SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 6 September 2016
Time: 2.30 pm
Place: New Century House, Progress Way, Windmill Lane, Denton, M34 2GP

Item No.	AGENDA	Page No
1.	**WELCOME & APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the minutes of the previous meeting held on 2 August 2016.	1 - 12
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the report of the Director of Finance, Single Commissioning.	13 - 38
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the report of the Director of Public Health, Single Commissioning.	39 - 68
6.	**COMMISSIONING FOR REFORM**	
a)	**INTEGRATED NEIGHBOURHOOD BUSINESS PROPOSITION** To consider the report of the Director of Commissioning, Single Commissioning.	69 - 92
b)	**INDEPENDENT SERVICES TO TAMESIDE BIRTH PARENTS AND RELEVANT GRANDPARENTS** To consider the report of the Director of Commissioning, Single Commissioning.	93 - 96
c)	**SEND - INSPECTIONS TO LOCAL REPORT** To consider the report of the Director of Commissioning, Single Commissioning.	97 - 102
d)	**NEURO REHABILITATION** To consider the report of the Director of Commissioning, Single Commissioning.	103 - 112

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

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e) INTEGRATED NEIGHBOURHOOD PHARMACY PROPOSAL 113 - 122

To consider the report of the Director of Commissioning, Single Commissioning.

f) ENHANCED APPROACH TO 'DO NOT PRESCRIBE', GREY LIST AND RED MEDICINES 123 - 136

To consider the report of the Director of Commissioning, Single Commissioning.

7. URGENT ITEMS

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

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on the 4 October 2016 at 3 pm – 5 pm New Century House Denton

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

TAMESIDE AND GLOSSOP
CARE TOGETHER SINGLE COMMISSIONING BOARD

2 August 2016

Commenced: 3.00 pm **Terminated: 4.45 pm**

PRESENT: Christina Greenhough (Chair) – Tameside and Glossop CCG
Richard Bircher – Tameside and Glossop CCG
Graham Curtis – Tameside and Glossop CCG
Councillor Gerald P Cooney – Tameside MBC
Councillor Brenda Warrington – Tameside MBC
Councillor Peter Robinson – Tameside MBC

IN ATTENDANCE: Sandra Stewart – Director of Governance,
Stephanie Butterworth – Director of People
Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Damien Bourke – Assistant Executive Director (Development and Investment)
Sandra Whitehead – Assistant Executive Director (Adult Services)
Ali Rehman – Public Health
Emma Varnam – Head of Stronger Communities
Michelle Rothwell – Interim Director of Nursing, Quality and Patient Safety

APOLOGIES: Alan Dow – Tameside and Glossop CCG
Steven Pleasant – Chief Executive

45. DECLARATIONS OF INTEREST

Members	Subject Matter	Type of Interest	Nature of Interest
Christina Greenhough	Item 6(i) and (j) – Over 75's Scheme Proposal and Directed Enhanced Services	Personal	GP in Tameside
Richard Bircher	Item 6 (i) and (j) – Over 75;s Scheme Proposal and Directed Enhanced Services	Personal	GP in Tameside
Councillor Gerald P Cooney	Item 6 (e) – Extension of Contract with New charter For Bridges Services	Prejudicial	Director of New Charter Housing Trust

Councillor Cooney left the room during consideration of Item 6(e) and took no part in the voting or discussions thereon.

46. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 5 July 2016 were agreed as a correct record.

47. FINANCIAL POSITION OF THE CARE TOGETHER ECONOMY

The Director of Finance, Single Commissioning Team, presented a joint report of the Tameside and Glossop Care together constituent organisations on the revenue financial position of the Economy.

The report provided a 2016/17 financial year update on the month 3 financial position (at 30 June 2016) and the projected outturn (at 31 March 2017).

Particular reference was made to the budgets, expenditure and forecast outturn of the ICF and the Tameside Hospital NHS Foundation Trust. In order to achieve a balanced position by the year end there were a number of risks that had to be managed which were explained in the report and summarised as follows:

- Achievement of the original £21.5 million projected commissioner financial gap (£13.5 million T & G CCG and £8.0 million TMBC);
- Delivery of the £17.3 million projected financial deficit (i.e. agreed control total) of Tameside Hospital NHS Foundation Trust;
- Management of any potential over spend within Acute services. Any over spend would be an additional pressure over and above the financial gap stated above;
- Ensure Parity of Esteem was achieved in relation to Mental Health Services;
- Management of Care Home placements due to the volatility in this area;
- Management of unexpected and complex dependency placements within Children's Services;
- Emergency in-year reductions to Central Government resource allocations;
- Pro-active management of continuing Healthcare and Prescribing which were subject to volatility; and
- Remaining within the running cost allocated for2016/17.

The report also contained a summary of the Tameside Hospital NHS Foundation Trust financial position. This was to ensure members had an awareness of the overall financial position of the whole Care together economy and highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the gap next year and through 2020/21.

RESOLVED

(i) That the 2016/17 financial year update on the month 3 financial position (at 30 June 2016) and the projected outturn (at 31 March 2017) be noted;

(ii) That the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget be acknowledged; and

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

48. DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE

Consideration was given to a report of the Director of Public Health providing an update on CCG assurance and performance based on the latest published data. The May position was shown for elective care and a July 'snapshot' in time for urgent care. Also attached was a CCG NHS Consultation scorecard showing the CCG performance across that indicator set.

The Single Commissioning Board was advised that performance issues remained around waiting times in diagnostics and the A & E performance. The number of patients still waiting for planned treatment 18 weeks and over continued to decrease and the risk to delivery of incomplete standard and zero 52 week wait was being reduced.

It was noted that cancer standards were achieved in May and endoscopy was still the key challenge in diagnostics particularly at Central Manchester.

It was explained that A & E standards were failed at Tameside Hospital Foundation Trust and ambulance response times were not met at a local or at North West level.

The assurance framework for 2016/17 had been published nationally however, the framework from Greater Manchester Devolution was awaited.

In noting that Tameside was currently the third best performer across the GM Trusts reported through Utilisation Management, Board members discussed that the standard had not been achieved during June and up to 10 July 2016. Particular concerns were raised with regard to the hospital discharge process and it was explained that a number of Social Workers had recently been recruited and Senior Managers based at the Hospital were now assisting with the discharge process. However, it was further explained that there were real pressures in the system in respect of care home beds and that a meeting with home care providers had been arranged for 11 August 2016.

RESOLVED
(i) That the 2016/17 CCG Assurance position be noted; and
(ii) That the current levels of performance be noted.

49. STRATEGIC ESTATES PLAN – UPDATE ON PROGRESS

Consideration was given to a report of the Director of Commissioning, which provided a summary of progress towards an agreed Strategic Estates Plan for Tameside and Glossop. The latest version of the Strategic Estates Plan was appended to the report.

