing	0	0	0	9,638	8,236	1,402	413	989
Contingency	-887	1,027	-1,914	-2,660	-3,388	728	728	0
Corporate Costs	623	-2,088	2,712	1,870	550	1,320	1,502	-182
Integrated Commissioning Fund	**195,928**	**196,317**	**-389**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**
CCG Expenditure	130,726	130,726	-0	395,374	396,920	-1,546	-2,537	991
TMBC Expenditure	65,202	65,591	-389	186,514	189,029	-2,515	-3,311	796
Integrated Commissioning Fund	**195,928**	**196,317**	**-389**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**
A: Section 75 Services	94,380	90,625	3,755	266,713	269,235	-2,522	-3,354	832
B: Aligned Services	80,956	81,238	-282	241,487	242,468	-981	-1,708	727
C: In Collaboration Services	20,592	24,454	-3,862	73,687	74,246	-558	-786	228
Integrated Commissioning Fund	**195,928**	**196,317**	**-389**	**581,888**	**585,949**	**-4,061**	**-5,848**	**1,787**
ICFT - post PSF Agreed Deficit	-9,079	-9,044	35	-19,149	-19,149	0		
Economy Wide In Year Deficit	**-9,079**	**-9,433**	**-354**	**-19,149**	**-23,210**	**-4,061**		

Tameside & Glossop ICFT Financial Position

Summary

- For the financial period to the **31st July 2018**, the Trust has reported a net deficit of c.£2.0m (Post Provider Sustainability Funding [PSF])
- Cumulatively the Trust has reported a net deficit of c.£9.0m (post PSF), which is c.£34k better than plan.
- The Trust delivered c.£954k of savings in month, this is an overachievement against target by c.£0.1m in month and c.£0.8m cumulatively.
- To date the Trust has spent c.£2.9m on Agency spend, against a plan of £3.1m; based on this run rate, spend should be within the agency cap of £9.5m.

	Month 4			YTD			Annual
Financial performance metric	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)	Actual (£000)	Variance (£000)	Plan (£000)
Normalised Surplus/(Deficit) before PSF	(£2,334)	(£2,322)	£12	(£9,993)	(£9,958)	£34	(£23,370)
PSF	£281	£281	£0	£914	£914	£0	£4,221
Surplus/(Deficit) post PSF	(£2,053)	(£2,041)	£12	(£9,079)	(£9,044)	£34	(£19,149)
Capital Expenditure	£347	£73	(£274)	£1,071	£503	(£568)	£5,600
Cash and Equivalents	£1,220	£1,683	£463				
Trust Efficiency Savings	£830	£954	£124	£2,742	£3,550	£808	£13,000
Use of Resources Metric	3	3		3	3		3

Key risks

- **Control Total –** The Trust now has an agreed control for 2018/19 of c£19.2m, this assumes the Trust will be in receipt of the full Provider Sustainability fund and deliver the performance and financial requirements set by NHSI.

- **Provider Sustainability Fund** - The Trust must achieve its financial plan at the end of each quarter to achieve 70% of the PSF, the remainder is predicated on achievement of the A&E target for each quarter based on the improvement trajectories stated by NHSI.

- **TEP** – The Trust is currently forecasting an underachievement against its in year TEP delivery of **c£1.9m** and recurrently of **c£2.2m**. **Failure to achieve TEP will result in the Trust not achieving its plan**. Work is on-going with Theme groups to develop high risk schemes and generate hopper ideas to improve this forecast position.

- **Loan Liability -** The Trust currently has a loan of **£75.4m** at the end of 2017/18. The Trust may be required to repay part of this liability in 2018. To do this the Trust would require a new loan, now the Trust has agreed a control total this now would be at the standard borrowing rate of 1.5%.

Strategic Commissioner Financial Position

£275K
Car Park Pressure
Delay in construction of Darnton Road car park (which will have fewer spaces than originally envisaged) creating pressure to the position.

£1,000k
Manchester FT
Forecast overspend, based on £366k over YTD. £254k of YTD pressure relates to emergency pathway (8.5% increase in A&E attendances). £148k overspend outpatient related.

£220k
MH Beds
Contribution to additional mental health capacity in Pennine Care. While this is a pressure, the costs is funded from the wider FYFV investment and included in a risk share arrangement.

£1,400k
Capital & Financing
Continued financing of capital expenditure from receipts and reserves resulting in significant savings on borrowing costs. Additional investment income also being achieved.

Acute — R

➢The overall position for acute services includes underspend against independent sector contracts and a TEP adjustment which masks significant risk on associate contracts. Underspend at Stockport is offset by pressures at The Christie and Pennine Acute, but Manchester University FT is currently forecast to overspend by £1m.

➢ In the first 4 months of the year there is an actual overspend of £366k

➢£254k of this relates to pressures in the emergency pathway, driven by
- 8.4% increase in A&E attendances in Q1 18/19 vs Q1 17/18
- 18.5% increase in emergency admissions
- Small number of high cost long length of stay emergency patients

➢£148k pressure in outpatients, driven by 11% increase in first attendances and a £130k pressure in treatment for Macular Degeneration

➢Offsetting this is a significant underspend on Elective/Daycase. While activity is slightly higher than in the corresponding period last year, the plan expected activity to increase by 10% to meet RTT targets.

➢However considerable future risk around Elective/Daycase position:
- People on waiting list (3,212) increased by 6.7% since March
- 29 T&G patients breached 52 week target - plan to treat by September

➢These issues require further investigation in order to fully understand and will form basis of deep dive at M5.

Children's Services — R

➢The financial position has improved slightly due to staff vacancies but this remains a significant pressure. The Council continues to experience extraordinary increases in demand for Children's Social Care Services, placing significant pressures on staff and resources.

➢The number of Looked after Children has gradually increased from 612 at 31 March 2018 to 636 at 31 July 2018. Despite the additional financial investment in the service in 2017/18 and 2018/19, the service is projecting to exceed the approved budget by £3,002k; due to the additional placement costs. It should be noted that the 2018/19 placements budget was based on the level of Looked After Children at December 2017 (585) ; the current level at 31 July 2018 is 636; a resulting increase of 51 (8.7%). This should also be considered alongside the current average weekly cost of placements in the independent sector with residential at £3,681 and foster care £761.

Individualised Commissioning — R

➢Growth in the cost and volume of individualised packages of care is the amongst the biggest financial risks facing the Strategic Commissioner.

➢Deep dive into Individualised Commissioning Recovery plan included later in this report.

Strategic Commissioner Financial Position

Growth Directorate — R

➢The service continues to face pressures due to non-delivery of savings and additional cost pressures. Following the liquidation of Carillion the appointed liquidator PwC has been managing the contracts to enable the smooth transfer to other providers. This transfer took place on 31 July 2017 but significant costs were incurred up to this date which were not included in the budget.

➢Significant pressures are also being experienced in relation to loss of income due to the sale of assets and utilisation of assets for Council purposes, income from advertising and income from Building Control and Development Control is currently forecast to be less than budget.

➢Non delivery of savings is also creating further pressures. The additional Services contract with the Local Education Partnership (LEP) was due to end at the end of October 2018, it was anticipated that savings as a result of a new provision would be achievable. As a result of the collapse of Carillion the existing contract with the LEP has been extended until July 2019 to enable a full review of the Service. Savings anticipated will therefore not materialise in 2018/19. In addition, the purchase of the Plantation Industrial Estate is no longer proceeding and the anticipated additional income will not be realised.

➢The movement from the prior period is due to the forecast surplus on the Ecology Unit being included in the period 3 forecast. This is a hosted service and any surplus or deficit on the service is not held within the Council budget.

Operations and Neighbourhoods — A

➢The service continues to face pressures due to non-delivery of savings and additional cost pressures. The new Car parking provision around the hospital on Darnton Road was expected to generate additional income of £500k per annum. Delays in the construction of the spaces has resulted in the non-delivery of the saving in 2018/19 of £275k. There have been additional pressures of £207k due to waste disposal levy and construction costs. There are also growing budget pressures in this area due to more proactive gully cleansing (to prevent flooding) and increased maintenance for Children's playgrounds as a result of delayed capital investment.

Capital Financing, Contingency and Corporate Costs — G

➢The 2018/19 budget assumed some of the prior year capital expenditure would be financed from borrowing and that additional borrowing would be required. Continued use of reserves and capital receipts to finance capital expenditure has meant that this borrowing is not yet required and interest charges in 2018/19 will be lower that budget.

➢Interest earned to date on cash investments is higher than budget due to an increase in the average rate of interest being achieved. This is due to a combination of increase rates overall and a more proactive investment strategy, together with the new investment in Manchester Airport.

Primary Care — G

➢Cat M price increases of £15m per month have been agreed at a national level from August. Prices expected to change again from October, but unclear what the impact of this will be. Estimated price increase will cost the CCG around £100k per month for as long as the prices remain at new rates. Current position assumes pressure will persist until March.

➢Significant progress against TEP, particularly for repeat ordering protocols means the Cat M pressure has been contained and we have actually increased expected achievement at M4.

Mental Health — G

➢An additional £2.5m of recurrent investment was agreed in 2018/19 in order to meet requirements of the Five Year Forward View. While this recurrent commitment remains in place, there is likely to be some non recurrent slippage against this which can count towards TEP this year.

➢Budgets included an expectation that 5 specialist MH placements would be required. There have been 2 new admissions this month, which based on average lengths of stay has created a £100k pressure.

➢The position this month also includes £220k for Mental Health beds at Pennine Care. This creates additional capacity and has been agreed across all Pennine commissioners. Both the specialist placements and MH beds are contained within the additional £2.5m investment and do not impact upon expected slippage forecast within TEP.

TEP – Targeted/Trust Efficiency Plan

£212k

GP Prescribing

Despite pressures on Category M drugs, significant savings realised by meds mgt team in Q1. Most notably around repeat ordering protocols, where value of forecast has improved by £212k.

£533k

Growth

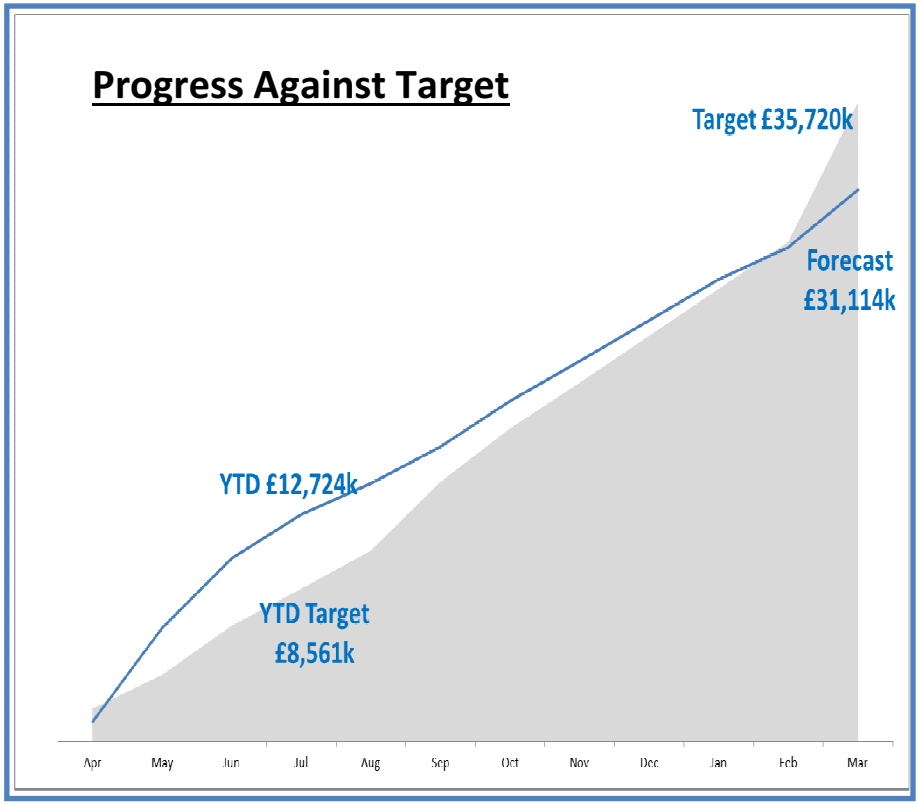
Savings previously rated as high risk have now been removed from the TEP as they will not be achieved. Removal of these savings is contributing to the forecast overspend in this area.

£1,124k

CCG Emerging Pipeline

Not yet realised any savings in relation to emerging schemes which would change policy or limit activity. Therefore forecast savings reduced. High risk schemes, therefore post optimism bias impact limited.

- The economy wide savings target for 2018/19 is £35,720k:
  - Commissioner £22,919k (£19,800k CCG & £3,119k TMBC)
  - Provider £12,801k
- Against this target, £12,724k of savings have been realised in the first four months, 36% of the required savings.
- Expected savings by the end of the year are £31,114k, a shortfall of £4,606k against target. It is an improvement of £1,092k against the position reported last month. The key driver of the improvement is a re-assessment of the risk against a CCG scheme to release risk reserve .
- A sample of some of the most significant changes over the last month are highlighted in the boxes above. Because of early realisation of non recurrent schemes, we are significantly ahead of the planned savings trajectory at M4, but unless new schemes are identified we still struggle to maintain this performance in the months to come.
- More work is required to identify new schemes and turn red and amber schemes green.
- £17,005 (55%) of forecast savings expected to be delivered recurrently



TEP – Targeted/Trust Efficiency Plan

Economy Wide TEP Summary - 18/19 - Month 4

Organisation	High Risk	Medium Risk	Low Risk	Savings Posted	Total	Opening Target	Post Bias Expected Saving	Post Bias Variance
CCG	1,456	5,147	6,853	8,682	22,138	19,800	18,254	(1,546)
TMBC	313	552	990	456	2,311	3,119	1,753	(1,366)
Strategic Commissioner	**1,769**	**5,699**	**7,843**	**9,138**	**24,449**	**22,919**	**20,007**	**(2,912)**
ICFT	1,793	1,559	5,962	3,586	12,900	12,801	11,107	(1,695)
Economy Total	**3,562**	**7,258**	**13,804**	**12,724**	**37,349**	**35,720**	**31,114**	**(4,606)**

Org	Theme	High Risk	Medium Risk	Low Risk	Savings Posted	Total	Opening Target	Post Bias Expected Saving	Post Bias Variance
CCG	Emerging Pipeline Schemes	1,026	0	0	0	1,026	3,239	103	(3,136)
	GP Prescribing	180	1,640	180	802	2,802	2,000	1,820	(180)
	Individualised Commissioning Recovery Plan	250	255	305	144	954	1,326	601	(725)
	Other Established Schemes	0	2,253	351	1,561	4,165	4,283	3,039	(1,244)
	Tameside ICFT	0	0	1,653	827	2,480	2,480	2,480	0
	Technical Financial Adjustments	0	1,000	4,363	5,348	10,711	6,472	10,211	3,739
CCG Total		**1,456**	**5,147**	**6,853**	**8,682**	**22,138**	**19,800**	**18,254**	**(1,546)**
TMBC	Adults	213	272	212	0	697	697	369	(328)
	Growth	0	25	340	0	365	898	353	(546)
	Finance & IT	50	0	0	122	172	172	127	(45)
	Governance	0	0	129	25	154	154	154	0
	Childrens (Learning)	0	0	90	0	90	90	90	0
	Operations & Neighbourhoods	50	255	0	0	305	580	133	(448)
	Pop. Health	0	0	219	309	528	528	528	0
TMBC Total		**313**	**552**	**990**	**456**	**2,311**	**3,119**	**1,753**	**(1,366)**
Strategic Commissioner Total		**1,769**	**5,699**	**7,843**	**9,138**	**24,449**	**22,919**	**20,007**	**(2,912)**
ICFT	Corporate	0	0	435	508	943	1,300	943	(357)
	Demand Management	662	71	601	293	1,626	1,631	964	(666)
	Estates	89	50	186	87	412	450	323	(127)
	Finance Improvement Team	72	340	641	415	1,468	1,067	1,396	329
	Medical Staffing	394	148	3	24	569	1,103	176	(927)
	Nursing	238	63	540	406	1,247	1,250	1,010	(240)
	Paperlite	117	64	32	28	240	250	123	(127)
	Pharmacy	0	221	176	34	431	450	431	(19)
	Procurement	223	402	83	28	736	752	513	(238)
	Transformation Schemes	0	0	2,200	1,000	3,200	3,200	3,200	0
	Technical Target	0	200	117	58	375	0	375	375
	Vacancy Factor	0	0	947	705	1,653	1,350	1,653	303
ICFT Total		**1,793**	**1,559**	**5,962**	**3,586**	**12,900**	**12,801**	**11,107**	**(1,695)**
Economy Total		**3,562**	**7,258**	**13,804**	**12,724**	**37,349**	**35,720**	**31,114**	**(4,606)**

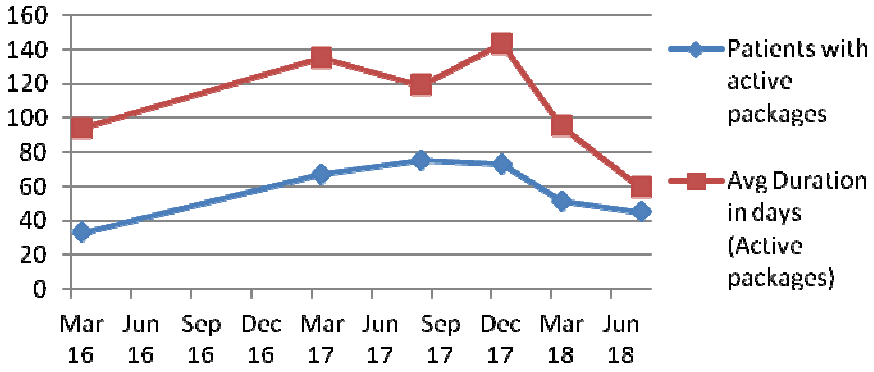
Individualised Commissioning – Deep Dive

Fast Track Packages

➢45 active packages are in place at July 2018. This is a net reduction of 6 patients since March 2018, and represents a 40% reduction from the August peak when we were funding 75 active packages.

➢The average duration in days is currently 59 days, a reduction of 50% over the past 12 months and a reduction of 38% since March 2018.

➢The team are closely monitoring length of stay in fast track packages (37% of packages in April were over 90 days). There is now a tracker in place to make this process more robust and ensure only valid reasons if 3 month breaches occur.



Neuro Rehabilitation

➢Neuro network have now completed individual assessments on all 'out of borough' placements.

➢The review found that all T&G CCG specialist Neuro rehab placements were made appropriately.

➢However the review has highlighted that current local provision has not developed sufficiently to meet the complex needs of these individuals. The next Individualised Commissioning recovery plan will update on progress against this issue.

Carson House Risk

➢CQC has issued a notice of decision to remove the registration of Carson house . The provider has 28 days to request a tier 1 tribunal appeal .

➢There are currently 35 residents that would be affected by a possible removal of registration.

➢Provision has been made in the current forecast for potential additional costs which may arise as consideration may need to be made for alternative accommodation.

Chairing of MDT's

➢Chairing of MDT's has been in place since 1st May 2018. The teams have played a crucial role thus far in supporting a 2018-19 YTD reduction in CHC expenditure of £144k.

➢Work is ongoing with the hospital discharge to ensure that criteria is applied robustly and that the number of assessments using the Decision Support Tool in the acute trust is reduced in order to meet the Quality Premium.

Funded Nursing Care

➢There has been an increase in FNC placement numbers from 209 at April 2018 to 229 as at July, work is ongoing to establish the reason for the upward trend and whether there is a link to the reduction in CHC spend. Further updates will be provided periodically throughout the year.

Liaison Review of Payments

➢Lack of confidence in Liaison findings thus far due to misinterpretation of data that the CCG have provided.

➢Figures provided on 10th August by Liaison indicate a potential clawback of £9k for 2017-18 packages (reduction of £500k from their initial estimates)

➢Further meeting scheduled with Liaison, Finance and the Individualised Commissioning team to agree next steps.

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	19 September 2018
Reporting Member /Officer of Strategic Commissioning Board	Councillor Brenda Warrington – Executive Leader Sandra Whitehead – Assistant Director (Adults)
Subject:	**BANDING PAYMENT SYSTEM AND AGE POLICY CHANGE FOR SHARED LIVES PLACEMENTS**
Report Summary:	This report seeks permission to introduce a banding payment system for Shared Lives carers to reflect the complexity of need of those cared for, and also change the age of entry into Shared Lives from 18 years of age to 16 years of age to improve transition and continuity of care for young people. This is part of a wider transformation plan focused on improving access to Shared Lives for people with more complex needs and young people coming through transition.
Recommendations:	The Strategic Commissioning Board is recommended to agree: 1. Introduce a new banding payment system for Shared Lives carers. 2. That the age of entry to Shared Lives is changed from 18 to 16 years in the Shared Lives Policy. 3. Existing Shared Lives arrangements will be protected if the banding for an existing service user is assessed as being Band 1. 4. That the implementation of a banding system will be by 1 April 2019. 5. Where an emergency placement is made this will initially be paid at the higher rate until an assessment is completed.

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

Integrated Commissioning Fund	Section 75
Decision Required By	Strategic Commissioning Board
Organisation and Directorate	Tameside MBC – Adult Services
Net Budget Allocation	£0.777 million

Additional Comments

The proposed banded payment system outlined in this report acknowledges the different complexities of care provided. It also looks to future proof the service by attracting new carers through a more incentivised payment approach.

The average gross cost of a long term Shared Lives placement is £405 per week which is partially offset by housing benefit income for working age adults.

The proposed policy change outlined in this report will enable the Shared Lives placements to be made from the age of 16. Whilst it may not be possible to charge service user contributions under the age of 18, a Shared Lives placement is a considerably lower cost alternative than a Children's independent sector residential care placemen which currently averages £3,680 per week depending on the needs of the young person.

It is estimated that there will be a low costs additional impact on the service budget via this proposed banding system. The additional cost is estimated at £11,000 per annum for existing service users.

It should be noted that there are wider cost and qualitative benefits that are realised by the Shared Lives service being in place as the service provided improved outcomes and is a more cost effective option when compared to the cost of these placements in the independent sector.

In addition, recent work undertaken alongside the Social Care Institute of Excellence (SCIE) also highlighted wider benefits to the health and social care economy in terms of reduced attendances in both primary and secondary healthcare.

Legal Implications: (Authorised by the Borough Solicitor)

The Shared Lives Scheme is regulated under Health and Social Care Act 2008 and The Care Act 2014, which now provides a single framework for charging for care and support under sections 14 and 17 supplemented by The Care and Support (Charging and Assessment of Resources) Regulations 2014.

The framework is based on the following principles that local authorities should take into account when making decisions on charging:

- Ensure that people are not charged more than is reasonably practicable for them to pay;
- Be comprehensive, to reduce variation in the way people are assessed and charged;
- Be clear and transparent, so people know what they will be charged;
- Promote wellbeing, social inclusion and support the vision of personalisation, independence, choice and control;
- Support carers to look after their own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet their needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable those who wish to stay in or take up employment, education or training or plan for the future costs of meeting their needs to do so; and
- Be sustainable for local authorities in the long-term.

	The new framework is intended to make charging fairer and more clearly understood by everyone. There is however no singe prescribed national charging policy for care services provided in a setting other than a care home (e.g. own home, extra care housing, supported living or share lives accommodation). The same principles should be applied when therefore looking at a payments scheme for carers. When charging or setting up payments scheme Local Authorities must enter into consultation when deciding how to exercise this discretion. The consultation must be full and meaningful. A consultation should ensure that all relevant parties receive sufficient information to enable them to provided informed feedback which should be taken into account prior to any final decision being made. The consultation process and timing should be sufficient to enable consultees to be informed of the proposals, raise queries, consider alternatives and respond to the issues and complexities of the proposals whilst remaining coherent, focused and proportionate. A public body is not bound to act upon the preferred option of consultees but must take full account of any preferred view, expressed opinion and overall feedback. The requirement is for consultation to be meaningful. Clear reasons must be given for not taking a preferred course of action expressed by consultees. Members must ensure fully considered equality impact assessment and he feedback from consultees.
How do proposals align with Health & Wellbeing Strategy?	The proposals align the Developing Well, Living Well programmes for action.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'.
Recommendations / views of the Health and Care Advisory Group:	The report has not been presented at the Health and Care Advisory Group.
Public and Patient Implications:	Carers banded at level 1 could lose income which could impact on willingness to be carers. We anticipate the impact and probability of this being low.
Quality Implications:	This work is focused on expanding the Shared Lives offer to a wider number of people to better meet person centred needs and improve outcomes.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside an Safe Tameside.

What are the Equality and Diversity implications?	The proposals will not affect protected characteristic group(s) within the Equality Act. The service will be available to Adults regardless of ethnicity, gender, sexual orientation, religious belief, gender reassignment, pregnancy/maternity, marriage/civil and partnership. The introduction of a banding system is a more equitable means of reimbursing cares based on complexity of the needs of those cared for.
What are the safeguarding implications?	That all carers working with under 18 year olds will be subject to training through Children's Services and the Children's Safeguarding process.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	A privacy impact assessment has not been completed. Services adhere to the Data Protection Act when handling confidential personally identifiable information.
Risk Management:	The key risks are: • The banding payment system cost could exceed the current cost of service placing significant financial risk to implementation. Initial work indicates that the current banding system when applied will not have a significant impact on cost. • Failure to recruit carers to meet diverse range of services being planned. A recent recruitment drive has been successful and if these recommendations are accepted a more targeted recruitment campaign will be undertaken for carers with specific interests and skill sets.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Mark Whitehead: Telephone: 0161 342 3719 e-mail: mark.whitehead@tameside.gov.uk

1. INTRODUCTION

1.1 This report follows the previous two reports submitted in 23 May 2018 that sought permission to enter into consultation with Shared Lives carers, service users and key stakeholders of the Shared Lives Service regarding the implementation of a banded payment system for carers and the introduction of a lower age limit of access to the service from 18 years of age to 16 years of age.

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

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

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

1.5 Benchmarking across Greater Manchester and the national Shared Lived Plus scheme has also been undertaken to ensure a best model practice is reflected in the proposal in terms of the banding and payment structures (see **Appendix 1** for GM benchmarking information).

1.6 The change to the Shared Lives age of access from 18+ to 16+ is focused on working with young people as part of a wider piece of work with Shared Lives Plus, which is the national Shared Lives umbrella body and the Department of Education (DoE) to expand the offer of shared lives services to younger people. We are currently trying to secure a grant from DoE to support this work.

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

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

SHARED LIVES SERVICE – CURRENT SERVICE / POLICY CONTEXT

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

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

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

1.12 There are currently 132 service users being supported by 88 carers (June 2018). Any person aged 18 or over who meet eligibility criteria for services may use Shared Lives.

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

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

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

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

1.16 Current payments to Shared Lives carers are as follows:

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

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

1.18 The Shared Lives sector nationally has seen a 31% growth over the past three years. The positive outcomes experienced by people using Shared Lives are reflected in a 92% good or outstanding CQC rating across the country. Tameside Shared Lives scheme was inspected in June 2018 and has received a Good rating across all areas. The Greater Manchester Combined Authority (GMCA) have recently set targets for Shared Lives with an ultimate target of 15% of all learning disability provision being provided through Shared Lives Schemes.

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

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

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

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

1.23 Shared Lives can play a supporting role in the new Integrated Care Organisation particularly if the current service offer is expanded through the wider review. As an example, only 4.5% of users of Shared Lives have mental health issues and we want to ensure through better joint working across the ICFT, Pennine NHS Mental Health Trust that some of the system and process barriers are addressed to allow more people with mental health issues to access the service.

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

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

1.26 Consultation has taken place with Children's Services relating to the legislative requirements of working with young people below the age of 18 and have only identified specific training and screening requirements of carers and staff in terms of working with young people 16-18 years of age. Our intentions are to run a specific targeted recruitment campaign for carers interested in working with young people and will link with Children's Services training and development programme in terms of providing necessary training and development requirements.

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

2. AGE OF ENTRY CHANGE FROM 18+ TO 16+

2.1 Shared Lives Plus were awarded a £365,000 grant to embark on a new project to develop and raise the profile of Shared Lives to young care leavers. This project is funded by the Department of Education (DoE) as part of the Children Social Innovation Programme, which funds innovative and different approaches in care which are currently limited in this area. Tameside Shared Lives scheme is being considered as a pilot area for this project and if successful will receive a small bursary to achieve its aims.

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

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

2.4 There are also a number of young people with complex needs that reside with foster carers and as they transition into Adult Services they may require placement in residential care which can be out of area because there may not be Shared Lives carers who can meet their needs. Part of the Shared Lives transformation programme is to work with foster carers to transition with the young person to become Shared Lives carers to offer continuity and stability for the young person. The Shared Lives banding report, presented at 23 May 2018 SCB, proposes financial recompense to carers providing complex support. This policy change would assist with smoothing the transition process with foster carers at a much earlier point in the transition process.

3. BANDING PAYMENT SYSTEM AND PAYMENT OPTIONS

3.1 In the vast majority of cases the Shared Lives Scheme pays approved carers one payment irrespective of the level of needs or complexity of the individual/s they support (see 2.8 above for current payment system). This can be viewed as inequitable as it does not recognise the differing levels of complexity of those cared for, and does not recognise the different levels of care provided by carers.

3.2 There are a very small number of exceptional cases where a higher weekly fee is paid. This particularly applies for some younger adults transitioning from Children's to Adult Services who have previously been cared for by a foster placement and the foster carer wishes to continue to care for the young adult and become an approved Shared Lives

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

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

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

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

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

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

3.6 Following a benchmarking exercise against Greater Manchester and other North West schemes, the following payment bands are proposed:

Day Support

Band 1	**Band 2**	**Complex Needs**
£7.06 per hour	**£8.47 per hour**	**£12.71 per hour**
In line with current proposed rate for 2018-19.	20% premium on Band 1.	80% premium on Band 1.

Respite

Band 1	**Band 2**	**Complex Needs**
£45.56 per night	**£80 per night**	**£110 per night**
In line with current proposed rate for 2018-19.		

Long Term Support & Interim

	Per week £	**Per Annum £**
Band 1	**300**	**15,600**
Band 2 (In line with current proposed rate for 2018-19.)	**405.54**	**21,088**
Complex Needs - Rate subject to assessment.	**Subject to assessment**	**Subject to assessment**

3.7 There are currently two carers who are supported on an enhanced rate of pay due to the service users level of complexity. These rates are paid at a rate of £600 and £800 per week. This is based on the individuals assessment of need.

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

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

Emergencies

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

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

4. CONSULTATION

4.1 On 23 May 2018, two reports were submitted seeking permission to enter into consultation with Shared Lives carers and key stakeholders on implementing a banding arrangement and reduced age of access to Shared Lives. Consultation was undertaken by Shared Lives staff and managers, supported by Policy and Communications Team and included:

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

4.2 Consultation results are contained in **Appendix 2** of this report. More detailed analysis of the consultation results are available from the report's author should the reader wish to access them. 30 people responded to the consultation with 20 of these respondents only responding to the banding element.

4.3 The proposed introduction of a banding system was welcomed by respondents with 15 people (75%) of respondents stating they felt that the system will create a fairer and more equitable system for carers.

4.4 3 people, (15%) of respondents stated that they would have liked to have explored the banding model further as part of the consultation. A number of methods of consultation were employed within this process including the Carers Forum and specific briefing sessions as well as contact details for any questions should respondents wish to discuss the model further. Use of these consultation options were poor with very few respondents choosing to access and ask this question. The service is confident that adequate opportunities were offered to explore the model with interested parties.

4.5 There were positive comments and feedback regarding the change of age of access to Shared Lives. The only issue raised was that some carers were concerned that they did

not want to support young people and/or were concerned about the legal requirements associated with working with under 18's. Assurances were provided that no carers would be forced to provide these services and we would only train individuals who showed an interest in supporting young people in this age group.

5. FINANCE

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

5.2 All service users will be reviewed against the proposed banding payment scheme. Existing Shared Lives carers payments will be protected if the banding (payment) for an existing service user is assessed at a lower rate than their existing payment, for the duration that they are caring for that service user. It is estimated that a reduction will impact on four carers in Long Term Support.

5.3 All new service users to the scheme will be paid at the banding rate they are assessed at.

5.4 From a preliminary desktop exercise, it is anticipated that the majority of current service users would remain on comparable payments to the current position. It is anticipated (based on financial modelling) that this will result in an additional £11,000 cost per annum to the Council.

5.5 Service users will continue to be assessed for their eligible unmet needs, and their contributions will determined by a financial assessment (based on Charging Guidelines).

5.6 The benefits of increased carer recruitment will mean increased availability as an alternative to other more costly services, e.g. Shared Lives respite at £55 per night in comparison to £150 per night for Learning Disability based respite care.

5.7 The key concern to implementing a banding payment system is that it could lead established long term placements to be ended if the carer payment is reduced to a level the carer deems to be unacceptable. It is anticipated that the number of carers whose payment will reduce will be low in terms of potential reduced payment based on the table top exercise. As described in paragraph 6.2, existing service user placements will be protected against a reduction in payment, for the duration of the placement with that Shared Lives carer.

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

5.9 The service is attempting to secure a small grant (£10k) from the Department for Education, paid each year for a two year period, to provide support to this piece of work and take part in a pilot nationally. This is dependent on the decision to amend the policy to 16+. Initial work has also commenced in anticipation of the decision with Children's Services to help facilitate a pathway for access to Shared Lives by young people.

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

6. RISK MANAGEMENT

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

Risk	Consequence	Impact	Likelihood	Action to Mitigate Risk
Financial impact of banding costing more than existing budget available	Increased cost of service. Potential impact on financial viability of service.	High	Low	Banding structure should closely reflect current payment system. Increases in complex people (higher cost) accessing Shared Lives will be offset by potential cost avoidance to services
Inability to recruit sufficient numbers of carers to support younger people and people with complex needs	Potential unmet need.	High	Low	A full recruitment programme targeting potential carers. Joint work with Children's Services looking at young people and young people who have complex needs accessing Shared Lives.

7. EQUALITIES

7.1 An Equalities Impact (EIA) has been undertaken and is available in **Appendix 3**.

7.2 The EIA has identified a differential positive impact on protected characteristic groups of age, disability, mental health and carers.

7.3 If approved, the service would expand to accept people aged 16+ allowing the service to improve transition and work with young people leaving care.

7.4 The banding system will potentially open the Shared Lives Scheme to people with more complex disabilities, and people with mental health issues who might not previously had the opportunity to be supported in this service.

7.5 The banding system proposes an increase in carer's payment for respite and day services, and also reflects the degree of assistance provided in the payment system. In terms of attracting carers, an individual's decision to provide differing levels of support is fair and equitable on the basis that payment is commensurate with the support provided. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role of approved Shared Lives Carers.

8. CONCLUSION

8.1 The Council faces significant budgetary challenges over the foreseeable future which means it must diversify service delivery by looking at new and innovative approaches to deliver better outcomes whilst also reducing the cost of provision. This may also include a cost benefit analysis across the health and social care system identifying where efficiencies can be made.

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

8.3 The proposed banding payment system for Shared Lives carers, ensures the payment made to carers is reflective of the levels of need of the service users in their care, and providing a choice to carers of the amount of assistance they want to, or can, provide at a certain cost.

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

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

8.6 By changing the age of access to 16 years this allows a wider range of young people to consider Shared Lives as a viable alternative to other support approaches. This would include Looked After Children and also young people with complex needs who are currently in placements or with Foster carers.

8.7 Foster carers who care for young people with complex needs would in the interests of continuity be encouraged to become Shared Lives carers as the young person becomes an adult and the banding system would offer a more comparable payment system reflecting the complexity of need that a fixed rate system does not recognise.

8.8 The aim is to expand the Shared Lives offer to provide more person centred care as an alternative to other high cost alternatives such as placements in supported housing or out of area placements.