It was reported that Tameside and Glossop had developed a growing reputation as an innovative locality in relation to development of their estate within the Greater Manchester economy.

Work was ongoing across the five neighbourhoods of Glossop, Ashton (North), Hyde (South), Denton (West) and Stalybridge (East), gathering information on the supply of our current estate and mapping this onto the SHAPE database and a number of opportunities had been identified within each neighbourhood. Transformation funding had been secured to continue this enabling work and further bids had been made for One Public Estate monies and Estates and Technology Transformation Funds for four key projects across three localities.

It was explained that each neighbourhood would have a Hub where the integrated care model could be developed offering an extended range of health and social care together with added value services from the voluntary sector, police, DWP and other agencies. The Hub in each area would look slightly different depending on the available estate and the opportunities that presented themselves at present. Neighbourhood opportunities for each area were outlined in the report and discussed by Board members.

The report concluded by explaining that this was an exciting time within Tameside and Glossop with a firm commitment from all stakeholders to work collaboratively. The growing reputation at GM level of the work undertaken had provided investment ready status with only two other localities – Stockport and Salford. The SEG Chair would be reporting to the Programme Board with a full capital ask for the developments outlined in the report and all possible routes to procurement would be explored.

RESOLVED
That the content of the report be noted.

50. DISABLED FACILITIES GRANT DELIVERY CONSIDERATIONS

The Assistant Executive Director, (Development, Growth and Investment), submitted a report describing the current service for providing adaptations for people with disabilities through the Disabled Facilities Grant (DFG) and other revenue streams by the Housing Adaptations Team.

It was explained that the provision of adaptations was likely to be integrated into the Integrated Care Organisation, however, as a result of a 65% increase in Disabled Facilities Grant for 2016/17 compared to 2015/16, the report also noted measures to be implemented to ensure continued service delivery whilst discussions continued.

A number of proposals as part of a raft of changes to increase the number of adaptations delivered on time and at reduced cost were set out in the report as follows:

- Restoring the statutory upper level of £1,000 for Minor Adaptations;
- Remove the requirement for social housing tenants to be subject to a means related test; and
- Use of Disabled Facilities Grant in the 'Urgent' Criteria without referral for a means related test.

A draft Equalities Impact Assessment was appended to the report and an updated version was circulated immediately prior to the meeting. This covered the impacts of the policy change, and it would continue to operate alongside the implementation and changes to analyse and monitor the position to ensure the Council reduced health inequalities and there were no protected characteristics which suffered an unexpected detriment.

RESOLVED

(i) That the restoration of the statutory upper level of £1,000 for minor adaptations to bring it back in line with the national statutory limit before an application for a DFG is required, be approved;

(ii) That the removal of the requirement for social housing tenants to be subjected to a means related test for any proposed adaptations and make use of a new shorter application form to perform a reduced number of checks to ensure eligibility and for audit purposes, be approved; and

(iii) That the use of Disabled Facilities Grant in the 'urgent' criteria without referral for a means related test, be approved.

51. LEARNING DISABILITY DAY SERVICE REVIEW – PERMISSION TO CONSULT

Consideration was given to a report of the Interim Assistant Executive Director (Adults), explaining that Learning Disability Day Services were provided across a wide range of provider organisations. Provision to individuals with more complex needs had been retained by the internally provided council service. The review was driven by a need to achieve further savings from this area of operations which may require a reduction in capacity to achieve efficiencies. Current predicted demand for these services over the forthcoming years was set to increase significantly so it was necessary to understand the nature of this demand and current and future capacity in the wider context of the review.

The report sought permission to consult with people who use services, carers and key stakeholders including the market to establish current and future demand and capacity to future proof services and mitigate any increased future costs.

The consultation method was outlined in the report and copies of information/letters/questionnaire to be circulated to service users and their carers were appended to the report.

A number of risks had been identified a result of undertaking the review, which were outlined in the report. To try and further mitigate some of the risks, day services would ensure that service users and carers were fully informed about the service options and available support from Adult Social Care should they be able to move to community provision. The services would offer taster sessions and 'try it' days as part of the planning live consultation. A full Equality Impact Assessment would be completed following consultation to inform future recommendations.

The report concluded by explaining that the Council faced significant budgetary challenges over the coming years and therefore needed to diversify the service delivery market by looking at new and innovative approaches to deliver services whilst reducing cost of provision significantly. The Council had further significant savings to make over the forthcoming years so reviews of services were constantly being undertaken to mitigate the impact of the financial reductions.

Learning Disability Day Services supported some of the most vulnerable citizens across the Borough living at home with carers so this provision was an essential part of their day time respite in terms of supporting families and carers to have balanced lives, and enabled some very complex individuals to live at home. Alternative options would be to provide 24 hour care at a significantly higher cost than the provision of day time activities.

The Council further needed to ensure it considered the needs of young people coming through transition with current 5 year projections being 59 young people transitioning from Children's to Adult Services. Not all of these individuals would require complex service provision, however, current capacity would be unable to cope with small increases in demand and should a day centre base close capacity would be significantly reduced and possibly unable to meet demand. The market in some areas would also be unable to meet increased demand as current demand exceeded capacity. It was necessary to expand the current offer being made available by other providers if current and future eligible needs were to be met.

As part of the process, it was necessary to consider post 16 education provision and demand for 5 day service offers as part of investment in the development of alternative services that could assist in making significant savings within Education while supporting families and carers to support individuals to remain living at home.

It was important that the service communicated and consulted with customers regarding these changes and where appropriate, offer support to individuals to fully understand the implications of the proposals, their impact on the individual and their family and the commitment to delivering services differently. The service would fully include the sector in these discussions to assist in consultation and to contribute to future planning. Fundamentally a considered approach to this issue was essential to ensure problems were not created in the short to medium term in terms of capacity to meet future need, demand and capacity for general and complex service provision.

RESOVLED

(i) That approval be given to enter into consultation with the 84 day service customers and their carers who currently access day service provision from the council's internally provided learning disability day services to establish current and future needs and aspirations;

(ii) That approval be given to enter discussions with other day service providers, children's services and education to establish what they offer including current and future plans and capacity; and

(iii) That approval be given to enter into consultation with potential customers coming through transition (21 young people in the next two years with a rise to 59 young people over the next 5 years) and their carers and the wider public to ensure that future needs and demand is planned for appropriately.

52. ELIGIBLE NEEDS BASED ALLOCATION SYSTEM FOR ADULTS IN RECEIPT OF PLANNED RESPITE CARE

A report was submitted the Interim Assistant Executive Director (Adults), which explained the need to continue with the provision of a planned respite/short stay service to meet the eligible needs of individual service users and provide essential breaks for carers to support their ongoing caring role. It was explained that the health economy faced significant budgetary challenges over the coming years and therefore needed to ensure that services were delivered in a fairer and equitable way by ensuring the allocation of respite/short stay was provided in the most cost effective way.

It was reported that the current spend for planned respite was £186,323 per annum based on an enhanced residential EMI placement. This did not take into account any placements that were part Continuing Health Care/part Council funded. There were currently 39 residential and nursing homes on the Council's on/off framework, any of which an individual may access for their planned respite/short stay nights.

The Council currently had criteria for the allocation of planned respite/short stay for Adults with a Learning Disability. This was introduced in 2012 following a Key Decision. The allocation criteria had a set maximum number of nights or equivalent and formed part of the users' personal budget. Users could choose to take their personal budget as a Direct Payment and arrange their care and support form wherever they chose. There were instances when an individual would receive more than the maximum allocation, should exceptional circumstances be determined.

The Council did not currently have criteria for the allocation of an individuals planned respite/short stay allocation for all other Adults 18+. This resulted in a system of allocation that did not deliver a fair and equitable service across all residents of Tameside and gave little control of costs as there was currently no ceiling on the number of nights that could be allocated. Without eligibility criteria, the level of provision could not be aligned to the level of need as detailed in the Care Act 2014 as explained in the report.

Board members were informed of three main options moving forward with the service redesign project as follows:

- Close the service down;
- Continue with existing service and uncontrollable spend; or
- Introduce a fair and equitable cost effective provision that aligned with other adults receiving planned respite/short stay.

It was explained that a needs based allocation system for respite was first introduced in 2003 for all adults with a learning disability to be able to fully capture the level of need of individuals and carers to ensure fair and equitable allocation of respite nights. The allocation was based on an annual assessment of respite needs determined by bandings of low, medium and high needs. The allocation had a ceiling of 21 maximum respite nights per year. From 2011 a full comprehensive reassessment of need for all services was implemented across Adults Services, improving the quality of assessment and focused on achieving outcomes rather than demand. This identified that the implementation of the criteria and allocation required reviewing due to the continued perception of inequity. The revised eligible needs based allocation system was approved via a Key Decision on 27 March 2013 and implemented fully since this date.

The proposed revised needs based allocation system scored applications on a points system resulting in needs being assessed as high, medium or low with the maximum number of nights at 21 per annum. The implementation of the revised allocation system would have an impact for many of those who currently received over a maximum of 21 nights. It was noted that whilst the 21 nights was in principle a ceiling, it was recognised that there would be exceptional cases where it was appropriate to provide more support.

Members were further informed that consultation on the recommended model was launched via the Council's Big conversation website and also letters were sent to all service users of planned respite and their families. The consultation focused on the introduction of an eligible need based system allocation of planned respite with a maximum number of 21 allocated nights. A total of 12 responses were received by the Council, details of which were appended to the report.

Although the response was limited, the general consensus was one of recognising the important role that respite care played allowing users and carers to remain at home. Nearly all the respondents commented that if respite wasn't available that they would have to consider longer term care solutions.

A risk appraisal had been undertaken to ensure that risks, their consequences and impact were considered. Details of risk considerations were set out in the report.

The report concluded by explaining that the Care Act required the council to provide services that met assessed eligible needs. Planned Respite care was a service that allowed users and their families to have a break from each other in order to allow users to remain at home being cared for by their families for as long as possible.

Consultation with the public and more specifically, with users and carers of planned respite had clearly identified the importance of providing a respite service and the impact on carer's ability to continue if it was felt necessary to stop providing the service.

Discussion ensued with regard to the above and the impact on users and carers and the need to manage the situation carefully to ensure that breakdown of care did not occur.

In answer to a query from Board members, the Interim Assistant Executive Director explained that this system would not impact on emergency respite and applied to planned periods of respite only.

RESOLVED
That approval be given to introduce eligible needs based system for the allocation of planned respite with a maximum allocation of 21 nights per annum effective from1 October 2016. This would bring all adults in line with the system currently operated for adults with learning disabilities.

At this juncture, Councillor Cooney, having declared a prejudicial interest as a member of the Board of Directors of New Charter Housing Trust, left the room during consideration of the item below and took no part in the voting or discussions thereon.

53. EXTENSION OF CONTRACT WITH NEW CHARTER FOR BRIDGES SERVICE

Consideration was given to a report of the Executive Director (People), requesting approval of the financial arrangements to enable an extension of a contract with New Charter Housing Trust for the provision of The Domestic Abuse, Drug and Alcohol Service (known as Bridges).

It was explained that the contract commenced on 1 October 2013 and ran until 30 September 2016, with provision within the contract for the option to extend up to 30 September 2018.

It was further explained that the contract had been very successful in achieving its aim to increase awareness of domestic abuse and its core objective of providing support at both preventative and intensive intervention levels. The extension would allow Tameside victims of domestic abuse to continue to benefit from the service.

Demand for the service continued to increase. Greater Manchester Police (GMP) data on the prevalence of domestic abuse in Tameside showed an increase of 30% in 2014/15 when compared with the previous 12 months. An analysis of GMP data of domestic abuse incidents in Tameside by risk showed an increase in medium risk incidents in 2014/15. The trend for incidents assessed as 'high risk' was increasing above and beyond that for other risk types. These incidents increased by 27% in 2014/15 when compared with 2011/12.

It was explained that an extension of the contract would enable the Council and its partners to continue to address pressing issues around increased demand for this service and to improve services for children and young people who were linked to domestic abuse either as victims or perpetrators.

In respect of risks, Board members were informed that the biggest risk to the Council was ceasing the only service which was providing extensive integrated provision throughout the population of the Borough to victims, children, families and communities.

The report concluded that the current contractual arrangements had enabled the delivery of an effective service that both achieved good value and had realised significant outcomes in the early intervention and prevention of domestic abuse as well as dealing with the effects of domestic abuse as it occurred at every level.

The waiver would enable the service to continue to embed and expand this work significantly to support victims, children and young people who were both or either victims or perpetrators of domestic abuse and their communities. This would affect current and future generations of Tameside's population to deal with this subject differently understanding acceptable behaviour and growing respectful relationships.

The extent of the work being provided, alongside the integration with major partners in Tameside detailing the number of clients and families seen, evidenced the clear necessity to continue with such vital provision.

RESOLVED
That the continuation of financial resources to enable the extension of the contract for the provision of The Domestic Abuse, Drug and Alcohol Service to 30 September 2018, be approved.

54. TENDER FOR SUPPORTED ACCOMMODATION FOR PEOPLE WITH A LEARNING DISABILITY LIVING IN THEIR OWN HOME – INTENSIVE SUPPORT SERVICE

A report was submitted by the Director of Commissioning seeking authorisation for the re-commissioning of an intensive support service for people with a learning disability. The current contract was due to end on 31 March 2017. An indicative first year budget of £850,000 was proposed.

It was explained that the key aims and objectives of the service had been to empower service users to manage their lives in a manner that allowed them to achieve fulfilling and meaningful outcomes with a positive sense of belonging in their communities.