9. RECOMMENDATION

9.1 As stated on the report cover

APPENDIX 1

Greater Manchester Benchmarking exercise

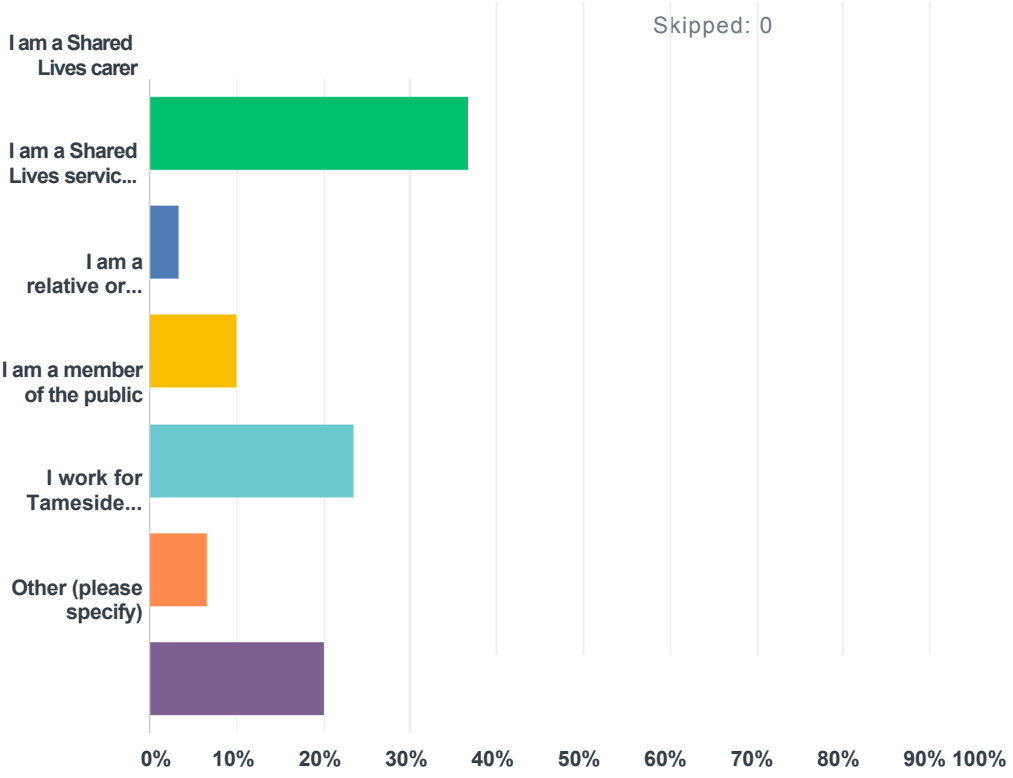
Long Term	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Trafford	Wigan
Level 1	£288.50	£365.87	(provider 1) £203.70 (provider 2) £310.00	£225.00	£207.20	£328.30	£220.00	£322.40	£279.09
Level 2	£346.50	£365.87	£377.00	£277.00	£207.20	£401.90	£242.00	£364.30	£279.09
Level 3	£394.50	£365.87	£416.00	£330.00	£207.20		£295.00	£389.00	£279.09
Level 4	£450.00	£365.87	£507.00	£416.00	£207.20		£372.00		£279.09
Level 5							£238.00 (block)		

Respite	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Trafford	Wigan
Level 1	£30.62 pn	£52.67 pn		£277.20		£44.90 pn	£81.00 pn	£46.06 pn	£39.87 pn (plus mileage at £0.25)
Level 2	£39.75 pn	£52.67 pn		£277.20		£51.03 pn		£52.04 pn	
Level 3	£47.05 pn	£52.67 pn		£277.20				£55.63 pn	
Level 4	£56.17 pn	£52.67 pn							
Level 5									

Day support	Bolton	Bury	Manchester	Oldham	Rochdale	Salford	Stockport	Trafford	Wigan
Level 1		£20 per 4 hour session				£8.49 ph		£6.89 ph	£15.75 per session
Level 2		£20 per 4 hour session				£8.49 ph			£21.00 per session
Level 3		£20 per 4 hour session							£26.25 per session
Level 4		£20 per 4 hour session							

Q1 Please indicate which of the following best describes your main interest in the Shared Lives consultation

Answered: 30 Skipped: 0

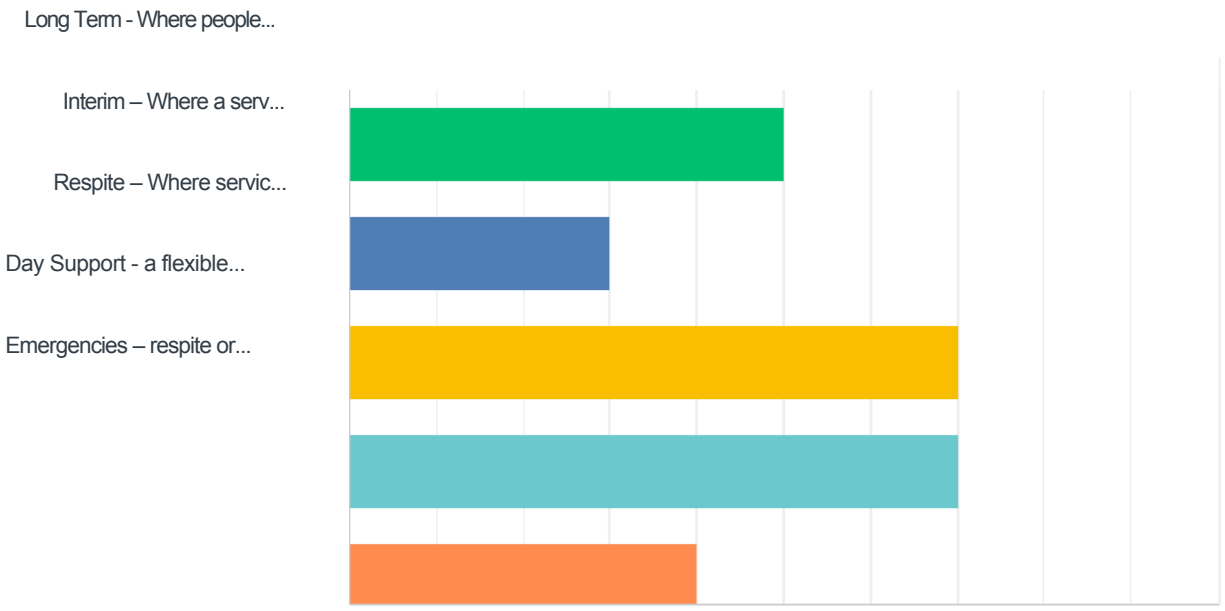


ANSWER CHOICES	RESPONSES	
I am a Shared Lives carer	36.67%	11
I am a Shared Lives service user	3.33%	1
I am a relative or friend of a Shared Lives service user	10.00%	3
I am a member of the public	23.33%	7
I work for Tameside Metropolitan Borough Council/NHS Tameside and Glossop Clinical Commissioning Group	6.67%	2
Other (please specify)	20.00%	6
TOTAL		30

#	OTHER (PLEASE SPECIFY)	DATE
1	prospective carers	7/19/2018 8:56 PM
2	prospective carer	7/17/2018 7:09 PM
3	Parent/carer of special needs adult	7/12/2018 5:13 PM
4	looking to become a shared lives carer	7/12/2018 4:12 PM
5	I am a shared lives carer and also a parent of a shared lives user	7/8/2018 11:51 AM
6	I am a retired foster carer	6/20/2018 9:10 PM

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

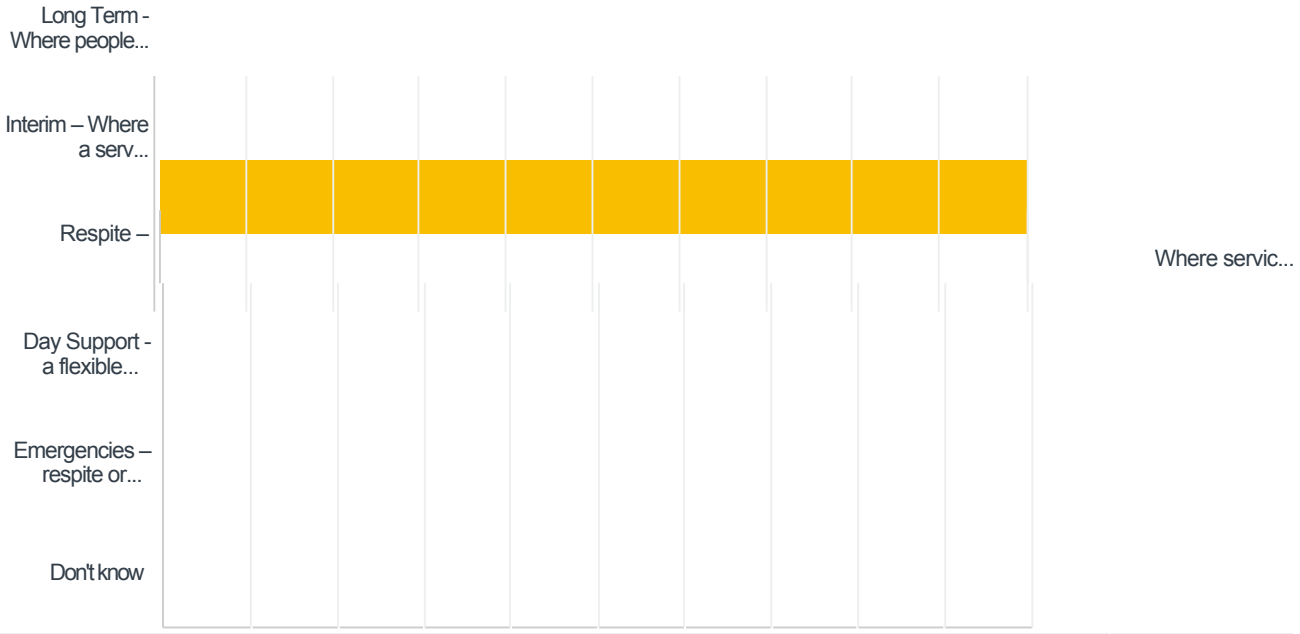
Answered: 10 Skipped: 20



ANSWER CHOICES	RESPONSES	
Long Term - Where people live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families		
Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living	50.00%	5
Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights	30.00%	3
Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home	70.00%	7
Emergencies – respite or interim provision due to emergency circumstances	70.00%	7
Total Respondents: 10	40.00%	4

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

Answered: 4 Skipped: 26



ANSWER CHOICES	RESPONSES	
Long Term - Where people live with approved Shared Lives Carers on a long-term basis, sharing in the ordinary lifestyles of the carers and their families		
Interim – Where a service user can live with a Shared Lives Carer for up to 12 months with a view to moving towards more independent living		
Respite – Where service users are enabled to take either regular short breaks or breaks of one off periods based on an allocated number of respite nights	0.00%	0
Day Support - a flexible service enabling service users to do activities of their choice, to use community facilities or to visit approved Shared Lives Carers in the carer's home	0.00%	0
Emergencies – respite or interim provision due to emergency circumstances	100.00%	4
Don't know	0.00%	0
Total Respondents: 4	0.00%	0
	0.00%	0
	0.00%	0

Q4 We would like to know your thoughts on the proposed changes to the Shared Lives payment system (i.e. change from a fixed payment to a banded system). If you, a friend or relative uses the Shared Lives Service please explain how this will impact you. Further information on the proposed changes to the payment system for Shared Lives can be found at (https://www.tameside.gov.uk/TamesideSharedLives) or with the letter which accompanied this questionnaire if you received a copy by post. (Please state in the box below)

Answered: 20 Skipped: 10

#	RESPONSES	DATE
1	At present it is one rate for all no matter what the persons needs are. this has created a pick and choose situation which is a bad thing for the more disabled. In our situation we tried shared lives twice, once our son didn't take kind to it, then at another house they didn't take to him, but deep down we feel that he was rejected because of his needs The new proposals are long over due.	7/20/2018 2:48 PM

2	Proposals to the changes in payments for carers and the extended provision for 16+ Firstly, I would think that the banding system, would go some way to incentivise carers into caring for service users that have complex need... but only partly. I also think they would need greater support, on a day to day or throughout the week and greater lenghts of respite themselves. It is not only about the money...but the support that carers who choose to work with service users with complex needs. In fife shared lives, they have regular carer meetings and regular training. Also, it is not clearly defined, what will be level 1,2 and complex needs – this needs to be clarified. Secondly, I agree with the banding system as a general principle. However, done like this, it will have a major impact on the quality and breadth of opportunities open to service users and their carers in band 1. The proposed cuts will invariably mean a loss to the carers income by £105 per week... which is about £5,460 a year. This is a massive cut to their income and will invariably affect people on lower wages hardest. A major consideration for my partner and I is: “will we have enough money to support the service user, in an economy where all the basics day to day necessities have gone up disproportionately to wage increases”, plus do all the life enhancing activities that make up a happy and fulfilled life, such as hobbies, interests, socialising and volunteering. There are very few volunteering opportunities now that will give volunteers even out of pocket expenses! For example, we recently went to the beach with a friend who is a carer in shared lives and two of her service users she is caring. We required: • Two reliable cars • Beach gazebo – for shade • Deck chairs • Sun cream and hats • Sandwiches and food, which we made and bought ourselves • A trip to costa coffe, for drinks and cakes for 6 to round the day off All this had to be paid for and is an example of a social activity which enables service users to build confidence with a wider range of people, enjoy socialising and all the health benefits being outdoors in the sun. I dont think any of these are excessive, but when you add up the costs.... It isn’t “cheap” doing activities that most people would consider modest. It also concerns me that this somewhat arbitary cuts, could be the start of more...what is the financial bottom line that would never be crossed? Although we are looking forward to being carers with shared lives, we could not financially do it voluntary, if the service was cut in this way. In researching shared lives, I came across this from the PSS site: What are the benefits over other forms of care? Shared Lives or Adult Placement is truly unique because it allows individuals who may not be fully able to live on their own the chance to experience independence. These individuals can live in a safe environment, which PSS has approved and with carers who are trained to deal with their individual needs. Because each carer family is different and each user of our services is too, we can truly ensure we plan for each individual. No one size fits all and no two families are the same. Aside from the personal advantages of this service, in terms of providing a family environment, safety, support and independence, Shared Lives or Adult Placement has significant cost savings for each individual. It is estimated that being part of the service can save at least £13,000 per annum per person in comparison to residential care and supported living and in some areas this figure is much higher. This leads me to the question.... Why start cutting carers allowances, when they are already saving thousands per person in comparison to residential care and supported living? It seems to me that there are other area’s that should be looked at, rather than services that are actually saving money and are in many cases transforming services users lives for the better. I also think to do this job justice, I would only consider working part time in another job... at the very outside and it would have to fit around their needs, certainly at the start. Which full time job, isn’t demanding, time consuming and tiring? ... Then to try and support a service user with a wide variety of needs....? Our personal opinion is that carers end up exhausted... maybe leaving the scheme and not being able to give service users proper time and attention. By the very ethos of the scheme... they need quality time with you...! Of course, they may be going to college, volunteering or working.... But we understand that we may be called upon... incidents of bullying are very common, learning to get to places independently may require support as is potential difficulties making friends and adjusting to new environments.... Having time and being able to support service users more intensely, particularly at the beginning of their “shared lives” with us In researching carers allowance from other schemes, manchester city council and rochdale have carers allowance at around £400 per week. I am unaware that any other shared lives schemes are considering such proposals Lastly, I would think having a 16+ option would be great for young people who maybe transitioning from young peoples services to have continuation of support...	7/19/2018 8:58 PM
3	We feel that is a fair system.	7/18/2018 6:52 PM
4	1. What criteria has used to base the separate banding? I believe the Carer's should have had access and more consultation	7/17/2018 7:16 PM
5	If the changes mean that more Carers will be joining the scheme then it is a good idea. My daughter has for the last two years been unable to use her 21 days respite awarded to her due to the lack of Carers available. My only concern is that due to her needs (she has Autism) may now be overlooked in favour of children who are far more independent and do not need as much support as she requires.	7/15/2018 11:54 AM

6	Banding system will hopefully support recruitment and retention of shared lives carers who can accommodate more complex needs. These are often the service users most difficult to place, whether respite, emergency or permanent and most likely to break down when needs increase. Increased payment, reflecting the intensity of support may attract people with the skills and commitment needed.	7/13/2018 3:29 PM
7	At present I understand that the payment at present is standard regardless of the cared fors needs. This system has been open to abuse by carers by the fact that they can pick and choose who they care for. In our own instance when trying to place our son into shared lives one of the families parents gave us the impression that his needs were too complex. They gave another reason as to why but that didn't fir well with us as we know our son better than them. The banding system that you intent to implement go a long way to righting it. Having 2/3 users to care for is too many, I feel that the carer should be restricted to one, I know that it isn't possible at the moment but could be something to be looked at in the future.	7/12/2018 5:28 PM
8	As a carer I agree with the banded payment system that ensures my son gets the best and appropriate care,for his needs. This was also ensure that the carer receives the right payment for the amount of care he/she provides.	7/8/2018 11:54 AM
9	much needed differentiation for different types of work, no change to minimum payment and increments for harder work. I agree.	7/2/2018 7:14 PM
10	I agree with the proposal, no carer will lose out as the minimum remains the same, but carers with the most demanding clients should get more money.	7/2/2018 7:09 PM
11	I think it is a positive thing to change to a banded system. Unsure how we will be affected by the changes who decides what band a person is to be placed	7/2/2018 5:05 PM
12	I agree with the banded payments	7/2/2018 4:17 PM
13	I think the changes are fare and there should be a banded system	7/2/2018 3:18 PM
14	Letter came in post. I am 77yrs old and a full time Carer for my daughter, who has Learning difficulties, plus other physical needs. We use respite care 30nights per year, without which I know that I could not continue being her Carer. I am concerned that with the new banding system, just what banding she would come into and about the problem with Shared Lives Carers being more likely to opt for caring for those in Band 2, at almost twice the amount of payment as for those in Band 1. So we could see less take up of Service Users in Band 1, which my daughter could possibly be classed in.	7/2/2018 11:56 AM
15	Some service users can be more difficult than others in terms of their needs and their emotional needs	7/2/2018 10:05 AM
16	I fully support this change	6/21/2018 7:29 PM
17	The proposed change would seem to be an improvement to incentivise families to consider sharing lives with people with more complex needs.	6/21/2018 3:58 PM
18	All current long term placements should continue with current payment level. Only new placements should be paid via the banded levels.	6/20/2018 9:13 PM
19	Good idea but I don't think the payment for a session is enough as the hourly rate is a lot lower than the minimum wage. I work as a carer and know how much work is involved.	6/20/2018 6:28 PM
20	cap everything to £25 per night.	6/20/2018 2:26 PM

Q5 We would like to know your thoughts on the proposed changes to the Shared Lives age of access (i.e. change from working with people aged 16 rather than 18 years of age) If you, a friend or relative uses the Shared Lives Service please explain how this will impact you. (Please state in the box below)

Answered: 18 Skipped: 12

#	RESPONSES	DATE
1	At present there isn't enough shared lives properties to satisfy the demand as it is. If the age is reduced it will put more pressures on the carers who use the system now. As a user of the system for our son we know how difficult it is to try and get some respite when we need it. At present we have 30 days and it is difficult trying to marry up a holiday with respite, sometimes having to use as much as 10 days for a 7 day holiday.	7/20/2018 2:56 PM
2	I would think having a 16+ option would be great for young people who maybe transitioning from young peoples services to have continuation of support...	7/19/2018 8:59 PM
3	We again feel that this is a necessary change as there was a need for a change to accommodate a younger age group into the scheme. Yes we feel this is an important change and one one which benefit a lot of younger people.	7/18/2018 6:58 PM
4	My concerns are that the needs of the service users can not be met already so lowering the age of access will only add pressure on the existing Carers	7/15/2018 11:56 AM
5	Adult Services are already overstretched, so although I feel Shared Lives could be considered as part of the long term transition process, it needs to be resources. Maybe better use of the Transitions Worker, could support this role.	7/13/2018 3:31 PM
6	I can see lots of problems, there is more legislation regarding children needing care for whatever problem they have, support for children has to be more closely supervised, as an ex foster carer I received visits from a social worker every 6 weeks to check on placement, I can't see this happening in shared lives. I also don't know where you will find the carers, my son has not been able to have his full allocation of respite due to the lack of carers. I have also been informed that most new carers only want to do day care. Extending the age range will only put more strain on present carers and shared lives staff.	7/8/2018 11:58 AM
7	I agree with this, children should not be expected to be adults at 16. More support is needed.	7/2/2018 7:15 PM
8	I agree with this proposal, much needed support to children who are NOT adults at 16!	7/2/2018 7:10 PM
9	It don't think the age difference wilol impact at all	7/2/2018 5:06 PM
10	I personally would not feel able or knowledgable to work with people under 16	7/2/2018 4:18 PM
11	I personally would not like to work with a 16 year old...	7/2/2018 3:19 PM
12	As my daughter is 50yrs old, this hopefully should not affect us	7/2/2018 11:58 AM
13	Will bring a much fairer system. Having to work really hard with someone when another carer has a much easier job can be very frustrating when we all get the same hourly rate	7/2/2018 10:06 AM
14	I agree with changing the age	6/21/2018 7:29 PM
15	I am not sure why this age change would be proposed - I thought other services were available to people between the ages of 16 & 18. However, if there is a need that is not being met then I would support the change.	6/21/2018 3:59 PM
16	I think it is a good idea to give additional flexibility for young people aged 16 to 18	6/20/2018 9:15 PM
17	I think this is a good idea as this will offer young people more much needed support.	6/20/2018 6:30 PM
18	Money can be spent better elsewhere like potholes	6/20/2018 2:26 PM