It was further explained that the service proposal would continue to deliver these outcomes with an increased emphasis on promoting independence pathways for individuals and ensuring there was an opportunity to move on. This would be achieved through the provider delivering person centred approaches and working in a multi-disciplinary way with key partners including care management and forensic nursing teams.

It was reported that alternatives had been considered through the planning group of the Single Commissioning Team and consideration to the Equalities Impact Assessment which was detailed in the report. Alternatives considered had included the use of personal budgets for individuals to directly purchase their own services. This in itself posed some issues in that individuals within a property may choose to purchase their support from different providers which then had the potential not to deliver the levels of 24 hour support that may be required.
It was concluded that this was an established service which met the needs of those who received support, therefore it was felt appropriate to re-tender this service. The decision to move forward with a restricted tender exercise had been driven by the vulnerable group supported through this contract and implications for more expensive residential care should this service not continue.

RESOLVED
That approval be granted for the proposed re-tender of the service provision.

55. PROVISION OF PERSONALISED EXTRA CARE SUPPORT FOR PEOPLE WITH A PHYSICAL AND SENSORY DISABILITY AGES 18-55 (LOMAS COURT)

The Director of Commissioning submitted a report seeking authorisation for the re-commissioning of extra care support to twenty people with physical and/or sensory disabilities. The current contract was due to end on 31 March 2017. An indicative first year budget of £164,000 was proposed to purchase 200 hours of 'background' support and seven sleep-in's per week.

It was explained that consultation with the tenants at Lomas Court had taken place in April 2016 to establish how best to commission support. Tenants indicated the need for a continuation of 24 hour support within the scheme. Given the needs of the people who lived at Lomas Court, the option to cease the service had been ruled out of considerations. Failure to provide the service could put tenants at risk and may increase the numbers who entered residential care due to a breakdown in their care and support at home.

RESOLVED
That approval be granted for the proposed market testing and re-tender of the service provision.

56. CONTROL OF PHARMACY MANAGED REPEAT SYSTEMS

Consideration was given to a report of the Director of Commissioning setting out a policy for practices to use to control community pharmacy managed repeat activity.

It was reported that, with patient written consent, pharmacies were allowed to order prescriptions on their behalf as well as collect these from the GP and dispense and deliver them to the patient's home. These services were not NHS contracted services but entered into voluntarily by pharmacies for their commercial benefit. It could be a very helpful service in the case of elderly, housebound patients who have little social support. Pharmacies compete to sign patients up to their managed repeat service some of them having hundreds of patients signed up and their repeat slips retained at the pharmacy. This applied whether the scripts were processed as paper scripts or electronically.

Repeat prescribing enabled patients to obtain further supplies of medicines without routinely seeing the prescriber, thereby reducing unnecessary consultations. It was estimated that in some cases, 50% of ordering of repeats was carried out by pharmacies on behalf of patients.

The majority of pharmacists endeavoured to give a safe and high quality service to patients, however, there had been increasing instances of pharmacies ordering inappropriately or unnecessarily, which generated waste and could cause patient safety issues.

It was explained that the CCG had received numerous complaints from practices about these schemes, including instances where pharmacies had ordered repeat medication for:

- Deceased patients;
- Patients who were in hospital;
- Patients who had been discharged from hospital on new medication regimes but their pharmacy had ordered discontinued medicines;
- Patients who medication had recently been changed by their GP but their pharmacy had ordered discontinued medicines;
- Patients who already had sufficient supplies of medication.

Whilst Tameside & Glossop CCG acknowledged that repeat prescription ordering could be beneficial to some patients who had little social support and struggled to cope themselves, wherever possible, patients should be encouraged to take responsibility for the ordering of their own repeat prescription as this encouraged patients to be independent and in control of their medicines.

The standards that should be applied to managed repeat systems were set out in the report. It was added that they had been drawn up to ensure patient safety and prevent waste of NHS resources through ordering of unwanted and unneeded items. To this end, any pharmacy offering a prescription service should do so in compliance with the General Pharmaceutical Council (GPhC), standards of conduct, ethics and performance (July 2012).

Discussion ensued with regard to the above and the recommended options for Practices outlined in the report and Board members sought clarification in respect of monitoring arrangements, for whichever option practices chose. The Director of Commissioning explained that technicians could run reports in order to ensure that whichever option chosen by the Practice was successful in addressing the issues raised.

RESOLVED

(i) That practices choose one of the following approaches to take regarding pharmacy ordering of repeat prescriptions:

Either

Continue as current practice, insisting on best practice from pharmacies in order to accept their ordering of repeats but instigate the 'three (or less if desired) strikes method which had been used by HMR. This involves working in conjunction with the LPC such that when within a 3 month period three (or less if decided upon) examples of poor practice are detected the pharmacy is temporarily suspended form ordering with the surgery. The pharmacy has to contact any patients that it has to order for and help them make alternative arrangements to order their medicines. Working with the CCG and LPC the pharmacy can, after it has investigated the incidents including reviewing SOPs and reported how it will avoid making the same error again be reinstated allowing to order once again. Further contraventions would result in permanent suspension.

Or

In the main, pharmacies are not allowed to order for patients. Patient or carer self-ordering will be promoted. Repeat orders from pharmacies are only to be accepted for those patients who are not capable of or do not have sufficient support to order their prescriptions themselves (once these have been identified).

(ii) That Practices be urged to choose and implement one of the above options as a matter of the upmost priority.

57. OVER 75s REVIEW PAPER

The Director of Commissioning submitted a report, which explained that the National Operating Framework 2014/15 outlined, as part of its plans for a modern model of integrated care, a request to ensure that the NHS provided tailored care for vulnerable and older people. The CCG allocated £1.2 million recurrent funding (£600K) pro rate for 2014/15) to invest in General Practice to deliver this. This equated to £5 per registered patient. Practices were required to meet the outcomes outlined in both the Better Care Fund (BCF) and the Care Together Programme. Whilst the funding was provided by the CCG, it sat jointly with TMBC in the pooled budget element of the Integrated Commissioning Fund.

It was reported that, although, as part of BCF this was a national initiative there was no standard template for how this should be delivered beyond adhering to the BCF framework. The CCG adopted a process and practices were invited to submit a business case to be considered at PIQ, regarding the care of over 75's, which would meet the aims of the Better Care Fund and Care Together Programme.

It was explained that the purpose of the report was as follows:

- To present an evaluation of the process, which had been in place since the introduction of the over 75 schemes. The aim was to investigate whether the current way of working provided a robust and equitable system to evaluate the bids;

- To summarise the schemes, present themes, examples of good practice and identify lessons learnt and to identify where schemes already align with the Integrated Neighbourhood Team model; and
- To reconfirm the approach for 2017/18.

The report concluded that clarity on the position for 2017/18, and beyond was required. The funding formed part of the CCG's recurrent allocation, however confirmation was needed as to whether it was available for 2017/18. If funding was agreed as available the approach in terms of future schemes was also to be agreed, recognising the neighbourhood model being adopted across the locality.

It was recommended that the proposed approach include:

- Start the process sooner for schemes to be considered for 2017/18 to ensure a go live of 1 April 2017 could be achieved;
- Same start and end time where possible to maximise the period schemes were in place and therefore maximise the potential impact;
- Neighbourhood bids only; take the best from previous individual schemes and include this. (as per the agreement from the paper Primary Care transformation and new models of care update, presented and agreed at April PRG);
- Be clear about the strategic aims the bids need to address;
- Have a rating process, similar to that which might be used when interviewing staff, to give PRG members to use whilst bids are being presented; part of this should be to match up the scheme outcomes to the BCF;
- Finance to provide a value for money analysis, comparative data, to allow for benchmarking and comparisons to be drawn between schemes during the consideration and approval of bids;
- Increase the emphasis for bids to demonstrate activity levels for previous years, where they are continuation of existing scheme, to show where criteria had been met, e.g. reduced A&E admissions;
- Recommend use of clinical system template and read codes where possible;
- Alignment with Integrated Neighbourhood Model would be encouraged, however PRG may wish to consider innovative projects which would enhance the existing Integrated Neighbourhood model proposition; and
- The CCG would serve notice during 2016/17 on any scheme not meeting the criteria referred to above.

RESOLVED

(i) That Board members are reassured that the direction of existing schemes align to the Integrated Neighbourhood model;

(ii) That the process for developing and assessing proposals be refined as outlined in the report; and

(iii) That the intention for 2017/18 in terms of recurrent financial resource with an approach for 5 neighbourhood schemes, serving notice on existing sub neighbourhood/individual practice schemes, be agreed.

58. DIRECTED ENHANCED SERVICES

Consideration was given to a report of the Director of Commissioning, which considered how the existing Directed Enhanced Services aligned with the Care Together programme and the developing model of care, and put forward proposals for the management of the Directed Enhanced Services in 2016/17 and 2017/18 from a contractual perspective.

It was explained that Enhanced services were currently commissioned through each of the primary medical care contracting vehicles (GMS, PMS, APMS) and could be commissioned from a range of other service providers (e.g. Community Pharmacies). They currently comprised of:

- Local Enhanced Services; and

- Directed Enhanced Services.

The 'Primary Care Actions and Update' paper received by PRG in April set out the aim of moving toward one contract and therefore one claim per practice for enhanced services, with neighbourhood contracts by the end of 2016/17. Under delegated commissioning, the CCG could offer an alternative scheme as well as the Directed Enhanced Services as long as the local scheme had the national requirements as a minimum. The challenges involved in meeting this were outlined in the report.

Details were also given in respect of the current position and options available on avoiding unplanned admissions.

The report concluded that, in respect of Directed Enhanced Services, the proposed approach was to continue to support the offer of the package of Directed Enhanced Services across Tameside & Glossop, aligning with the commissioning priorities of the Single Commission, encouraging optimum uptake by member practices and therefore ensuring the optimum investment in primary care locally was secured.

With regard to Avoiding Unplanned Admissions Directed Enhanced Services, the national service specification was in line with the approach to Integrated Neighbourhoods therefore did not need to be reviewed or amended. However, practices had not, to date, been supported with the delivery or to engage with partner organisations in its delivery. This could be remedied within the current specification without the complication of designing a local scheme. In doing so, the issue of the reporting and auditing could be addressed, to ensure that this was robust and supported our integrated working.

RESOLVED

(i) That in respect of Avoiding Unplanned Admissions Directed Enhanced Services the current procedure be continued, but to implement the Integrated Neighbourhood alignment recommendations (as detailed in Appendix 2 to the report), as soon as possible and at the latest by Autumn 2016;

(ii) That in respect of the wider Directed Enhanced Service portfolio this be aligned with the appropriate commissioning intentions within the Care Together Programme, to be completed by September 2016 to enable inclusion in the commissioning intentions for 2017/18;

(iii) That in respect of contracting and Performance Management develop and implement plans for Neighbourhood Directed Enhanced Services contracts in readiness for the 2017/18 commissioning intentions and contracting process; and

(iv) The Practices' comments (as detailed in Appendix 1 to the report), be taken into account in implementing the recommendations.

59. URGENT ITEMS

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

60. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on 6 September 2016 commencing at 2.30 pm at New Century House, Denton.

CHAIR

Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Kathy Roe – Director of Finance – Single Commissioning Team Ian Duncan - Assistant Executive Director – Tameside Metropolitan Borough Council Finance Claire Yarwood – Director of Finance – Tameside Hospital NHS Foundation Trust
Subject:	**TAMESIDE & GLOSSOP CARE TOGETHER ECONOMY – 2016/17 REVENUE MONITORING STATEMENT AT 31 JULY 2016 AND PROJECTED OUTTURN TO 31 MARCH 2017**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the revenue financial position of the Economy. The report provides a 2016/2017 financial year update on the month 4 financial position (at 31 July 2016) and the projected outturn (at 31 March 2017). The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions. A CCG financial recovery plan has now been requested by NHS England due to the risk of the CCG meeting its control total targets in 2016-17. If we are unsuccessful at implementing the totality of the schemes within this plan, we will be facing substantial pressures resulting in a significant risk of the CCG moving into a deficit position and therefore non-delivery against the financial control target for 2016/17. A summary of the Tameside Hospital NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended : To note the 2016/2017 financial year update on the month 4 financial position (at 31 July 2016) and the projected outturn (at 31 March 2017). Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period. This has become even more pertinent following the request from NHS England for a CCG financial recovery plan by 9th September.

Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	This report provides the financial position statement of the 2016/17 Care Together Economy for the period ending 31 July 2016 (Month 4 – 2016/17) together with a projection to 31 March 2017 for each of the three partner organisations. The report explains that there is a clear urgency to implement associated strategies to ensure the projected funding gap is addressed and closed on a recurrent basis across the whole economy. Each constituent organisation will be responsible for the financing of their resulting deficit at 31 March 2017. It should be noted that additional non recurrent budget has been allocated by the Council to Adult Services (£8 million) and Childrens' Services (£4 million) in 2016/17 to support the transition towards the delivery of a balanced budget within these services during the current financial year. The Council's position has improved significantly from the previous report. This is primarily as a result of additional budget being allocated to fund in year cost pressures within Adults, Children's and Public Health services (£5.172 million). It should be noted that the Integrated Commissioning Fund for the partner Commissioner organisations will be bound by the terms within the existing Section 75 agreement and associated Financial Framework agreement which has been duly approved by both the Council and CCG.
Legal Implications: (Authorised by the Borough Solicitor)	There is a need to deliver a balanced budget. Consequently, there are significant changes required to achieve this and reduce the current levels of spend which previously have been bailed out. This requires new models of working and relentless focus on budgets without compromising patient care and safety. Many of the new models are intended to achieve this rather than simply look to cut out waste.
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 Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference 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:	These are detailed in Section 6 of the report
Access to Information :	Background papers relating to this report can be inspected by contacting : Stephen Wilde, Head Of Resource Management, Tameside Metropolitan Borough Council Telephone:0161 342 3726 e-mail: stephen.wilde@tameside.gov.uk Tracey Simpson, Deputy Chief Finance Officer, Tameside and Glossop Clinical Commissioning Group Telephone:0161 304 5449 e-mail: tracey.simpson@nhs.net Ann Bracegirdle, Associate Director Of Finance, Tameside Hospital NHS Foundation Trust Telephone:0161 922 5544 e-mail: Ann.Bracegirdle@tgh.nhs.uk

1. INTRODUCTION

1.1 This report aims to provide an update on the overall financial position of the economy as at Month 4 and to highlight the increased risk of achieving financial sustainability in the short term whilst we all acknowledge how much it will take to bridge the financial gap next year also.