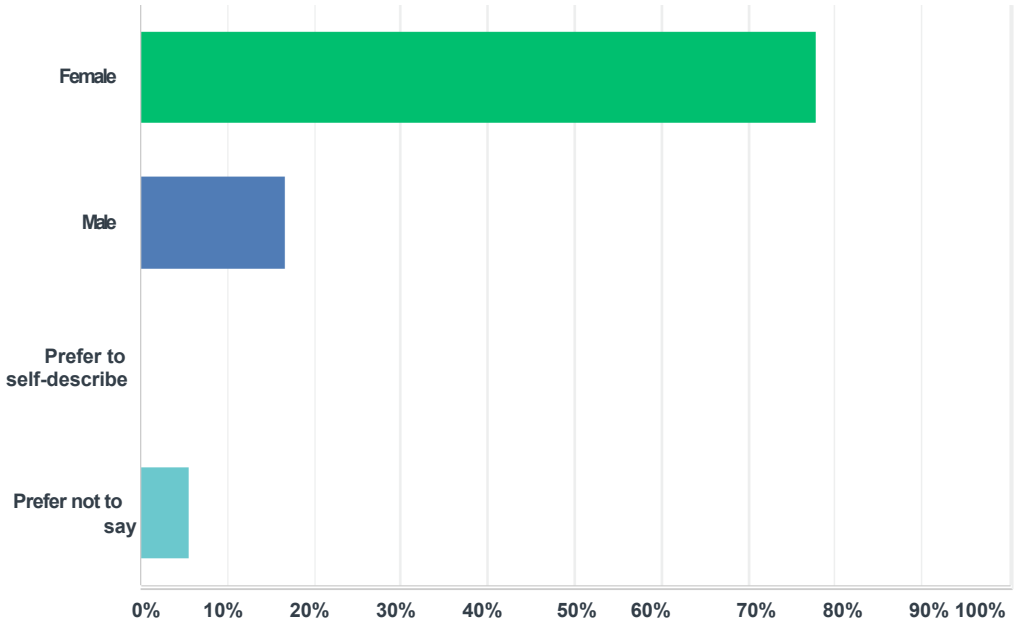
Q6 Do you have any other comments you wish to make about the Shared Lives Service in general? (Please state in the box below)

Answered: 16 Skipped: 14

#	RESPONSES	DATE
1	We like working for Shared lives. They give us valuable support and in turn we feel we give the necessary support to the people we look after.	7/18/2018 7:01 PM
2	The right families need to be approved so they are doing it because they genuinely care about the people they are looking after and not just for the money.	7/15/2018 12:01 PM
3	When it works well Shared Lives is a fantastic option and I have seen brilliant outcomes. However it is becoming increasingly difficult to access as so few carers seem to be recruited. The process is long and due to the lack of numbers of carers the matching process is limited.	7/13/2018 3:33 PM
4	Until more carers are recruited to support the service in all areas I can't see expanding the scheme will be beneficial, as a carer in contact with others in my position I know that they do not get the care support they would like	7/8/2018 12:05 PM
5	all good thanks	7/2/2018 7:15 PM
6	al great thanks	7/2/2018 7:10 PM
7	I think to mix adults with disabilities in with adults leaving care is wrong they are totally separate departments and totally different needs need to be met. Requiring different skills	7/2/2018 5:08 PM
8	I think the service is excellent and a very rewarding job... I do however feel more exposure is needed to promote the service and the pathway more accessible for Parents/Guardians to apply ...	7/2/2018 3:31 PM
9	My daughter loves spending time with her current respite Carer and her family. I do worry though that, although I have asked Shared Lives some time ago for a back up Carer, they as yet haven't come up with anyone. Obviously with the age access being lowered, which will create more demand for placements, it could prove to be even more difficult, to find her a back up Carer.	7/2/2018 12:06 PM
10	Respite care needs looking at. I have just completed a 2 night respite for a service user but in effect I had that person for 2 whole days. There should be some form of day support rate added in somehow, especially when the service user does not access other day services so it's a full day care service we provide aswell	7/2/2018 10:08 AM
11	No	6/21/2018 7:29 PM
12	This service offers an approach that is family oriented with the prospects of a more sensitive and humane option.	6/21/2018 4:00 PM
13	Each band should have a minimum of £9 per hour as they are specialist trained jobs & to get the right person for the job they need insentive & a right to afford to live without benefits to top up their wages.	6/21/2018 1:26 PM
14	All I have heard is that it is a very good scheme	6/20/2018 9:15 PM
15	I support the scheme as it aids people to maintain a good level of independence but with support.	6/20/2018 6:31 PM
16	Should just be abolished.	6/20/2018 2:27 PM

Q7 What best describes your gender?

Answered: 18 Skipped: 12



ANSWER CHOICES	RESPONSES	
Female	77.78%	14
Male	16.67%	3
Prefer to self-describe	0.00%	0
Prefer not to say	5.56%	1
TOTAL		18

Q8 What is your age? (Please state)

Answered: 18 Skipped: 12

#	RESPONSES	DATE
1	72	7/20/2018 2:59 PM
2	57	7/19/2018 9:01 PM
3	50	7/18/2018 7:01 PM
4	63	7/15/2018 12:03 PM
5	56	7/13/2018 3:34 PM
6	64yrs	7/8/2018 12:06 PM
7	55	7/2/2018 7:18 PM
8	54	7/2/2018 5:10 PM
9	57	7/2/2018 4:18 PM
10	55	7/2/2018 3:32 PM
11	77	7/2/2018 12:08 PM
12	53	7/2/2018 10:09 AM
13	44	6/21/2018 7:30 PM
14	70	6/21/2018 4:01 PM
15	41	6/21/2018 1:27 PM
16	64	6/20/2018 9:16 PM
17	61	6/20/2018 6:32 PM
18	45	6/20/2018 2:27 PM

Q9 What is your postcode? (Please state)

Answered: 18 Skipped: 12

#	RESPONSES	DATE
1	M34 5SD	7/20/2018 2:59 PM
2	ST4 1NY	7/19/2018 9:01 PM
3	sk153df	7/18/2018 7:01 PM
4	M34 6LG	7/15/2018 12:03 PM
5	M34 7RT	7/13/2018 3:34 PM
6	M34 6NP	7/8/2018 12:06 PM
7	sk151bp	7/2/2018 7:18 PM
8	M43 6hb	7/2/2018 5:10 PM
9	Sk144tz	7/2/2018 4:18 PM
10	M34	7/2/2018 3:32 PM
11	M34 5QB	7/2/2018 12:08 PM
12	Sk15 2hf	7/2/2018 10:09 AM
13	SK15 1JG	6/21/2018 7:30 PM
14	SK14 1PR	6/21/2018 4:01 PM
15	OL7	6/21/2018 1:27 PM
16	SK16 5DS	6/20/2018 9:16 PM
17	SK142JX	6/20/2018 6:32 PM
18	ol6	6/20/2018 2:27 PM

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

Answered: 18 Skipped: 12

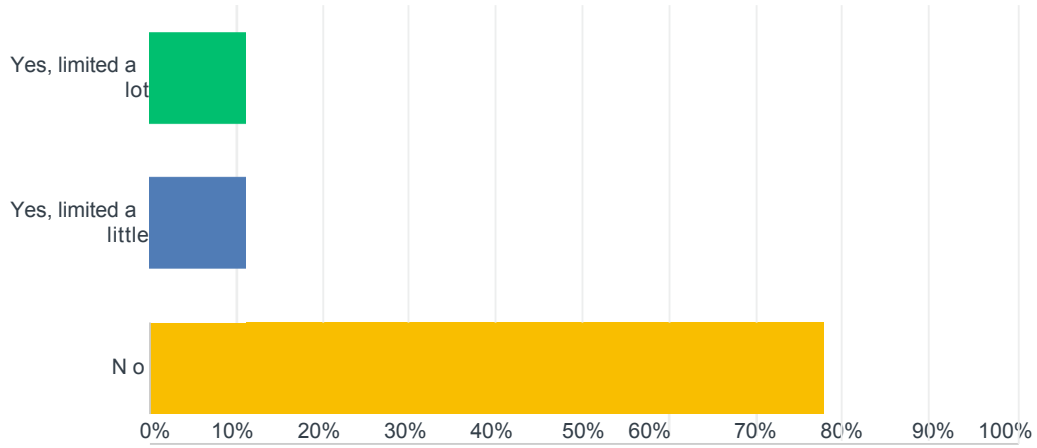

White: English / Welsh /...
White: Irish
White: Gypsy or Irish...
Any other White...
Mixed/multiple ethnic group...
Mixed/multiple ethnic group...
Mixed/multiple ethnic group...
Any other Mixed/multip...
Asian/Asian British: Indian
Asian/Asian British:...
Asian/Asian British:...
Asian/Asian British:...
Any other Asian...
Black/African/Caribbean/Bla...
Black/African/Caribbean/Bla...
Any other Black / Afri...
Arab
Any other nic group...

ANSWER CHOICES	RESPONSES	
White: English / Welsh / Scottish / Northern Irish / British	**94.44%**	**17**
White: Irish	0.00%	0
White: Gypsy or Irish Traveller	0.00%	0
Any other White background (please specify in the box below)	0.00%	0
Mixed/multiple ethnic groups: White & Black Caribbean	0.00%	0
Mixed/multiple ethnic groups: White & Black African	0.00%	0
Mixed/multiple ethnic groups: White & Asian	0.00%	0
Any other Mixed/multiple ethnic background (please specify in the box below)	0.00%	0
Asian/Asian British: Indian	0.00%	0
Asian/Asian British: Pakistani	0.00%	0
Asian/Asian British: Bangladeshi	0.00%	0
Asian/Asian British: Chinese	0.00%	0
Any other Asian background (please specify in the box below)	0.00%	0
Black/African/Caribbean/Black British: African	0.00%	0
Black/African/Caribbean/Black British: Caribbean	0.00%	0
Any other Black / African / Caribbean background (please specify in the box below)	0.00%	0
Arab	0.00%	0
Any other Ethnic group (please specify in the box below)	5.56%	1
TOTAL		18

#	PLEASE SPECIFY BELOW	DATE
	There are no responses.	

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

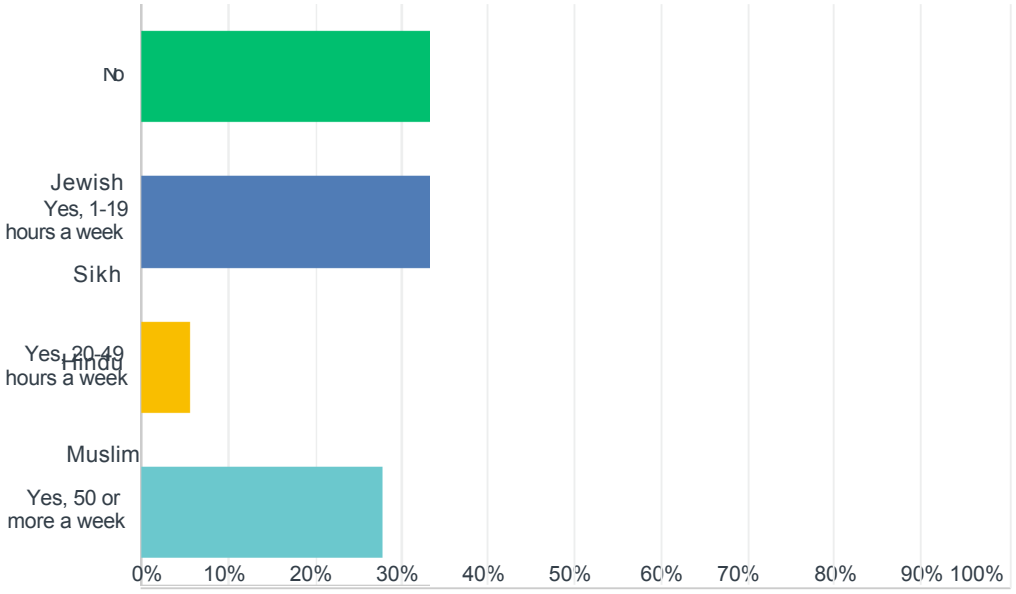
Answered: 18 Skipped: 12



ANSWER CHOICES	RESPONSES	
Yes, limited a lot	11.11%	2
Yes, limited a little	11.11%	2
No	77.78%	14
TOTAL		18

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

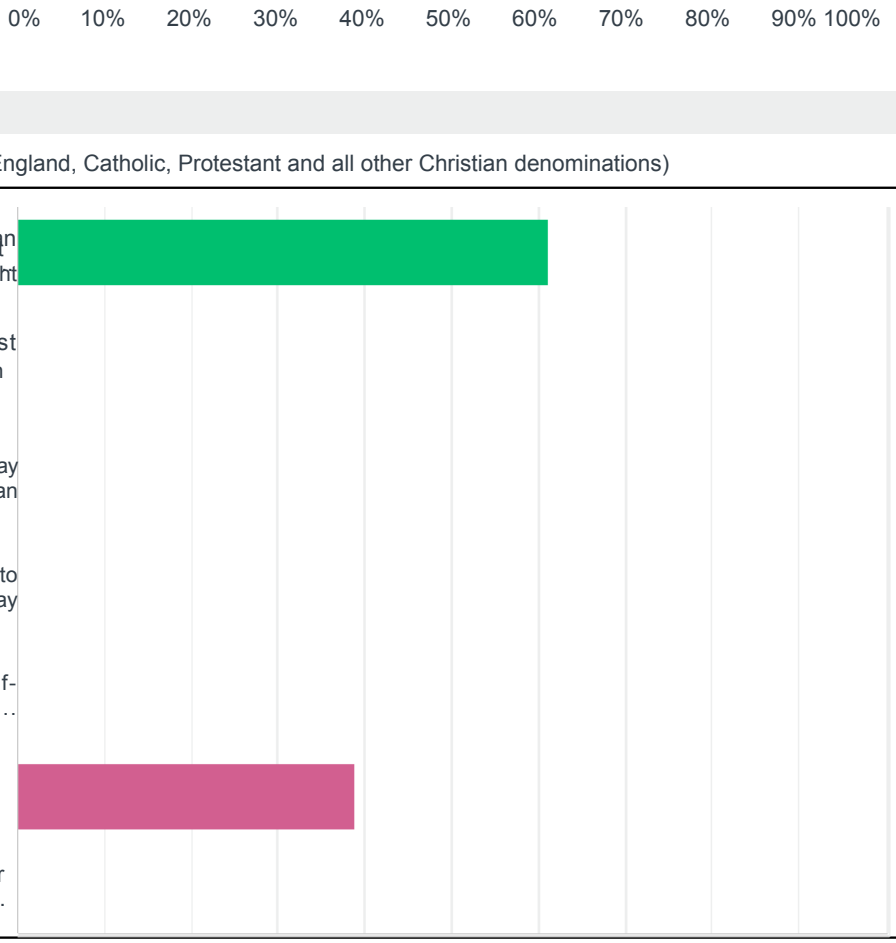
Answered: 18 Skipped: 12



ANSWER CHOICES	RESPONSES	
No	33.33%	6
Yes, 1-19 hours a week	33.33%	6
Yes, 20-49 hours a week	5.56%	1
Yes, 50 or more a week	27.78%	5
TOTAL		18

Q13 What is your religion?

Answered: 18 Skipped: 12

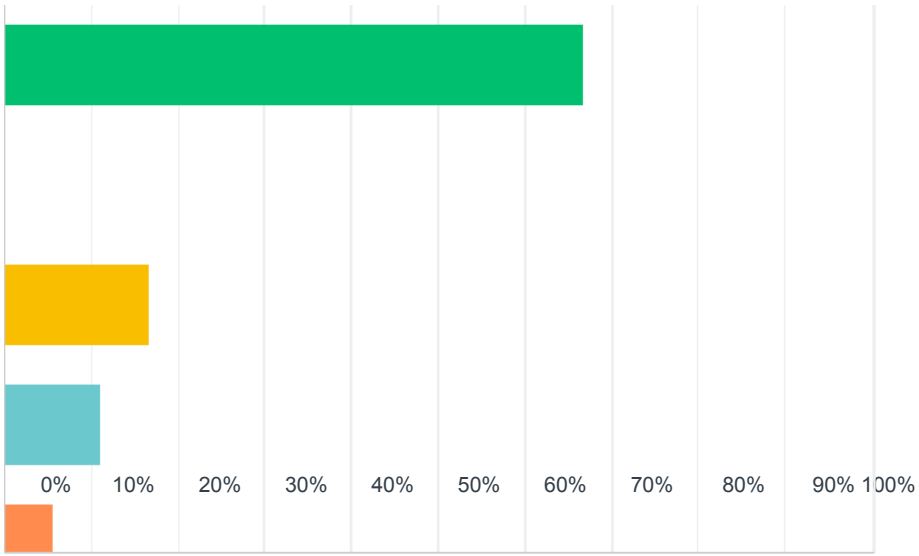


ANSWER CHOICES	RESPONSES	
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	61.11%	11
Buddhist	0.00%	0
Jewish	0.00%	0
Sikh	0.00%	0
Hindu	0.00%	0
Muslim	0.00%	0
No religion	38.89%	7
Any other religion, please state	0.00%	0
TOTAL		18

#	ANY OTHER RELIGION, PLEASE STATE	DATE
	There are no responses.	

Q14 What is your sexual orientation?

Answered: 18 Skipped: 12



ANSWER CHOICES	RESPONSES	
Heterosexual/Straight	66.67%	12
Gay man	0.00%	0
Gay woman/lesbian	16.67%	3
Prefer not to say	11.11%	2
Prefer to self-describe (Please self-describe below)	5.56%	1
TOTAL		18

#	PREFER TO SELF-DESCRIBE (PLEASE SELF-DESCRIBE BELOW)	DATE
	Bi-sexual	6/21/2018 7:30 PM

APPENDIX 3

TAMESIDE & GLOSSOP STRATEGIC COMMISSIONING FUNCTION

EQUALITY IMPACT ASSESSMENT FORM (EIA)

Subject / Title	Shared Lives Scheme Banded Carer Payment and Change of Age.