1.2 The report includes the components of the Integrated Commissioning Fund (ICF) and the progress made in closing the financial gap for the 2016/17 financial year. The total ICF is £447.5m in value (**Appendix C**), however this value is subject to change throughout the year as new Inter Authority Transfers (IATs) are actioned and allocations are amended.

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

1.4 The 2016/17 financial year is particularly challenging due to the significant financial gap and the risk of CCG QIPP schemes not being sufficiently developed to deliver the required level of efficiencies in year. A financial recovery plan is required by NHS England by 9th September and an extraordinary meeting of the Governing Body will consider the plan on the 7th September. This report also considers the financial risks of the ICF in 2016/17. Please refer to section 6 for further details.

1.5 It should be noted that section 2 of the report includes details of the financial position of Tameside Hospital NHS Foundation Trust. This provides members with an awareness of the projected total financial challenge which the Tameside and Glossop economy is required to address during 2016/17.

1.6 Please note that any reference throughout this report to the Tameside and Glossop economy refers to the three partner organisations within the Care Together programme, namely:

- Tameside Hospital NHS Foundation Trust
- NHS Tameside and Glossop CCG
- Tameside Metropolitan Borough Council

2 FINANCIAL SUMMARY

2.1 Table 1 details the 2016/17 budgets, expenditure and forecast outturn of the ICF and Tameside Hospital NHS Foundation Trust. However there are a number of key risks that have to be managed within the economy during the financial year:-

- Achievement of the original £21.5m projected commissioner financial gap (£13.5m T&G CCG and £8.0m TMBC);
- Delivery of the £17.3m projected financial deficit (i.e. agreed control total) of Tameside Hospital NHS Foundation Trust;
- Management of any potential over spend within Acute services. Any over spend would be an additional pressure over and above the financial gap stated above;
- Ensure Parity of Esteem is achieved in relation to Mental Health Services;
- Financial pressures as a result of national changes to the health contribution of funded nursing care payments (40% increase). This will generate an estimated increased liability to the CCG of approximately £ 0.6 million but this will be confirmed and reported at month 5.
- Management of Care Home placements due to the volatility in this area;
- Unexpected and complex dependency placements within Children's Services;
- Emergency In-year reductions to Central Government resource allocations;

- Pro-active management of Continuing Healthcare and Prescribing – both of which are subject to volatility;
- Remaining within the running cost allocation for 2016/17.

Table 1 – Summary of the Tameside and Glossop Economy – 2016/17

Tameside & Glossop Integrated Commissioning Fund 2016/2017

	Year to Date (M4)			Year End			Movement	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	66,044	66,788	(744)	198,348	198,622	(274)	(185)	(89)
Mental Health	9,699	9,732	(33)	29,097	29,300	(203)	(134)	(69)
Primary Care	26,908	27,461	(553)	80,379	80,969	(590)	(437)	(153)
Continuing Care	4,864	4,927	(63)	14,236	14,442	(206)	(207)	1
Community	9,124	9,122	2	27,357	27,362	(5)	0	(5)
Other	9,194	7,686	1,508	23,471	22,688	783	557	226
QIPP	0	4,500	(4,500)	0	12,893	(12,893)	(13,010)	117
CCG Running Costs	1,497	1,614	(117)	5,162	4,737	425	406	19
CCG Sub Total **	**127,330**	**131,830**	**(4,500)**	**378,050**	**391,013**	**(12,963)**	**(13,010)**	**47**
Adult Social Care& Early Intervention	13,995	14,311	(316)	41,980	43,243	(1,263)	(5,123)	3,860
Childrens Services, Strategy & Early Intervention	8,635	8,712	(77)	25,877	26,185	(308)	(1,594)	1,286
Public Health	(2,401)	(2,342)	(59)	1,639	1,876	(237)	(1,164)	927
TMBC Sub Total *	**20,229**	**20,681**	**(452)**	**69,496**	**71,304**	**(1,808)**	**(7,881)**	**6,073**
GRAND TOTAL	**147,559**	**152,511**	**(4,952)**	**447,546**	**462,317**	**(14,771)**	**(20,891)**	**6,120**

Tameside Hospital NHS Foundation Trust

	Year to Date (M4)			Year End			Movement	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Net Surplus/(Deficit)	(6,397)	(6,159)	268	(17,300)	(17,300)	0	(17,300)	0

Summary

Tameside & Glossop Commissioner - Projected Gap - 31 March 2017	(14,771)
Tameside Hospital NHS Foundation Trust - Projected Gap - 31 March 2017	(17,300)
Tameside & Glossop Economy - Projected Gap - 31 March 2017	(32,198)

** Please note that accruals are included within the year end projections for the Council and not within the year to date totals. Projected expenditure and income within Council services is monitored on a monthly basis via data maintained within the respective service management information systems.*

*** The CCG figure quoted in table 1 differs from that reported to NHS England in the Non ISFE return, due to the treatment of QIPP. This is to ensure consistency of reporting across the Integrated Commissioning Fund, for both CCG and Local Authority. This is presentational only and does not affect the underlying position. It has been agreed at Single Commissioning Board, that all financial gaps (including QIPP) should be treated as a deficit until the savings have been achieved (ie, Reported as green in the QIPP table below)*

2.2 Assumptions included to deliver the Tameside Hospital NHS Foundation Trust projected deficit of £17.3m include:

- Savings of £7.8m (the FT's Cost Improvement Plan) are delivered (section 3.10 refers)
- £1.1m of additional income is received for the use of independent sector providers (this will finance associated expenditure incurred);
- There is a small over performance on PbR associate commissioner contracts;
- £6.9m Sustainability and Transformation funding is received (it should be noted that this is reliant on the condition that all financial and performance criteria is met);
- £17.3m working capital/loan is received to finance the projected year end deficit position;
- The Trust bed base is not increased;
- No significant unfunded additional expenditure materialises;

2.3 If these assumptions are not realised, sensitivity analysis suggests there is a risk that the projected year end deficit could increase by £1.4m (to a projected £18.7m deficit). It should be noted that by the end of 2016/17, the Trust will have £52m of repayable loans which have been borrowed to fund the deficit over the past 3 financial years. Repayment of this sum is scheduled to begin in 2018. However whilst it is anticipated the Department of Health will convert the loans into non repayable loans, the timescales and exact criteria required to facilitate this remains subject to confirmation.

3 FINANCIAL GAP

3.1 The Commissioner Financial Gap in 2016/17 for the ICF is £21.5m which includes £13.5m CCG QIPP target and an £8.0m TMBC financial savings target. It should be noted that this gap is a commissioner only gap. The economy wide position including the deficit at Tameside FT increases the scale of the challenge to £45.7m.

Commissioner Financial Gap

3.2 Table 2 lists the schemes identified to address the commissioner financial challenge and meet the QIPP targets in 2016/17. Each scheme is summarised with an evaluation of the risk of achievement and delivery in 2016/17.

Table 2 – Commissioner - Financial Gap Schemes (£'000) 2016/17

Scheme	16/17 Savings			Risk	Notes
	CCG	TMBC	Total		
SCHEMES WITH A QUANTIFIED FINANCIAL IMPACT IN 2016/17					
Public Health - savings found	0	217	217	G	Planned reduction to the annual management fee payable to Active Tameside and additional incidental savings delivered within the service
Public Health - savings found	0	169	169	G	A reduction in the Community Services contract value has been agreed with Tameside FT
Public Health - additional resource (projected cost pressures)	0	49	49	G	
Public Health - reduction in estimated capital financing repayments (Active Tameside)	0	514	514	G	The capital financing figure in 16-17 has redeuced due to a rephasing of works to reconfigure the Active Tameside estate
Public Health - savings still to find	0	432	432	A	.
Adult Social Care - additional resource (projected cost pressures)	0	3,908	3,908	G	
Adult Social Care - savings still to find	0	997	997	R	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.
Childrens Social Care - savings found	0	120	120	G	Reduction to inflationary increases that were projected to materialise during 2016/17.
Childrens Social Care - additional resource (projected cost pressures	0	1,215	1,215	G	
Childrens Social Care - savings still to find	0	379	379	R	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.
Wheelchair Service	230	0	230	G	Contract now signed, guaranteeing 16/17 saving. Procurement exercise is on-going to determine scale of recurrent benefit.
ISCAN	230	0	230	G	Business case rejected at June PRG. Therefore money which was held in reserves is no longer required
RADAR	32	0	32	G	Money held in reserve in anticipation of additional spend with Greater Manchester West FT. No longer required.
MH Safer Staffing	100	0	100	A	Business case to PRG in August. Depending on outcome and subsequent negotiation with Pennine Care savings of upto £200k could be available.
Efficiency Savings: Admin Budgets	115	0	115	G	Confirmed savings made in 16/17 from running costs budgets. Chiefly driven by no longer having to fund salary of Chief Operating Officer.
Efficiency Savings: Admin Budgets	385	0	385	A	Further savings/slippage possible following budget holder review and in the event of any staff vacancies
Efficiency Savings: Programme Budgets	500	0	500	A	Individual budget holder review meetings already held as part of budget setting process. Therefore all of the obvious savings have already been captured. However further reviews to identify slippage and savings will be held in year.
Risk Stratification/Review of high risk patients	1,000	0	1,000	A	Review by Practices of high risk patients via risk-strat information - All practices and neighbourhoods to be supported to analyse their risk stratification data and identify where support can be optimised to prevent unnecessary urgent and planned care system demand. Data has been shared with practices and benefits are expected from September onwards
Integrated Elective Services	800	0	800	A	Bridging arrangements in place with Care UK / GM Primary Eye Care for 2016/17, with fully integrated service in place for MSK, ENT & ophthalmology through the ICO from April 2017. Based on budgets in place as part of the bridging service, 16/17 in year savings in the region of £800k are expected. Longer term recurrent savings will be made once new integrated services start in April 2017.
Referral Interceptor Scheme	100	0	100	A	Short term scheme while detail of the full RMS are developed and implemented. Will enable quick wins and reduce inapropriate referrals . Also supportive of EUR target below.
Effective Use of Resources	500	0	500	A	Non-payment of un-authorised EUR procedures. Significant potential savings based on benchmarking data across GM. Monitoring and financial challenge system being finalised and will go live at the end of July to challenge M3 data. THFT implementing internal processes to prevent listing
GP Prescribing	1,000	0	1,000	R	Challenging target to reduce prescribing costs, building on schemes implemented in 15/16. See separate schedule for detailed exploration of prescribing QIPP schemes.
Total	**4,992**	**8,000**	**12,992**		

SCHEMES WITHOUT A QUANTIFIED FINANCIAL IMPACT IN 2016/17 - BUT WHERE WE ASPIRE TO REALISING SOME BENEFITS IN YEAR					
Neighbourhood Development	0	0	0		Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge.
Home Care	0	0	0		Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge.
Living Well - Self Care	0	0	0		Part of the transformational funding request from devolution. Joint savings claimed in the business case (from neighbourhood development, home care and healthy lives) to stop future years activity growth and maintain at 16/17 plan levels. Dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge.
Referral Management System	0	0	0		New referral management system reviewing all referrals. Will ensure availability of advice & guidance and appropriate use of diagnostics prior to consultation. Not part of the GM Devolution transformation fund bit but will require non-recurrent funding. Service design on-going and currently reviewing IM&T solution. Business case pushed back to allow for more work to be done on IM&T solution, but Referral Interceptor scheme above brought forward to ensure quick wins are achieved.
Digital Health	0	0	0		Part of the transformational funding request from devolution. Digital Health Suite allowing care home residents/carers to consult on health conditions as they arise and allowing the person to be treated remotely which will reduce A&E attendances and emergency admissions. Savings dependent upon GM funding in order to realise the benefits. While the business case does not assume any savings until 2017/18, we hope to be able to bring forward some of the benefits to address the 16/17 QIPP challenge.
Home First	0	0	0		Admission Avoidance & Discharge to Assess. Part of the transformational funding request from devolution which should reduce length of stay allowing the FT to close wards. Early implementation pilot on 2 wards from June but full realisation of benefits is dependent upon GM funding.
Flexible Community Beds	0	0	0		Reconfiguration of intermediate care beds. Part of the transformational funding request from devolution. Savings dependent upon GM funding in order to realise the benefits.
Commissioning Improvement Scheme	0	0	0		GP led schemes to manage demand, reduce inappropriate referrals and ensure value for money. Practices may be eligible to receive a payment under the scheme in 2017/18 based on achievement at both individual practice and neighbourhood
Anti Coag Review	0	0	0		Work on-going in transformation directorate to standardise service across all providers and ensure appropriate level of follow up in secondary care
Estates	0	0	0		Potential savings against the budgeted payments to Propco/CHP
Total	**0**	**0**	**0**		
SAVINGS TARGET	**13,500**	**8,000**	**21,500**		
SAVINGS STILL TO FIND	**8,508**	**1,808**	**10,316**		
SAVINGS STILL TO FIND FOLLOWING OPTIMISM BIAS ADJUSTMENT	**11,201**	**1,592**	**12,793**		**Assumes: 10% of red rated schemes will be realised in 2016/17. 50% of amber rated schemes will be realised in 2016/17. 100% of green rated schemes will be realised in 2016/17.**