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

Start Date	**Completion Date**
05/02/18	

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

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

PART 1 – INITIAL SCREENING

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

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

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

1a.	**What is the project, proposal or service / contract change?**	Tameside MBC Shared Lives scheme would like to introduce a banded payment system for carers. The use of banded payment systems has been implemented by six of the Greater manchester boroughs and is seen as national best practice. The banded payment system allows carer payments to be reflective of the level of complexity of care being given. Tameside MBC Shared Lives would also like to lower the age that individuals can access the service from 18+ to 16+ allowing us to improve transition and work with young people leaving care.
1b.	**What are the main aims of the project, proposal or service / contract change?**	The introduction of a banded payment system will enable the Shared Lives Scheme to develop and expand in the knowledge that service users have different needs. The service users who are referred to the Shared Lives service vary in complexity of needs and levels of support required. These levels of support are currently not reflected in a fixed payment. In order to maximise the opportunities to offer Shared Lives as an option for the widest range of people, there was a need to review the fixed payments that are currently offered to carers, and consider a payment mechanism that is more reflective of the complexity of service users that carers currently support, and could support in the future as we expand our services. The banding system will potentially open the Shared Lives Scheme to people with more complex disabilities, and people with mental health issues who might not previously had the opportunity to be supported in this service. The banding system proposes an increase in carer's payment for respite and day services, and also reflects the degree of assistance provided in the payment system. In terms of attracting carers, an individual's decision to provide differing levels of support is fair and equitable on the basis that payment commensurate to the support provided. Some kind of differential pay system segments the market and should have the effect of attracting a larger number of carers to the role of approved Shared Lives Carers. Tameside MBC Shared Lives would also like to lower the age that individuals can access the service from 18+ to 16+ allowing us to improve transition and work with young people leaving care.

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics? Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.				
Protected Characteristic	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Age	X			Shared Lives Services are targeted at the adults age group (18+)
Disability	X			Service Users for Shared Lives have services commissioned due to qualifying needs, using national eligibility criteria.
Ethnicity			x	Shared Lives Service users come from a range of ethnic backgrounds.
Sex / Gender			X	Shared Lives is not a gender specific service.
Religion or Belief			X	
Sexual Orientation			X	
Gender Reassignment			X	
Pregnancy & Maternity			X	
Marriage & Civil Partnership			X	
Other protected groups determined locally by Tameside and Glossop Single Commissioning Function?				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**
Mental Health	X			Shared Lives supports service users with mental health needs
Carers	X			Shared Lives services provide respite for carers.
Military Veterans			X	There are some Shared Lives Carers who are Military Veterans
Breast Feeding			X	
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

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

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

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

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

Tameside MBC Shared Lives aims to create a fair and transparent banded system to align with the best practice. The introduction of a three band system would enable the Shared Lives Scheme to pay carers according to the level of need the service users they support have.

The bands will be;

- Low needs (Band one).
- Medium needs (Band two).
- Discretionary complex banding for exceptional circumstances (Complex band).

It is proposed that banding will be introduced for long term, respite and day support provision. A banding toolkit has been produced, based on national best practice guidelines from Shared Lives Plus, which will support workers and refers to understand which band service users would be allocated to. Following a benchmarking exercise against Greater Manchester and other North West schemes, and consultation with Tameside Finance Team, the following payment bands are being proposed:

Day Support

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

Respite

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

Long Term and Interim

	Per week	**Per Annum**
Band One	**£300**	**£15,600**
Band Two (In line with current proposed rate for 18/19.)	**£405.54**	**£21,088.08**
Complex Needs - Rate subject to assessment	**£800**	**£41,600**

Shared Lives would also like to lower the age of access to the service from 18+ to 16+. Shared Lives schemes can provide transition arrangements from as early as 16 years old and can start to look at potential matches from 15 years old. CQC and Ofsted have developed guidance to help Shared Lives Schemes to register with CQC for anyone under 18 but not lower than 16. Currently Tameside MBC Shared Lives are unable to accept referrals for service users under the age of 18, however will assess and prepare carers prior to the 18th birthday. Changing the age of service

would allow children's services to refer those young people who meet the criteria for adult services at an earlier age easing the transition for both carers and service users. It would also allow for these young people to be introduced to respite carers who may be able to continue their support post 18 or become possible long term carers minimising disruptions.

Changing the service age will allow the service to meet the needs of vulnerable young people leaving care, who would not meet the criteria for adult services, transitioning into adulthood through an alternative model that can provide a period of stability in what is a very turbulent and stressful time. The transition to a Shared Lives placement may allow young people to maintain support in CQC regulated service. Shared Lives plus have made agreements with Ofsted to ensure the regulations are upheld, for those young people who transition to Shared Lives at 16+ will be regulated under the CQC guidelines, allowing them greater independence to develop their skills while still being monitored by a regulated service.

A change in service may also support the attraction of a larger number of prospective carers to meet the varying needs. Some individuals may be attracted to providing support for young people leaving care who may not have previously considered Shared Lives a potential option for them and their family. The expansion of the service to support young people will allow the scheme to develop a targeted recruitment campaign with a focus on supporting young people in their transition to independent adulthood.

There are currently 132 service users accessing the service (as of 20/8/18) and their primary needs are as follows*:* The Service users access the following services;

Long Term Placements	*34*
Short term/ Respite Placements	*29*
Day Support Placements	*58*
Receive Short Stay & Day Support	*11*

The Scheme currently has :

Approved Carers	93
Prospective Carers Undergoing assessment	5

2b. Issues to Consider

The Tameside MBC Shared Lives service considered the appropriate legislation relevant to the decision. The service explored the partnership working which would be required with children's services when working with those who are 16+. A Path day was held with relevant stakeholders from Children's and Adults services to explore the key issues. We also consulted with Shared lives Plus and received advice and guidance from their Development Officer for Young People Leaving Care. Tameside are provisionally accepted onto a Department of Education pilot project and have attended seminars with partner schemes from across the country. There has also been agreement between CQC and OSTED that young people accessing Shard Lives services from the age of 16 will come under CQC regulations so Shared Lives will not need to undergo assessment via OFSTED.

Agreement has been made via Tameside MBC training and development for Shared Lives Carers who wish to work with young people to access specialist training available to foster carer. A mandatory training list has been completed. It has also been agreed that all carers who wish to complete this work will have additional DBS clearance for working with Children as part of their approval. Shared Lives has taken inspiration from other services nationally who are have implemented this policy and have been successfully supporting the young people of their locality, e.g Telford. These schemes have shared information and resources to support the implementation

in Tameside.

Consideration has also been given to the financial impacts of implementing changes to the Scheme. These are highlighted within the report, however the key financial consideration is towards future cost avoidance by offering early service intervention and supporting service users to maintain positive supportive relationships in transition from Children's Services to Adult Services.

- Increased demand for the service, increase cost to deliver…?
- Banding will only attract people wanting to work with complex service users for higher payment.
- Attracting more carers for complex needs, and for younger service users aged 16-18

2c. Impact

Positive impacts on the following characteristics of Age, disability, mental health and carers have been identified.

- There are direct impacts on these areas but from evidence shown the proposed policy changes will be positive.
- Fairer payment system for carers, and in line with national Shared Lives Service recommendation.
- Increasing support for borough to care for people in a family environment, supporting people to stay as independent as possible closer to home.
- Improved outcomes for service users, including those young people going through transition.

The proposed changes to the Shared Lives service will also support the Greater Manchester transformation for Shared Lives. The proposed changes to the service align with the expansion plan for Shared Lives as a regional approach. The action plan completed in partnership with all GM regions proposes expanding the usage of Shared Lives for people with complex needs and proposing a banded system to support the recruitment of Carers. Within GM six boroughs have already implemented a banded payment system and it is proposed that all areas move to banded payments for carers.

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Impact 1 *General positive impact*	Proposed changes to the service will increase the ability for residents of the borough from all service user areas. It allows Shared Lives carers to have increased flexibility and control over the level of support they provide and creates a fairer system of reimbursement for the support they provide. The changes will also propose an alternative accommodation and support option for young people with disabilities and those leaving care. The proposed changes are in line with the council, and services aims and objectives, as well as the wider health and social care integration programme that we are working alongside to deliver. It is aligned to Greater Manchester's Health and Social Care and GM Adult Social Care Transformation Programmes.
Impact 2 *Shift towards more complex rather than low needs*	There is potential that Shared Lives Carers will only take on more complex cases for more payment. Meaning that established placements will not be accessible due to carers looking for more complex work. Shared Lives carers come from a diverse range of backgrounds, and possess a differing range of skills. When completing recruitment drives The Shared Lives service has an open recruitment policy to attract the most diverse range of carers possible. The role of a Shared Lives carer is flexible so potential carers are able to provide support which fits around their family and personal circumstances. This leads to a diverse carer team who meet the differing needs of the individuals of the borough. The introduction of a banded system will support the recruitment of carers from all of these ranges, combined with targeted recruitment cycles when appropriate. Throughout the process of exploring a banded system, carers have been consulted and the responses from the consultations are that carers who have established relationships want these to continue, and do not plan to break their arrangements.

Impact 3 *Increased demand on the services.*	Increased demand due to banding system and expansion of service to people aged 16+. More engagement and communication, further recruitment drives, and more targeted recruitment to attract more carers to the service – whether that is to for carers to support people with more complex needs or for carers to support people aged 16+. Close monitoring of demand for the service will be continued, and campaigns can be planned around predicted demand. When completing recruitment drives The Shared Lives service has an open recruitment policy to attract the most diverse range of carers possible. Furthermore, the service will continue to monitor staffing levels and caseloads to ensure that if demand for the service increases, the benefits are captured, and a full business case process is followed to be able to request increased resources to expand the service in line with demand. As interim measures, the Shared Lives team can recruit temporary workers to increase team capacity to meet the expansion needs as a shirt term solution.
Impact 4 *Carers may need additional skills and training to take on caring for younger people*	Shared Lives has liaised with the training and development team within Tameside MBC. There has been agreement that Shared Lives carers who wish to work with young people from 16+ have access to the specialist training and support that is provided to foster carers. This can be added to the mandatory training for Shared Lives carers who wish to undertake this role. Any further training needs will be considered per carer and service user requirements and needs.
Impact 5 *Additional legislation and expectations from children's services.*	Shared Lives Plus has worked with CQC and OFSTED that states that young people leaving care who enter into Shared Lives agreements will fall under the regulation of CQC. This allows for young people to be in a transitionary placement moving them towards Adulthood. Shared Lives has also began working with children's services to explore the provision for young people and create joint working agreements to allow Children's social workers to maintain their responsibilities under the Children Act.

2e. Evidence Sources

- Shared Lives Consultation report re the proposed changes.
- Monthly reporting records.
- Path Day.
- Shared Lives Plus Young Persons Project Seminars.
- Greater Manchester Action Plan.
- Greater Manchester costing benchmarking.

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Monthly reporting returns	*Alison White*	*monthly*
Training Schedule	*Adam Lomas*	*Completed*

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

Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	19 September 2018
Reporting Member /Officer of Strategic Commissioning Board	Jessica Williams, Interim Director of Commissioning
Subject:	**GREATER MANCHESTER RESPONSE TO NHS ENGLAND CONSULTATION ON EVIDENCE BASED INTERVENTIONS**

Report Summary:

This report summarises the NHS England (NHSE) consultation on evidence based interventions and proposes a Greater Manchester response that will be submitted on behalf of Tameside and Glossop and other GM Clinical Commissioning Groups.

The NHSE proposal is stop routinely funding the following interventions:

- Surgery for simple snoring i.e. in the absence of obstructive sleep apnoea;
- Dilation and curettage as a diagnostic or treatment option for heavy menstrual bleeding;
- Knee arthroscopy for patients with osteoarthritis;
- Injections for non-specific low back pain without sciatica.

Set qualifying criteria for a further thirteen:

1. Breast reduction (includes asymmetry and gynaecomastia;
2. Benign skin lesions;
3. Grommets for glue ear;
4. Tonsillectomy for recurrent tonsillitis;
5. Haemorrhoid surgery;
6. Hysterectomy for heavy menstrual bleeding;
7. Chalazion removal;
8. Arthroscopic shoulder decompression for subacromial shoulder pain;
9. Carpal tunnel syndrome release;
10. Dupuytren's contracture release;
11. Ganglion excision;
12. Varicose Vein surgery;
13. Trigger finger release.

The proposed response indicates general agreement whilst suggesting the additional intervention of cataracts and removal of Varicose Veins. It also suggests amendments to the clinical criteria

Recommendations:

The Strategic Commissioning Board is recommended to:

1. Note the report and implications;
2. Confirm agreement with the proposed response to NHS England set out in section 6.

Financial Implications:

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

Budget Allocation (if Investment Decision)	N/A
CCG or TMBC Budget Allocation	CCG
Integrated Commissioning Fund Section – S75, Aligned, In-Collaboration	S75
Decision Body – SCB, Executive Cabinet, CCG Governing Body	SCB
Value For Money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark Comparisons	This paper provides the views of Tameside and Glossop to inform a GM response to an NHSE consultation. The purpose of the consultation is to ensure clinical effectiveness and value for money so this is inherent in the proposals.
Additional Comments The implementation of zero tariff for category one would result in reduced expenditure than is currently the case to comply with EUR processes. However, if the criteria as outlined in the NHSE consultation were adopted, additional costs could be incurred which would present budgetary pressures.	

Legal Implications:

(Authorised by the Borough Solicitor)

Before making their decision Board Members should ensure they fully understand the equality and financial implications of the proposals in order to comply with their equality and fiduciary duties to the public and public purse.

How do proposals align with Health & Wellbeing Strategy?

Focussing on clinically effective interventions will help ensure all patients are able to access the care needed to promote a long Healthy Life Expectancy.

How do proposals align with Locality Plan?

The delivery of clinical effective treatments supports improve patient outcomes and cost effectiveness.

How do proposals align with the Commissioning Strategy?

The NHSE consultation is regarding a proposal to reduce the number of clinically ineffective interventions which will ensure that commissioning resources focus on evidence based treatments that support people to live well.

Recommendations / views of the Health and Care Advisory Group:

The response developed by GMSS was reviewed and the Health and Care Advisory Group confirmed agreement with the response to NHS England set out in section 6.

Public and Patient Implications:

This report sets out our response to a national public consultation the outcome of which will then be implemented locally in line with other national directives and guidance.

Quality Implications:

The proposal focuses on improving clinical outcomes through reducing ineffective treatments.

How do the proposals help to reduce health inequalities?	NHSE in developing their proposal have given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities
What are the Equality and Diversity implications?	The NHSE document includes the following Equality Impact Assessment. 1. Throughout the development of the policies and processes cited in this document, we have: • Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic[1] (as cited under the Equality Act 2010) and those who do not share it; and • Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities 2. We are completing a full Equality and Health Inequalities Assessment (EHIA) as part of this consultation which we will publish alongside the consultation response and other guidance documents. As part of the EHIA we will be engaging with representatives from relevant protected characteristics and asking specific questions in the consultation. Consultation Questions What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for: • groups protected under the Equality Act 2010?31 • those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?
What are the safeguarding implications?	The reducing in clinically ineffective treatments would reduce the risk of harm.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Following the outcome of the national consultation if required a privacy impact assessment will be carried out.
Risk Management:	None at this stage in the consultation
Access to Information :	The background papers relating to this report can be inspected by contacting the report writer Elaine Richardson, Head of Delivery and assurance Telephone:07855469931 e-mail: Elaine.richardson@nhs.net

1 BACKGROUND / INTRODUCTION

1.1 NHS England (NHSE) are consulting on proposals for reducing the number of clinically ineffective interventions carried out in the NHS economy at present. The link to which is https://www.engage.england.nhs.uk/consultation/evidence-based-interventions/user_uploads/evidence-based-interventions-consultation-document-1.pdf

The consultation will run from the 4 July until the 28 September 2018.

1.2 Greater Manchester Shared Services are commissioned to provide EUR policy development support to Tameside and Glossop Strategic Commission and the GM EUR Policy Development Team on behalf of the GM EUR Steering Group, has undertaken a review of the consultation documentation and produced a comparison of the proposed NHS England commissioning criteria against the current commissioning criteria across Greater Manchester.

1.3 The review has been used to develop a response on behalf of the Clinical Commissioning Groups in Greater Manchester.

1.4 This report summarises the NHSE Proposal and sets out the proposed response.

2. NHSE PROPOSAL

2.1 NHSE has set out a hierarchy of five goals for this initiative:

1. Reduce avoidable harm;
2. Save precious professional time;
3. Help clinicians maintain their professional practice;
4. Create headroom for innovation;
5. Maximize value and avoid waste.

2.2 The proposal initially focuses on seventeen specific types of intervention split into two categories:- Category one is essentially “do not do” and Category two interventions which will be restricted to patients who meet the criteria developed to target the intervention to those who will gain the most benefit. In both categories clinicians can apply for funding on the grounds of exceptionality.

2.3 NHSE has set out to identify restrictions that are rooted in research and evidence-based guidance, for which they can establish clear, quantifiable national and local goals. It is intended that a broad consensus should be achieved to take this forward. By starting with an initial, relatively narrow, focus on a few interventions it is hoped that rapid progress can be made. NHSE also propose an array of specific actions to support the achievement of these targets.

2.4 NHSE hopes to identify established local systems that can make early progress toward these reductions in activity and can input their experience and learning into the national programme. Greater Manchester have identified themselves as potential partners.

3. NHSE PROPOSAL FOR CATEGORY ONE INTERVENTIONS

3.1 The interventions which should no longer be commissioned are:

1. Surgery for simple snoring i.e. in the absence of obstructive sleep apnoea;
2. Dilation and curettage as a diagnostic or treatment option for heavy menstrual bleeding;
3. Knee arthroscopy for patients with osteoarthritis;
4. Injections for non-specific low back pain without sciatica.

3.2 Within the consultation NHSE includes data on the current activity levels. Greater Manchester, despite having policies for 3 of these interventions and local policies for the fourth (D&C), are the 5th highest Sustainability and Transformation Partnershp in the country for spend in this area. Six of the 10 GM CCGs are in the top 50 CCGs for spend in this area and 4 of the provider trusts in GM are in the top 50 for activity with Pennine Acute Trust topping the list. Tameside and Glossop is not one of the top 50 CCGs nor is Tameside and Glossop Integrated Care Foundation Trust one of the top 50 providers.

3.3 Work is already planned in GM that will result in a significant reduction in category one interventions specifically in the revised back pain policy which will include a statement that Facet Joint Injection is no longer commissioned, in line with NG59, and the adoption of the revised knee arthroscopy policy.

4. NHSE PROPOSAL FOR CATEGORY TWO INTERVENTIONS

4.1 There are thirteen interventions for which qualifying criteria are proposed and Greater Manchester has existing policies for twelve of these as shown below:

NHSE Category 2 intervention	**GM policy status for the same intervention(s)**	**Notes**
1.Breast reduction (includes asymmetry and gynaecomastia	Policy in place for reduction, enhancement, mastopexy, asymmetry, gynaecomastia and nipple inversion	GMEUR criteria more detailed and restrictive than proposed NHSE criteria
2.Benign skin lesions	Common benign skin lesion policy in place	GMEUR do not limit the restrictions to a specific list of lesions – it has generic criteria and some criteria specific to types of lesion
3.Grommets for glue ear	Drainage of the middle ear (with or without the insertion of grommets) in place	GMEUR and NHSE criteria similar but GMEUR more detailed at present so easier to apply
4.Tonsillectomy for recurrent tonsillitis	Tonsillectomy policy in place	GMEUR policy also covers tonsillar crypts and stones
5. Haemorrhoid surgery	Surgical management including banding) of haemorrhoids & anal skin tags policy currently going through governance	GMEUR policy also restricts the type of surgery as there are excess cost when haemorrhoidectomy is done when banding could be. This has been out to clinical consultation
6.Hysterectomy for heavy menstrual bleeding	**No GMEUR policy but T&G do have a policy**	Local policies apply
7.Chalazion removal	Common benign eyelid lesion policy in place	GMEUR policy covers all benign skin lesions not just chalazion
8.Arthroscopic shoulder decompression for subacromial shoulder pain	Arthroscopic subacromial decompression for shoulder impingement policy currently going through the governance process	The proposed GMEUR policy is in line with NHSE proposals and has been out to clinical consultation
9.Carpal tunnel syndrome release	Carpal tunnel policy in place	Criteria are in line with NHSE but are more detailed at this stage
10.Dupuytren's contracture release	Dupuytren's contracture policy	Criteria are in line with NHSE but are more detailed at this stage
11.Ganglion excision	Revised GMEUR ganglion policy waiting to go through governance	Current policy in line with NHSE proposals but revised policy has stricter criteria in line with the latest royal college guidelines

12.Varicose Vein surgery	GMEUR policy in place	NHSE propose adoption of NICE CG168 criteria which is less strict than our current policy – this carries a significant financial risk
13.Trigger finger release	GMEUR Trigger finger (surgical correction of) policy in place	Criteria are in line with NHSE but are more detailed at this stage

4.2 Within the consultation NHSE includes data on the current activity levels. Greater Manchester, despite having policies for 12 of the 13 interventions with stricter criteria than those proposed by NHSE, are 24th on the list of Sustainability and Transformation Partnerships for activity in these areas. However only one GM CCG is in the top 50 list and 3 providers (the highest of which is Pennine Acute) are in the top 50 providers for activity. Tameside and Glossop is not one of the top 50 CCGs nor is Tameside and Glossop Integrated Care Foundation Trust one of the top 50 providers.

4.3 Work is already planned in GM that will support reduction in category two interventions specifically in the adoption and implementation of the following policies:

- Revised ganglion policy;
- Haemorrhoid surgery;
- Shoulder impingement policy (July GM EUR Steering Group approved the policy to go through the governance process);
- Surgical Repair of Hernias Policy (out for clinical engagement).

5. PROPOSED ACTION BY NHSE TO ALIGN INCENTIVES TO THE EVIDENCE

5.1 The interventions will not be routinely offered to NHS funded patients or offered only if specific criteria apply. However, clinicians will be able to apply for funding for category one interventions if they can demonstrate exceptionality and for prior approval for all category two interventions. The expectation is that the GP will apply for funding rather than the provider clinician.

5.2 Category one interventions will be removed from the scope of National Tariff price or a national variation will be sued so that providers are not paid for activity unless they have an individual funding request number. The proposal is this applies from April 2019.

5.3 With effect from 1 April 2019 the NHS Standard Contract will be amended to mandate compliance with the Evidence-Based Interventions policy. The proposed additions to the Contract will require both commissioners and providers to comply with the Evidence-Based Interventions policy; and enable the commissioner to withhold payment for the relevant procedure where the provider treats a patient without evidence of individual funding request approval (Category one) or other prior approval (Category two).

5.4 NHSE propose aligning the e-referral system with the new programme by excluding Category one interventions from the e-referral system except where an individual funding request has been agreed. They intend to work with CCGs and GPs on how best to implement this.

6. PROPOSED GM RESPONSE TO NHS ENGLAND'S CONSULTATION ON EVIDENCE-BASED INTERVENTIONS

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
Introduction			
1	***In what capacity are you responding?***	• ***Other (if other please specify)*** The Greater Manchester EUR Steering Group on behalf of the 10 Greater Manchester CCGs	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
2	***Have you read the document: Evidence-Based Interventions: Consultation Document?***	***Yes/No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Design Principles			
3	***Do you agree with our six design principles?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Phase 1: A focus on 17 proposed interventions			
4	***Do you agree that selecting circa 17 interventions is about the right number for this first phase?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
5	***Are there interventions you think we should add for the first phase?***	***Yes/No*** ***If you have selected 'Yes', please share your suggestions.*** Please find attached the GM EUR Policy for Cataract removal as there were (local) financial pressures related to surgery for the second eye particularly with some NHS contracted private providers – this may be happening elsewhere as well.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
6	***Are there interventions we should remove?***	***Yes/No*** ***If you have selected 'Yes', please tell us why:*** The proposed criteria for Varicose veins are not currently affordable for the GM commissioners. A recent finance report concluded: The projected costs of moving to a NICE CG168 compliant policy vary depending on the assumptions applied: • a possible saving of £98,597- assumes full compliance with NICE by providers and assumes they meet the activity split assumptions contained in CG168 and that activity remains at current levels • a cost of £403,525 - assumes full compliance with NICE by providers and that they meet the activity split assumptions contained in CG168 • a possible cost of £530,278 if activity increases by the 25% anticipated by and the procedure split remains as it is at present and there is a 25% increase in activity. **NONE of the potential costs calculated include reduced tariffs for sclerotherapy and endothermal ablation which could reduce the costs significantly if managed alongside a move to these interventions from current ratios.** The above figures do not include the cost of additional infrastructure in the community that would be needed by approx 5 of the CCGs to be able to reach full compliance.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
7	***Do you agree this should become an on-going rolling programme, subject to making sufficient progress?***	***Yes/No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
8	***What positive and negative impact will these changes make to improving access, experience and outcomes for the following groups and how can any risks be mitigated to ensure the changes do not worsen health inequalities for:*** **Groups protected under the Equality Act 2010? Those individuals who experience health inequalities such as homeless people/rough sleepers, vulnerable migrants, gypsy traveller groups and carers?**	Evidence based interventions target rather than ration health care, so the needs of all vulnerable groups should be part of that process. Removing ineffective treatments that can carry risk is a positive impact. There may be a perceived impact on those elderly and disabled individuals currently receiving regular facet joint and other injections for back pain as they may not currently be aware of the risks and they perceive these to be effective. However, in health terms the risks outweigh the benefits so the actual (not perceived) impact is positive.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Illustrative Activity Goals			
9	***At what level should we pitch our ambition?***	***Ambitious,*** ***Moderate,*** ***Conservative*** ***Please tell us why*** Ambitious for the category one interventions as these are of no benefit and if the zero tariff is introduced then compliance should be achieved quickly Moderate for category two as local consultation and involvement is essential for success and may take time to achieve Any goal should take account of progress to date.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
10	***Do you have any suggestions to improve our methodology?***	***Yes/No*** ***If you have selected 'Yes', please tell us your suggestions:*** Ensure any pre-existing local collaborations are fully involved and integrated into any regional /national collaboration When targets are set ensure that any monitoring arrangement for compliance are manageable and support local actions rather than adding to the local workload and therefore potentially undermining the process it is there to support.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Engaging the system: systematic, multi-channel communication and engagement with clinicians, patients and commissioners			
11	***What further suggestions do you have to enable effective communication and engagement to support with implementation?***	Take account of existing local structures and work with them rather than add another system which could cause local confusion and disengagement. Link to a key part of any local collaboration as well as with the individual organisations so that local cohesion can be maintained.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Engaging the system: Demonstrator Communities to test proposals before December 2018 and provide peer-to-peer support to other systems			
12	***Are you aware of any particular communities making good progress in implementing any of the clinical recommendations on the 17 interventions, which might like to be part of this before December 2018?***	***Yes / No*** ***If you have selected 'Yes', please provide a list:*** Greater Manchester Effective Use of Resources collaboration https://www.gmsharedservices.nhs.uk/services	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Require Individual Funding Requests for Category 1 interventions and Prior Approval for Category 2 interventions			
13	***Do you agree that with our proposals for IFR for Category 1 interventions?***	***Yes / No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		If you have selected 'No', what alternative(s) would you propose?	**Any additional comments:- None**
14	***Do you agree that with our proposals for prior approval for Category 2 interventions?***	***Yes / No*** ***If you have selected 'No', what alternative(s) would you propose?*** Cataract (particular criteria for the second eye) in place of Varicose Veins	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Introduce zero payment for Category 1 interventions without IFRs			
15	***Do you agree with our intention to mandate through the National Tariff by introducing arrangements so that providers should not be paid for delivering the four Category 1 interventions, unless a successful IFR is made?***	***Yes / No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
16	***Do you agree that this change should apply from 2019?***	***Yes / No*** ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
Amend the NHS Standard Contract for Category 1 and 2 interventions			
17	***Do you support our intention to mandate compliance with the Evidence- Based Interventions policy through the NHS Standard Contract?***	***Yes / No*** ***If you have selected 'No' please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
18	***In relation to the proposed wording for the NHS Standard Contract, as set out in Appendix 5:*** ***Do you support our proposed wording for the new Contract requirements?***	***Yes / No*** ***Yes / No***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
	Do you have any specific suggestions for how the Contract wording could be improved?	***Please tell us more about your answers:*** Requires clarification on which evidence based intervention policy applies – is this only the one to be produced by NHS England or will local policies carry the same weight particularly if they have stricter criteria.	
Applying a rigorous approach to assess implementation			
19	***Given the mixed record of applying research-based evidence to decommission ineffective treatments, do you agree that we should introduce the range of performance management measures proposed above?***	***Yes / No*** But in a supportive way as much as possible – see responses above ***If you have selected 'No', please tell us why:***	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**
	Do you have any suggested amendments to the proposed clinical criteria? If so, why so?	***Yes –*** Many of the criteria as set out can be open to different interpretation and some will not be easy for the lay members of the team who receive and action these requests to assess. In our experience criteria need to be very specific. **There is a lack of high level evidence linking large breasts with back pain, currently GM use this when considering exceptionality not as a qualifying criterion -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain and using the proposed NHSE criteria our activity would increase - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study supporting correctly fitted bras for larger women.	**We agree ~~/ disagree~~ with the proposed response. ~~If you disagree, please give your reasons why below:-~~** **Any additional comments:- None**

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		NOTE Professional bra fitting and correct bra fitting are **NOT** the same thing and it is very difficult to prove whether or not correctly fitting bras have been worn (proof of measurement / purchase does not prove compliance) • Breast size is disproportionate to chest wall circumference Are you proposing a guide for this? Currently our panels use a chart of back and cup sizes to determine where the individual is in relation to the rest of the female population • Breast reduction planned to be 500gms or more per breast. In practice for most non-surgeons – this is a very difficult measure – cup and back sizes using standardised measurements techniques are easier • Body mass index (BMI) is <27 and stable for at least twelve months. Why is the cut off 27? evidence for increased complication puts the cut off at 30- **The impact of obesity on breast surgery complications,** Chen, C L., Plast Reconstr Surg. 2011 Nov; 128(5):395e-402e. doi: 10.1097 / PRS.0b013e3182284c05 For Benign skin lesions the GM policy did? include a specific list but used general criteria for all benign skin lesions and specific additional criteria where need in order to avoid "it's not on the list so it's not restricted" The proposal entitled "Grommets for Glue Ear in Children" covers more interventions that the title suggests which could cause confusion. In this section you state "In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes	

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age)". Is it proposed that this is a policy exclusion? i.e. no restrictions apply to this surgery This section does not cover a number of the areas where we see requests for tonsillectomy and where the evidence suggests tonsillectomy is not the treatment of choice e.g. tonsillar stones and crypts. With regard to haemorrhoids - There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated or to allow funding to be agreed at screening The biggest cost in this area in GM is with the use of haemorrhoidectomy in place of banding – the rates for the former should be really low – any policy needs to be clear on what as well as when in relation to commissioning arrangements GM cover chalazia with other benign eyelid lesions as it is not the only benign lesion that does not normally need surgical intervention in secondary care The GM ganglion policy has only recently been reviewed in line with RCS guidance and updated following clinical consultation The criteria differ significantly from NICE proposed criteria (some differences relate to policy exclusions) We would prefer to keep locally agreed criteria.	

NHS England's Consultation Questions		Proposed Response on behalf of Greater Manchester	CCG Comments
		The GM policy for varicose veins differs significantly from NICE guidance – the policy criteria are based on historic restrictions and were agreed after a financial paper was taken through the GM governance structure that showed the cost of moving to full NICE compliance Based on current activity and projected activity if NICE guidance was implemented across the conurbation the paper concluded that: "The overall cost in 2015/16 across GM was £2,107,081, the potential cost if Greater Manchester adopts NICE CG168 based on NICE assumptions of increased activity with no change in tariff would be £2,637,359 showing an increase in cost of £530,278 Implementing the new GMEUR Varicose Vein policy is expected, at worst, to be cost neutral. At best there may be a small saving associated with targeting treatments for those with moderate varicose veins to those at the highest risk of ulceration / bleeding" This does not include the investment in the infrastructure which would be needed in the community to implement the NICE pathway of care.	
The details below will only be used by GMSS EUR Policy Team if they need contact you regarding your responses above.			
	Name of person completing the form: **Elaine Richardson**	**Organisation:** **Tameside and Glossop Strategic Commission**	**Role within the organisation:** **Head of Delivery and Assurance**
	Email address: **Elaine.richardson@nhs.net**	**Telephone Number:** **07855469931**	

7. RECOMMENDATIONS

7.1 As set out on the front of the report.

APPENDIX 1 COMPARISON OF NHS ENGLAND PROPOSED CRITERIA AND THOSE IN CURRENT OR "UNDER REVISION" GM EUR POLICIES

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
ENT				
A	**Snoring Surgery (in the absence of Obstructive Sleep Apnoea (OSA))**	In two systematic reviews of a combined 72 primary research studies7, there was no evidence that surgery to the palate to improve snoring provides any additional benefit compared to non-surgical treatments. The surgery has an up to 16% risk of severe complications (bleeding, airway compromise, death). We therefore propose it is no longer commissioned. A number of alternatives to surgery can improve snoring. These include lifestyle changes (weight loss, smoking cessation and reducing alcohol intake) and medical treatment of nasal congestion. It is on the basis of limited clinical evidence of effectiveness, and the significant risks that patients could be exposed to that NHS are proposing that this procedure should no longer be routinely commissioned. **Alternative Treatments** There are a number of alternatives to surgery that can improve the symptom of snoring. These include: • Weight loss • Stopping smoking • Reducing alcohol intake • Medical treatment of nasal congestion (rhinitis) • Mouth splints (to move jaw forward when sleeping)	**GM068 Invasive Treatments for Snoring** Invasive Treatments for Snoring	Surgical treatment of simple snoring (where snoring is not complicated by episodes of breathing cessation) is regarded as a procedure of low clinical priority and therefore not routinely commissioned.
Gynaecology				
B	**Dilatation and curettage (D&C)**	NICE guidelines recommend that D&C is not offered as a diagnostic or treatment option for heavy menstrual bleeding, as there is very little evidence to suggest that it works to investigate or treat heavy periods.[8] Ultrasound scans and camera tests, with sampling of the lining of the womb (hysteroscopy and biopsy), should be used to	No GM EUR Policy - Local CCG policies apply.	

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		investigate heavy periods. Medication and intrauterine systems (IUS), as well as weight loss (if appropriate) should be used to treat heavy periods. D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective. UIltrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) should be used to investigate heavy periods. Medication and intrauterine systems (IUS) should be used to treat heavy periods. For further information, please see: **https://www.nice.org.uk/guidance/ng88** **https://www.nhs.uk/conditions/hysteroscopy/#alternatives-to-hysteroscopy**		
Orthopaedics				
C	**Knee arthroscopy for patients with osteoarthritis**	NICE recommends that arthroscopic knee washout should not be used as a treatment for patients with osteoarthritis. More effective treatments include physiotherapy, exercise programmes like ESCAPE pain, losing weight (if necessary) and managing pain.[9] Arthroscopic knee washout should not be used as a treatment for osteoarthritis because it is clinically ineffective. More effective treatment includes exercise programmes (e.g. ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. In younger people with osteoarthritis, other procedures such as osteotomy may be appropriate. For further information, please see: **https://www.nice.org.uk/guidance/ipg230/evidence/overview-pdf-492463117** **https://www.nice.org.uk/guidance/ipg230/chapter/1-Guidance**	**GM034 Knee arthroscopy** Currently undergoing review draft new policy below: GM Knee Arthroscopy Policy v2.2 DRAFT .pdf	Knee arthroscopy is **only** commissioned if the following criteria are met: • Intermittent (true) locking[1] that has not responded to at least 3 months of non-surgical treatment. **AND one of the following:** • There is a loose body (or bodies) that is causing the locking and which has been confirmed by a magnetic resonance (MR) scan or on X-ray if a bony loose body is involved. **OR** • Where a detailed understanding of the degree of compartment damage within

[1] **Intermittent (True) locking:** A loose body in the knee joint gets stuck or caught and stops the knee from moving at all. The knee remains fixed for a variable period of time in the position where it 'locked' despite attempts to manipulate the knee.

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		https**://www.nice.org.uk/donotdo/referral-for-arthroscopic-lavage-and-debridement-should-not-be-offered-as-part-of-treatment-for-osteoarthritis-unless-the-person-has-knee-osteoarthritis-with-a-clear-history-of-mechanical-locking-not http://www.escape-pain.org/**		the knee is required **OR** • There is a significant meniscal tear (e.g. bucket handle tear, flap, cleavage or radial with refractory pain and) which is thought to be the cause of intermittent locking / giving way **OR** • The individual is between the ages of 35 and 55 with a history of trauma to the knee and the arthroscopy will delay the need for knee replacement **NOTE: Knee arthroscopy, lavage and debridement is not commissioned for a degenerative knee unless the above mandatory criteria are also present.**
D	**Injections for nonspecific low back pain without sciatica**	NICE recommends that spinal injections should not be offered for nonspecific low back pain. Alternative options like pain management and physiotherapy have been shown to work. Sciatica is tingling, pain or weakness in the leg due to irritation of the sciatic nerve. Spinal injections of local anaesthetic and steroid should not be offered for patients with nonspecific low back pain without sciatica, as they are unproven clinically. Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Radiofrequency denervation (destroying the nerve that supplies the painful facet joints in the spine) can be considered according to NICE guidance. For further information, please see:	**GM046 Low Back Pain** Back Pain (Treatment for Low Back Pain with or without sciatica) **GM070 Facet Joint Injections** Facet Joint Injections for Neck and Back Pain **GM004 Radiofrequency**	All 3 policies have been withdrawn and are currently under review to ensure compliance with NICE NG59.

	Intervention	NHS England summary of rationale	GMEUR policy (with link to policy) / local policies	GM Policy criteria
		https://www.nice.org.uk/guidance/ng59	**Denervation** Radiofrequency Denervation for Back Pain	
E	**Breast reduction**	The evidence highlights that breast reduction is only successful in specific circumstances and the procedure can lead to complications - for example not being able to breast feed permanently. 11 We are therefore proposing that breast reduction is only undertaken under the criteria outlined in Appendix 2.:_ From Appendix 2 We would like to seek views on the criteria as part of this consultation. Wearing a professionally fitted bra (**NOTE** Professional bra fitting and correct bra fitting are **NOT** the same thing) – very difficult to implement as proof of purchase is not proof it fits or has been worn , losing weight (if necessary), managing pain and physiotherapy often work well to help with symptoms like back pain from large breasts **NOTE the lack of evidence linking lage breasts with back pain -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study (see below supporting correctly fitted bras for larger women). We propose that the NHS will only provide breast reduction for women if all the following criteria are met: • The woman has received a full package of supportive care from their GP and a physiotherapy assessment has been	**GM006 - Aesthetic Breast Surgery** Breast Surgery (Aesthetic) **NOTE the lack of evidence linking large breasts with back pain -** other causes of back pain may be aggravated by bad posture associated with large breasts but no high level evidence is available – most reduction requests cite back or shoulder pain - Kinesiology links large breasts with neck and back pain but equally chiropracty links it to ill-fitting bras plus one ergonomics study (see below supporting correctly fitted bras for	**This also covers breast augmentation, breast asymmetry, breast lift, inverted nipples. Adult and adolescent gynaecomastia** **Breast Reduction** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Breast reduction surgery is **not** routinely commissioned. **If applying for funding on the grounds of clinical exceptionality the following standard set of information will need to be provided in addition to the individual clinical exceptional circumstances.** ***Please NOTE that these are not qualifying criteria, they provide a standard set of information which is used by panels as an aid when determining exceptionality:*** • In order to ensure consistency in decision making and a full understanding of the clinical picture by all staff reviewing the case for **all** applications relating to the female breast, measurements **must** be submitted

		provided. • Breast size results in functional symptoms that require other treatments/interventions (e.g. intractable candidal intertrigo; thoracic backache/kyphosis where a professionally fitted bra has not helped with backache, soft tissue indentations at site of bra straps). • Breast size is disproportionate to chest wall circumference (Are you proposing a guide for this? Currently our panels use a chart of back and cup sizes to determine where the individual is in relation to the rest of the female population • Breast reduction planned to be 500gms or more per breast. (In practice for most non-surgeons – this is a very difficult measure – cup and back sizes using standardised measurements techniques are easier) • Body mass index (BMI) is <27 and stable for at least twelve months. (evidence for increased complication puts the cut off at 30) **The impact of obesity on breast surgery complications,** Chen, C L., Plast Reconstr Surg. 2011 Nov; 128(5):395e-402e. doi: 10.1097 / PRS.0b013e3182284c05 Woman must be provided with written information to allow her to balance the risks and benefits of breast surgery Ideally no further pregnancies are planned. **Unilateral breast reduction is considered for asymmetric breasts as opposed to breast augmentation**. Surgery can be approved for a difference of 150 - 200gms size difference as measured by a specialist. See comment above re difficulty measuring or assessing this for non-breast surgeons. The BMI needs to be <27 and stable for at least twelve months. Resection weights, for bilateral or unilateral (both breasts or one breast) breast reduction should be recorded for audit purposes. This proposal does not apply to therapeutic mammoplasty for breast cancer treatment or contralateral (other side) surgery following breast cancer surgery, and local policies should be	larger women). (**NOTE** Professional bra fitting and correct bra fitting are **NOT** the same thing)	using either method in Appendix 2 of this policy, please give actual measurements as well as the band and cup size. **Applications using other methods will not be accepted**. • Confirmation that a correctly fitted bra has been worn for a period of at least 6 months and has not relieved the symptoms. • Evidence of a history of intertrigo, if applicable, its frequency and medication used. • Where the patient has reported back and neck pain, evidence that a course of physiotherapy has been completed without improvement of symptoms. • The patient's height and weight records for the previous 2 years (or, if this is not available, a statement from the clinician that their weight has been stable for at least 2 years). This must include the patient's current height and weight (BMI must be less than 30). • Patients **must** be advised that if they go on to have further children they may develop further aesthetic problems with the breasts and it is unlikely that further aesthetic breast surgery would be funded on the NHS. • Non-identifiable photographs, preferably medical illustrations if available, will be requested, to support the decision making process, but will not form the sole basis of the decision. It is not mandatory for photographs to be provided by a patient. • The patient **must** have completed puberty **Breast Lifts (Mastopexy)** All surgery involving incision into healthy tissue in this case a healthy breast whatever

		adhered to. The Association of Breast Surgery support contralateral surgery to improve cosmesis as part of the reconstruction process. **Gynaecomastia:** Surgery for gynaecomastia is not funded under the NHS. Surgery can be performed for gynaecomastia secondary to treatment for prostate cancer.		its size and shape is considered to be aesthetic. Mastopexy surgery is **not** routinely commissioned, unless part of an approved breast reduction procedure. **Breast Asymmetry** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. • Surgery is only commissioned where there is a difference in breast size of 3 cups (i.e. there should be at least 2 cup sizes between the sizes given for each breast). ***For example:*** *the difference between a B cup on one side and a DD on the other is 3 cup sizes with 2 cup sizes in between: B to (C to D) to DD.* The application should include current band and cup measurements for both breasts. In order to ensure consistency in decision making and a full understanding of the clinical picture by all staff reviewing the case for **ALL** applications relating to the female breast, measurements **must** be submitted using **Method 1** in Appendix 2 of this policy, please give actual measurements as well as the band and cup size. **Applications using other methods will not be accepted**. • The patient **must** have completed puberty • The application should also include the patient's height and weight records for the previous 2 years (or, if this is not available, a statement from the clinician that their weight has been stable for at least 2 years). This must include the patient's current

				height and weight (BMI must be less than 30). **NOTE:** • Due to the risks and long term implications relating to breast implants, **surgery to reduce the larger breast only will be approved.** • Requests made by clinicians to enhance the smaller breast, will be considered under clinical exceptionality. This includes, but is not limited to, cases where reduction to the size of the larger breast would leave the women with a bust size disproportionate to her frame. • The outcome of reduction surgery can be affected by the individual's weight and how stable that weight is, which is why this information is requested. **Gynaecomastia (Adult)** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Gynaecomastia surgery is **not** routinely commissioned. **Adolescent Gynaecomastia** All surgery involving incision into healthy tissue in this case a healthy breast whatever its size and shape is considered to be aesthetic. Adolescent gynaecomastia surgery is **not** routinely commissioned. **NOTE for all breast surgery exceptionality requests there is a standard set of information required alongside any other evidence of exceptionality**

F	**Removal of benign skin lesions**	Removal of benign skin lesions cannot be offered for cosmetic reasons. It should only be offered in situations where the lesion is causing symptoms according to the criteria outlined in Appendix 2. Risks from the procedure can include bleeding, pain, infection, and scarring. We would like to seek views on the criteria proposed in Appendix 2.[12] Appendix 2: **This policy refers to the following benign lesions when there is diagnostic certainty and they do not meet the criteria listed below:** • benign moles (excluding large congenital naevi) • solar comedones • corn/callous • dermatofibroma • lipomas • milia • molluscum contagiosum (non-genital) • epidermoid & pilar cysts (sometimes incorrectly called sebaceous cysts) • seborrhoeic keratoses (basal cell papillomata) • skin tags (fibroepithelial polyps) including anal tags • spider naevi (telangiectasia) • non-genital viral warts in immunocompetent patients • xanthelasmata • neurofibromata **The GM policy does not have a specific list but uses general criteria for all benign skin lesions and specific additional criteria where needed (to avoid "it's not on the list so it's not restricted")** **The benign skin lesions, which are listed above, must meet at least ONE of the following criteria to be removed:** • The lesion is unavoidably and significantly	**GM013 - Common Benign Skin Lesions** Skin Lesions (Common Benign)	**Benign skin lesions** Removal of benign skin lesions will only be considered if **ONE** of the following applies: • Impairment of function or significant facial disfigurement, e.g. large lipoma. • Rapidly growing or abnormally located (e.g. sub-fascial, sub-muscular). • There is significant pain as a direct result of the lesion. • There is a confirmed history of recurrent infection / inflammation. • There is reason to believe that a commonly benign or non-aggressive lesion may be changing to a malignancy, or there is sufficient doubt over the diagnosis to warrant removal. The following additional criteria are also applicable to the lesions listed below and referral may be made if the patient meets the criteria for that specific lesion **AND / OR** the mandatory criteria above. **Lipoma (fatty lump)** • The lump is over 5cm in diameter (due to the increased risk of missed diagnosis of a liposarcoma). • Where there are any concerns, the soft tissue guidelines should be followed.

		traumatised on a regular basis with evidence of this causing regular bleeding or resulting in infections such that the patient requires 2 or more courses of antibiotics (oral or intravenous) per year • There is repeated infection requiring 2 or more antibiotics per year • The lesion bleeds in the course of normal everyday activity • The lesion causes regular pain • The lesion is obstructing an orifice or impairing field vision • The lesion significantly impacts on function e.g. restricts joint movement • The lesion causes pressure symptoms e.g. on nerve or tissue • If left untreated, more invasive intervention would be required for removal • Facial lesions > 1cm that cause significant disfigurement • Facial warts in all ages causing significant psychological impact • Facial spider naevi in children causing significant psychological impact • Lipomas on the body > 5cms, or in a sub-facial position, with rapid growth and/or pain. These should be referred to Sarcoma clinic.		**Warts** • The diagnosis is uncertain. **OR** • There are multiple recalcitrant warts and the person is immunocompromised. **OR** • The person has areas of skin that are extensively affected, for example, mosaic warts. **Verrucas** • The person has diabetes. **Actinic/Solar Keratosis** • If there is any reason to suspect that it is one of the small percentage at high risk of undergoing malignant change and transforming into a squamous cell carcinoma. The referral should include details of the reasons the referrer has for this suspicion.
ENT				
G	**Grommets for Glue Ear in Children** - this title is more restricted than the proposed criteria	Evidence suggests that grommets only offer a short-term hearing improvement in children with glue ear who have no other serious medical problems or disabilities. They should be offered in cases that have a history of persistent (at least 3 months) bilateral, hearing loss as defined by the NICE guidance. Hearing aids can also be offered as an alternative to surgery. [13]	**GM015** - **Surgical drainage of the middle ear (with or without the insertion of grommets)** Drainage of the middle ear, Surgical (with or without the insertion of grommets)	This policy applies to children under the age of 12 years (in line with NICE CG60). Adults with symptoms suggestive of otitis media with effusion (OME) should be referred for investigation. An IFR form with

		Appendix 2 We are proposing the NHS only commissions this surgery for the treatment of glue ear in children when the criteria set out by the NICE guidelines are met: All children must have had specialist audiology and ENT assessment. Persistent bilateral otitis media with effusion over a period of 3 months. Hearing level in the better ear of 25-30dbHL or worse averaged at 0.5, 1, 2, & 4kHz Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25-30dbHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. The guidance is different for children with Down's Syndrome and Cleft Palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance. It is also good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum. For further information, please see: https://www.nice.org.uk/Guidance/CG60 The risks to surgery are generally low, but the most common is persistent ear discharge (10-20%) and this can require treatment with antibiotic eardrops and water precautions. In rare cases (1-2%) a persistent hole in the eardrum may remain, and if this causes problems with recurrent infection, surgical repair may be required (however this is not normally done until around 8-10 years of age). Is it proposed that this is a policy exclusion?		details of clinical exceptionality is required for children over the age of 12 years. **Otitis media with effusion (OME) assessment** Referral for assessment for surgery for children with OME can be made if: • The child has Down's Syndrome or has a cleft palate. • The child has had a developmentally appropriate hearing test confirming hearing loss and there are functional issues (including but not limited to speech and language development). This should be evidenced by the hearing test result and/ or a corroborating statement from the child's school / nursery etc. • Significant hearing loss persists on two documented occasions. • The tympanic membrane is structurally abnormal. • An alternative diagnosis is suspected. **Persistent bilateral OME with a hearing level in the better ear of 25–30 dBHL or worse** Surgical drainage of the middle ear is commissioned for children with persistent bilateral OME documented over a period of 3 months with a hearing level in the better ear of 25–30 dBHL or worse averaged at 0.5, 1, 2 and

				4 kHz (or equivalent dBA where dBHL not available) should be considered for surgical intervention. **Persistent bilateral OME with a hearing loss less than 25–30 dBHL** Commissioned for children with persistent bilateral OME with a hearing loss less than 25–30 dBHL where the impact of the hearing loss on a child's developmental, social or educational status is judged to be significant. **NOTE:** The decision as to whether or not grommets are also needed is a clinical one based on the individual case and is at the discretion of the clinician, provided the child meets the criteria for surgical drainage. **Concurrent Adenoidectomy** Adenoidectomy for the management of otits media is not routinely commissioned but can be performed at the same time as OME surgery if it is indicated for a comorbidity. The request should include details of the indication for adenoidectomy as well as those for drainage of the middle ear. **Acute Otitis Media (AOM)** Referral for assessment for surgery for children with

				persistent UORU recurrent AOM can be made if all other standard treatments have been tried and failed (see NICE CKS AOM summary in the evidence review for details) with clear information provided on why this case is clinically exceptional.
H	**Tonsillectomy for recurrent tonsillitis**	Recurrent sore throats are a very common condition that present a considerable health burden. In most cases they can be treated with conservative measures. In some cases, where there are recurrent, documented episodes of acute tonsillitis that are disabling to normal function, then tonsillectomy is beneficial, but it should only be offered when the frequency of episodes set out by the SIGN criteria are met. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.[14] Appendix 2: We are proposing that the NHS only commissions this surgery for treatment of recurrent severe episodes of sore throat when the following criteria are met, as set out by the SIGN guidance and supported by ENT UK commissioning guidance: □ Sore throats are due to acute tonsillitis AND □ The episodes are disabling and prevent normal functioning AND □ Seven or more, well documented, clinically significant, adequately treated sore throats in the preceding year OR □ Five or more such episodes in each of the preceding two years OR □ Three or more such episodes in each of the preceding three years.	**GM028 Tonsillectomy** Tonsillectomy	**Commissioned** See High Value Care Pathway section 1.1 Pathway for children (<16 years) with obstructive sleep disordered breathing: ENT UK Tonsillectomy revised commissioning guide 2016 Tonsillectomy is commissioned for children and adults who meet the following criteria: • Sore throats are due to acute tonsillitis and recorded as such in medical notes. **AND** • The episodes of sore throat are disabling and prevent normal functioning. **AND** • Where there is a history of: Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year **OR** Five or more such episodes in each of the preceding two years **OR**

		Further information on the SIGN guidance can be found here: http://www.sign.ac.uk/assets/sign117.pdf It is important to note that national randomised control trial is underway comparing surgery versus conservative management for recurrent tonsillitis in adults in underway which may warrant review of this guidance in the near future. This does not cover a number of the areas where we see requests for tonsillectomy and where the evidence suggests tonsillectomy is not the treatment of choice.		Three or more such episodes in each of the preceding three years **OR** A second episode of Quinsy, irrespective of the timescale. **Tonsillectomy for snoring and sleep apnoea in children** See High Value Care Pathway section 1.2 Pathway for children (<16 years) with obstructive sleep disordered breathing: ENT UK Tonsillectomy revised commissioning guide 2016 • Do not refer children with simple snoring without symptoms or signs of apnoea as they are unlikely to benefit from adeno-tonsillectomy. o Consider allergy testing and appropriate treatment. • In older children >6 years with mild/moderate symptoms of obstructive sleep disordered breathing consider a trial of nasal saline irrigation and/or intranasal steroids for 6-8 weeks. • Refer for a specialist opinion if there are ongoing concerns about obstructive sleep disordered breathing. If the request is for surgery to treat apnoea and is from secondary care a statement that the following been

				undertaken should be included: • A reassessment of the patient's clinical history and examination and if available (to the requesting clinician) a recording of the child's sleep. • Evidence that a discussion of management options has taken place with the patient / family using shared decision making strategies and tools where appropriate, including surgery where there is a clear diagnosis of obstructive sleep apnoea. • Evidence that there has been a follow-up period of children with moderate signs and symptoms prior to a decision of surgery with (if indicated) the results of overnight pulse oximetry, ideally at home or in selected cases an overnight polysomnogram to determine further management (where the diagnosis is less certain). **NOTE: Children with suspected severe apnoea need urgent specialist assessment.** **Not commissioned** Tonsillectomy is not commissioned for tonsillar crypts / stones: conservative management is the treatment of choice.
General Surgery				

I	**Haemorrhoid surgery**	Numerous interventions exist for the management of haemorrhoids (piles). The evidence recommends that surgical treatment should only be considered for haemorrhoids that keep coming back after treatment or for haemorrhoids that are significantly affecting daily life. We would like to seek views on the proposed criteria included at Appendix 2 as part of this consultation.15 Changes to the diet like eating more fibre and drinking more water can often help with haemorrhoids. Treatments that can be done in clinic like rubber band ligation, may be effective especially for less severe haemorrhoids Appendix 2 Often haemorrhiods (especially early stage haemorrhoids) can be treated by simple measures such as eating more fibre or drinking more water. If these treatments are unsuccessful many patients will respond to outpatient treatment in the form of banding or perhaps injection. Surgical treatment should only be considered for those that do not respond to these non-operative measures or if the haemorrhoids are more severe, specifically: □ Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding; or □ Irreducible and large external haemorrhoids There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated and or so funding can be agreed at screening The biggest cost is with the use of haemorrhoidectomy in place of banding – the rates for the former should be really low – any policy needs to be clear on what as well as when in relation to commissioning arrangements	**Proposed GM042 GM policy** **Surgical Management of haemorrhoids and anal skin tags** Currently going through governance process  Haemorrhoids and Anal Skin Tags.pdf	**Policy Inclusion Criteria** Haemorrhoidectomy will not be carried out unless there is evidence to demonstrate that recurrent and persistent bleeding has failed to respond to conservative treatment **OR** haemorrhoids cannot be reduced. Haemorrhoidectomy is commissioned in line with the following: • Rrecurrent or persistent bleeding, which has not responded to primary care management. • Fourth degree haemorrhoids or third-degree haemorrhoids that are too large for non-operative measures (haemorrhoidectomy may be needed). • Perianal haematoma (a blue or dark coloured swelling at the anal verge) if symptoms are for less than 24 hours duration for clot evaluation. • Combined internal and external haemorrhoids with severe symptoms (surgery may be required). • Thrombosed haemorrhoids when bleeding is problematic,

				or there is chronic irritation or leakage. • Extremely painful, acutely thrombosed external haemorrhoids presenting within 72 hours of onset (reduction or excision may be needed). • Internal haemorrhoids that have prolapsed and become swollen, incarcerated, and thrombosed (haemorrhoidectomy may be needed). **Note:** Symptomatic haemorrhoids found as part of colonoscopy investigation can be banded if patient fully consented for the procedure, and this is included within the original costs, i.e. makes no change to the tariff charged). Surgical management (including banding) of anal skin tags is **not** commissioned. Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. **Policy Exclusions** Any perianal lesion or episodes of perianal bleeding that are

				suspected of being due to malignancy are excluded from this policy and should be referred via the normal 2-week pathway.
J	**Hysterectomy for heavy menstrual bleeding**	NICE recommends that hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding.16 Heavy periods can be reduced by using medicines or intrauterine systmes (IUS) or losing weight (if necessary). Appendix: Based on NICE guidelines [Heavy menstrual bleeding: assessment and management [NG88] Published date: March 2018], hysterectomy should not be used as a first-line treatment solely for heavy menstrual bleeding. It is important that healthcare professionals understand what matters most to each woman and support her personal priorities and choices. Hysterectomy should be considered only when: other treatment options have failed, are contradicted; there is a wish for amenorrhoea (no periods); the woman (who has been fully informed) requests it; the woman no longer wishes to retain her uterus and fertility.	No GM EUR policy - Local CCG policies apply.	
Ophthalmology				
K	**Chalazia removal**	The evidence shows that alternative treatment options (warm compresses, drops or ointment, steroid injection) or a “watch and wait” approach will lead to resolution of many chalazia without the risks of surgery. We propose chalazia be removed only according to the criteria listed in Appendix 2.17 Incision and curettage of chalazia should only be undertaken if at least **one** of the following criteria have been met: □ Has been present for more than 6 months and has	**GM044 Removal of Common Benign Eyelid Lesions** Eyelid Lesions (Removal of Common Benign)	**Referral to secondary care where the benign lesion may not be the primary condition** Referrals for the treatment of common benign eyelid lesions can be made if there is any indication that these indicate underlying disease, sight threatening issues with the eye or there is doubt of the diagnosis

		been managed conservatively with heat, lid cleaning and massage for 4 weeks □ Alternative treatment (e.g. injection with triamcinolone) has been considered (Need a meds management view on this one) □ Where it interferes significantly with vision. □ Where it interferes with the protection of the eye by the eyelid through affecting lid closure or lid anatomy □ Where it is a source of infection that has required medical attention twice or more within a six month time frame. □ Where it is a source of infection causing an abscess requiring drainage □ If malignancy (cancer) is suspected, lesion will be removed, in common with all suspicious lesions Some of the above would be GM policy exclusions and some apply to benign eyelid lesions in general. The cost of this activity isn't restricted to the treatment of Chalazion alone		and the lesion may not be benign in nature. Examples of reasons for referral include (but are not exclusive) to: • Significant pre-septal cellulitis / orbital cellulitis • Atypical presentation, re-occurrence in same site, may require cancer exclusion • Protrusion of the eye • Rapidly growing • Visual field affected • Ocular symptoms indicating either an underlying condition or the potential for serious damage to the eye • New and unexpected visual problems (e.g. double vision) • Reduced light reflexes or abnormal swinging light test • Symptomatically unwell • CNS symptoms or signs **Referral to secondary care where the benign lesion is the primary condition** Where the eyelid lesion is symptomatic referrals can be made for the following criteria: • Persistent (more than 6 months and not responded to conservative treatment) • There is significant pain as a direct result of the lesion • There is a confirmed history of recurrent infection / inflammation • Significant redness of the eye in the absence of an obvious cause

Orthopaedics				
L	**Arthroscopic shoulder decompression for subacromial shoulder pain**	Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases. Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery. Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. https://www.boa.ac.uk/wp-content/uploads/2014/08/Subacromial-Shoulder-Commissioning-Guide_final.pdf In order to facilitate non-operative treatment in primary and intermediate care, BESS and GIRFT have produced patient exercise rehab videos and booklets for GPs and patients to use. http://www.bess.org.uk/index.php/public-area/shpi-videos18 We propose that arthroscopic subacromial decompression for pure subacromial shoulder impingement is only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases. For patients who have persistent or progressive symptoms, in spite of adequate non-operative	**Proposed GM032 GM policy** **Arthroscopic sub-acromial decompression for shoulder impingement** GM Shoulder Impingement Policy v0	**Prior to referral** Patients must be provided with information to enable them to understand their condition and the following summary should be included in the consent for the procedure and signed by the patient. The presence of this signed consent may be the subject of future audits.: *'Current evidence informs us that there is uncertainty as to whether arthroscopic sub-acromial decompression is any better than physiotherapy. This means that after undergoing the procedure the same number of people may fail to improve as would fail with just physiotherapy. Reduced function and worse pain is experienced for some time after the procedure and rehabilitative physiotherapy is required to improve function to the level experienced before the procedure. This may mean that you are unable*

		treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.		*to work or undertake routine chores for up to 3 months. Risk of serious complication is very low. Very rarely an infection of the joint, septic arthritis, can occur.*[2] **Exclude degenerative cuff tears:** Prior to referral all steps should be taken to rule out degenerative partial and full cuff tears that are common in the 50+ age group which do not need referral. **Non-invasive management:** addition prior to Orthopaedic surgical referrals (for impingement) for consideration for arthroscopic sub-acromial decompression the following must apply: • A positive impingement test should be demonstrated **AND** • All methods of conservative management should be tried first: (analgesia, rest, and appropriate physiotherapy) **Initial treatment with steroid injection:** **ALL** of the following apply, then a

				steroid injection into the joint should be tried with conservative management continuing post injection *(the injection **MUST** be into the sub-acromial space, and done by someone competent to deliver the injection into the right space (i.e. the bursa) and in an appropriate clinical setting):* • The patient has been compliant with conservative management which was given for at least 6 weeks **AND** • Patient has been symptomatic for at least 3 months from the start of conservative treatment **AND** • Symptoms interfere with daily living or employment (for example waking several times a night, pain when dressing) **NOTE:** Steroid injections should be managed in line with any GMMMG recommendations and should be carried out by a practitioner trained in the technique in an appropriate setting. **Referral for consideration of surgical management**

				Consider referral for arthroscopic sub-acromial decompression if: • A degenerative partial, or full, cuff tear has been excluded by ultrasound scan if necessary **AND** • Steroid injections have been tried and have failed to relieve symptoms **OR** the patient has initially responded positively to a steroid injection but symptoms have returned despite compliance with post injection conservative management **AND** • The referral is at least 8 weeks after the last steroid injection **AND** • The patient has confirmed that they wish to have surgery **AND** • Findings on appropriate shoulder x-ray views are consistent with shoulder impingement (with ultrasound scan if rotator cuff tear needs to be excluded) **NOTE:** Open surgery for sub-

				acromial decompression is NOT commissioned unless part of a wider surgical procedure.
M	**Carpal tunnel syndrome release**	Carpal tunnel syndrome is common, and mild acute symptoms usually get better with time, splinting at night, pain relief and corticosteroid injection should be considered. Surgery should be considered for persistent severe symptoms. We are proposing that surgical treatment of carpal tunnel is only offered under the criteria included at Appendix 2 and would like to seek views on the proposed criteria as part of this consultation. 19 Appendix 2: Surgical treatment of carpal tunnel should be provided if the following criteria are met: □ Patient has acute, severe symptoms that persist for more than three months after conservative therapy with either local corticosteroid injection (medication injected into the wrist) and/or nocturnal splinting (stopping the wrist from moving during the night with a support); **OR** □ Mild to moderate symptoms persist for at least four months after conservative therapy with either local corticosteroid injection (if appropriate) and/or nocturnal splinting (used for at least eight weeks); **OR**	**GM035 Surgical Interventions for Carpal Tunnel Syndrome** Carpal Tunnel Syndrome (Surgical Interventions for)	**Commissioned** **NOTE: Please refer to any relevant GMMMG guidance prior to the following:** **Try corticosteroid injections if:** • there was no improvement with 3 months of conservative treatment **OR** • the symptoms are not severe or constant **OR** • there is no severe sensory disturbance and/or thenar motor weakness **OR** • there is no progressive motor or sensory deficit If the injection(s) fail to relieve

		□ There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction (moving the thumb away from the hand); **AND** □ Severe symptoms significantly interfering with daily activities and sleep which have been assessed. There is insufficient detail in the criteria to ensure the appropriate haemorrhoids are treated and or so funding can be agreed at screening. This can lead to the policy being bypassed as criteria are interpreted differently.		symptoms then refer for surgical intervention. **NOTE:** • Injections should be carried out by an appropriately trained clinician. If this is not available in primary care, then the patient should be referred to secondary care for the injections. • Refer for electromyography and nerve conduction studies if the diagnosis is uncertain **OR** if indicated prior to surgery. **Patients should be referred for surgical intervention without trying corticosteroid injections first if:** • electromyography and nerve conduction studies show nerve damage **OR** • the symptoms are severe and constant **OR** • there is severe sensory disturbance and/or thenar motor weakness **OR** • there is progressive motor or sensory deficit **Not commissioned** Surgery for carpal tunnel syndrome associated with

				pregnancy is not commissioned.
N	**Dupuytren's contracture release**	NICE has reviewed the evidence for surgical treatment of Dupuytren's contracture. It found that after 3 to 5 years, the problem had returned in about half of the patients treated. We propose that surgery is only offered according to the criteria outlined in Appendix 2. 20 Appendix 2 Surgery should be avoided in cases where there is no contracture, and in patients with a mild contracture that is not progressing and does not impair function. Less invasive techniques percutaneous needle fasciotomy (PNF, where the thickening in the palm is cut by using a needle inserted through the skin) or collagenase injection (injecting medication into the thickened tissue in the palm) can be considered in suitable cases. The criteria for surgical treatment of Dupuytren's contracture should be: □ Conservative and non-operative treatment tried; **AND** □ Patient has loss of extension in one or more joints exceeding 25 degrees; **OR** □ Patient has at least 10 degrees loss of extension in two or more joints. For further information, please see: □ **https://www.nice.org.uk/guidance/ipg43**	**GM049 Dupuytren's Contracture** Dupuytren's Contracture	Management of Dupuytren's Contracture depends on the stage of the disease. Dupuytren's can be classified as mild, moderate and severe to guide treatment options. These classifications are used for this policy. **Mild** • No functional problems **AND either:** • No contracture **OR** • TFD (total flexion deformity) between 0 and 45 degrees (TFD is the total of the degrees of flexion across all joints in a single finger.) **Treatment at this stage:** Reassurance and observation. **Moderate** Functional problems with activities of daily living as a direct result of the deformity **AND** there is evidence of moderate disease with up to 2 affected joints: • Metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° **OR**

				• First web contracture **Treatment at this stage:** Collagenase **OR** needle fasciotomy, if appropriately trained, **OR** in rapidly progressing cases, referral for limited fasciectomy. **Severe** • TFD greater than 90 degrees **Treatment at this stage**: Referral for surgery for limited fasciectomy **OR** dermofasciectomy, as appropriate. Single joint contractures classified as moderate **OR** severe may be treated with collagenase, needle fasciotomy **OR** limited fasciectomy, at the discretion of the treating physician. **Collagenese (Xiapex)** Commissioned in line with NICE TA459: Collagenase clostridium histolyticum for treating Dupuytren's contracture. Collagenase clostridium histolyticum (CCH) is recommended as an option for treating Dupuytren's contracture with a palpable cord in adults, only if the following apply: • There is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and

				proximal interphalangeal joint contracture of less than 30° **OR** • first web contracture) plus up to 2 affected joints. **AND ALL OF THE FOLLOWING:** • Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting. **Recurrent Disease** Recurrent disease may be treated in line with the above classification as for new disease. Any treatment outside of this will require a request via the IFR route
O	**Ganglion excision**	Most people live comfortably with ganglia and they often resolve spontaneously over time. Ganglion excision can cause complications, and recurrence is common following surgery. The complications may be	**GM025 Ganglion Cyst Removal** **Reference:**	Ganglion cyst surgery is not routinely commissioned. Surgery is only commissioned for ganglion of the flexor tendon

		similar to or worse than the original problem. We are proposing that Ganglion excision is only offered under the criteria outlined in Appendix 2. 21 Ganglion excision should only be provided in the following cases: □ The ganglion is painful seed ganglia and of diagnostic uncertainty; **OR** □ In patients presenting a significant skin breakdown, significant nail deformity, or repeated episodes of drainage caused by distal interphalangeal joint mucous cysts; **OR** □ The ganglia are mucoid cysts arising at the distal interphalangeal joint and disturbing nail growth or discharging; **OR** □ The ganglion is causing significant functional impairment and/or pain unrelieved by aspiration or injection. If there is diagnostic uncertainty after diagnostic tests have been performed (e.g. MRI) then referral to a specialist soft tissue cancer service should be considered. Alternative options include pain relief or needle aspiration of the ganglion.	 GM Ganglion Cyst Removal Policy v3.1 DI This policy has only recently been reviewed in line with RCS guidance and following clinical consultation The criteria differ significantly from NICE proposed criteria BUT some difference elate to policy exclusions	sheaths where grip is affected. NOTE needle puncture of the "sheath" should be considered first (where suitable facilities are available) as less than half recur after this Where indicted and where suitable facilities are available aspiration can be done in primary care for all ganglion as an aid reassurance (for all grades). **Mild** • an asymptomatic lump **Treatment:** Reassurance and observation. **Moderate** • symptomatic lump with a long duration of symptoms • occult ganglion **Severe** • severe pain • restriction of activities of daily living • concern over the diagnosis **Treatment:** As most ganglion will resolve spontaneously and as a high proportion will recur after surgery the routine treatment for

				all should be reassurance and observation, with aspiration in primary care for reassurance. Refer for ultrasound / MRI if there are concerns about the diagnosis.
P	**Trigger finger release**	Trigger finger often resolves following a period of conservative management (splinting, analgesia). Steroid injection can be considered. We are proposing that surgery is only offered in specific cases where alternative measures have not been successful and persistent or recurrent triggering, or a locked finger occurs. We would like to seek views on the proposed criteria in Appendix 2 as part of this consultation.[22] Appendix: Surgery should be only performed in specific cases where alternative measures have not been successful. Alternative treatments include rest, single dose steroid injection, splinting, and non-steroidal anti-inflammatory drugs. Surgery should only be offered in the following situations □ No response to conservative management (splinting, analgesia) AND □ At least one cortisone injection AND □ Persistent or recurrent triggering, or for a locked finger.	**GM038 Surgical Correction of Trigger Finger** Trigger Finger (Surgical Correction of)	All patients with trigger finger / thumb should have been managed as follows before referral for surgical intervention: • They have been given and followed advice on avoiding activities that cause pain, wherever possible. • They have used a small splint to hold the finger or thumb straight at night, preferably fitted by a hand therapist when available. The splint should hold the finger straight at night. • If indicated, they have been given a steroid injection in an appropriate clinical setting which would be expected to relieve the pain and triggering in up to 70% of cases (but the success rate is lower in people with diabetes). The risks of injection are small (it very occasionally causes some thinning or colour change in the skin at the site of injection). Improvement may occur within a few days of injection but may take several weeks. If clinically appropriate, the patient may be offered a second injection at the

				discretion of the treating clinician. • Patients whose trigger finger has recurred and in whom steroid injections previously failed should be offered the injection but, if they are reluctant to try an injection again, then they may be referred for surgery without having been injected for the recurrence.
Vascular Surgery				
Q	**Varicose vein surgery**	NICE has published detailed guidance on what treatment should be considered for varicose veins and when. Surgery for varicose veins is not recommended before alternative, less invasive options are considered. Surgery is a traditional treatment that involves removal of the vein by ligation (tying off the vein) and 'stripping' out the vein and does not always get rid of varicose veins; they often come back again. Treatments like endothermal ablation or ultrasound-guided foam sclerotherapy should be tried before considering surgery. Compression hosiery is not recommended if an interventional treatment is possible. 23 1.1 Intervention in terms of, endovenous thermal (laser ablation, and radiofrequency ablation), ultrasound guided foam sclerotherapy, open surgery (ligation and stripping) are all cost effective treatments for managing symptomatic varicose veins compared to no treatment or the use of compression hosiery. For truncal ablation there is a treatment hierarchy based on the cost effectiveness and suitability, which is endothermal ablation then ultrasound guided foam, then conventional surgery. 1.2 Refer people to a vascular service if they have any of the following;-	**GM003 Varicose Veins** Varicose Veins The GM policy differs significantly from NICE guidance – the policy criteria are based on historic restrictions and were agreed after a financial paper was taken through the GM governance structure that showed the cost of moving to full NICE compliance Based on current activity and projected activity if NICE was implemented the paper concluded the: “The overall cost in 2015/16 across GM was £2,107,081, the potential cost if Greater Manchester adopts NICE CG168 based on NICE assumptions of increased activity with no change in	All patients should be given advice on lifestyle changes, exercise and skin care. Secondary care referral and management is commissioned for the following: **Urgent referral for bleeding** • They are bleeding from a varicosity. • They have bled from a varicosity and are at risk of bleeding again. **Severe varicose veins** Referral to a vascular service for patients with severe varicose veins – these are varicose veins that are associated with any one of the following: • They have an ulcer which is progressive and/or painful. • They have recurrence of an ulcer • They have an ulcer which has failed to respond to 12 weeks or more of active treatment or is

		□ Symptomatic * primary or recurrent varicose veins. □ Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency. □ Superficial vein thrombophlebitis (characterised by the appearance of hard, painful veins) and suspected venous incompetence. □ A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks). □ A healed venous leg ulcer. *Symptomatic: “Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).” For patients whose veins are purely cosmetic and are not associated with any symptoms do not refer for NHS treatment 1.3 Refer people with bleeding varicose veins to a vascular service immediately 1.4 Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable. For further information, please see: 1.https://www.nice.org.uk/guidance/qs67 (NICE QUALITY STANDARD) 2.https://www.guidelinesinpractice.co.uk/nice-referral-advice-11-varicose-veins/300594.article	tariff would be £2,637,359 showing an increase in cost of £530,278 Implementing the new GMEUR Varicose Vein policy is expected, at worst, to be cost neutral. At best there may be a small saving associated with targeting treatments for those with moderate varicose veins to those at the highest risk of ulceration / bleeding” This does not include the investment in the infrastructure which would be needed to implement the NICE pathway of care.	deteriorating despite treatment • Progressive skin changes that have resulted in actual atrophie blanche, which is indicative of venous disease, that may benefit from surgery. **Moderate varicose veins** Patients with: • Extensive tortuous varicose veins of the whole lower limb (indicative of long saphenous insufficiency) who would be considered at high risk of bleeding due to coagulation disorders, anticoagulant and other therapies affecting clotting time and extensive superficial veins of the lower leg particularly over bony prominences at risk of bleeding from **minor** external trauma. • Single phlebitis which affects 5cm or greater length in the long saphenous vein. **NOTE:** Applications for exceptionality can be made for other cases of thrombophlebitis but these must include a balanced assessment of risk including the risk of DVT from the proposed intervention.