3.3 On a year to date basis £6.285m of savings have been achieved (the green rated schemes in the table), £0.607m of this relates to CCG schemes while £5.678m has been identified by TMBC to support the council services. For the council, this comprises additional budget that the Council has put into Care Together services to recognise the 2016-17 in-year cost pressures together with a reduction in Active Tameside borrowing requirements and reduction in the Community Services contract which Public Health holds with Tameside FT.

3.4 In total £12.992m of savings have been identified, of which £2.376m have been risk rated red. £8.508m remains unidentified. We expect that some of this funding gap will be met by a combination of new schemes and proposals which are due to start or be actioned imminently, together with the implementation and acceleration of schemes which are included in the table but are not currently quantified. If we are unsuccessful at implementing the totality of these schemes, we will be facing substantial pressures resulting in a significant risk of the CCG moving into a deficit position and therefore non-delivery against the financial control target for 2016/17. It is therefore essential that this risk is widely understood across the economy and all efforts channelled in addressing this problem whilst ensuring the provision of clinically safe and sustainable services for our residents.

3.5 If we make an assumption that we will be unable to realise all of amber and red rated savings in 2016/17 and apply some optimism bias, the total savings which still need to be identified by the Commissioners increases to £12.793m.

3.6 Since last month the CCG has realised £0.115m of savings as a result of admin budget reviews, which have been categorised from amber into green, while integrated elective services and referral interceptor have moved from the unquantified portion of the report into amber rated schemes with expected savings of £0.800m and £0.100m respectively.

3.7 Options have been considered at previous finance committees to address the residual gap non-recurrently for 2016/17. However, it is important to recognise that some of the interventions would in effect be a form of financial support and the risk associated with this action would need to be fully evaluated.

3.8 The 2016/17 CCG QIPP target assumes that expenditure on secondary care, CHC, prescribing and other areas at risk of overspending against plan are assumed to perform in line with plan. If we have significant over spend in these areas we will have to review our options for addressing the gap.

3.9 The Councils position has improved significantly from the previous reporting period due to additional budget being allocated to fund in year cost pressures as outlined above. The Council is still in the process of identifying options to address the projected recurrent financial gap that is expected to arise during 2016/17. It is anticipated that the outcome be reported within future monitoring reports.

Tameside Hospital NHS Foundation Trust Efficiency Savings

3.10 Table 3 provides a summary of the Tameside Hospital NHS Foundation Trust efficiency savings for delivery in 2016/17

Table 3 -Tameside Hospital NHS Foundation Trust: Efficiency Savings Programme 2016/17

	Month 4 - Year to Date				Year End Forecast		
	Plan (£'000)	Actual (£'000)	Variance (£'000)		Plan (£'000)	Actual (£'000)	Variance (£'000)
In Year Total Savings	2,482	2,224	(258)		7,832	7,832	0
Recurrent Savings	2,482	561	(1,921)		7,832	3,675	(4,157)

3.11 Although the savings are forecast to deliver in year, only 47% are recurrent which will result in a financial pressure in 2017/18 if recurrent savings are not identified.

3.12 £1.0m of the recurrent savings have a high risk of delivery. These schemes include reduction in use of medical agency by recruiting substantively and radiology reconfigurations.

3.13 Whilst the current priority of the economy is to deliver a balanced budget during the current financial year, it is essential that additional efficiency schemes are progressed at scale and with urgency to address the projected financial gap the economy will need to address in the next and subsequent financial years. A summary of the projected gap for each financial year to 2020/21 is provided within table 4. Please note that this is consistent with the existing Locality plan submission to GM Health and Social Care Partnership, which will be reviewed during the Autumn of 2016.

Table 4 – Projected Tameside and Glossop Economy Financial Gap

T&G Projected Financial Gap	**2016-17 £'000**	**2017-18 £'000**	**2018-19 £'000**	**2019-20 £'000**	**2020-21 £'000**
Tameside MBC	8,000	22,114	22,601	21,752	25,837
Tameside & Glossop CCG	13,500	22,485	22,083	22,209	18,547
Tameside FT (after CIP)	*24,200	24,380	24,686	25,049	25,786
Economy Wide Gap	**45,700**	**68,979**	**69,370**	**69,010**	**70,170**

. * *This represents the underlying recurrent financial position at THFT. However, the Trust is in receipt of £6.9m sustainability funding in 2016/17 resulting in a planned deficit of £ 17.3 m (referred to in section 2.2)*

4 MONTH 4 UPDATE

4.1 **Acute** The overall Acute budgets are forecast to over spend by (£0.274m) at year end. It must be noted only 3 months of activity data has been received at the time of writing therefore there is an element of risk associated with these figures. Activity will be monitored closely on a month by month basis.

4.2 Table 5 below details the position of our main acute providers. The full year forecast position of the main acute providers is an under spend of £0.023m which is partially offsetting the overall overspend of (£0.274m).

Table 5 - Main Acute Providers

Provider	Year to Date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
TFT	42,450	43,167	(717)	127,075	127,075	0
CMFT	7,441	7,579	(139)	22,280	22,546	(266)
SFT	3,974	3,766	208	11,969	11,770	198
UHSM	2,150	2,258	(108)	6,568	6,664	(96)
PAHT	1,336	1,242	94	4,029	3,896	133
SRFT	1,072	1,126	(54)	3,226	3,340	(114)
WWL	464	386	78	1,409	1,263	146
BOLT	27	19	0	80	58	22
Total	**58,914**	**59,544**	**(630)**	**176,635**	**176,612**	**23**

4.3 **Tameside FT** – Contract is over spending by (£0.717m) on a year to date basis based on month 3 data. This excludes a cross year pressure of (£0.178m) for excess bed days which is to be resolved alongside the other risks within the TFT contract at a senior level. We continue to forecast a year end break even position on the basis that there will be acceleration of transformational schemes which we anticipate will reduce activity back into line with budget from M07.

4.4 The risk associated with the forecast position needs to be appreciated within the context of the risk/gain share agreed as part of the contract, where a floor/ceiling has been set at £0.500m above/below this contract value. In the eventuality that full year overspend is in excess of this ceiling, premium payments of 50% are triggered. Based on the current levels of overspend and if the final contract reconciliation point was today, this clause would be triggered and over performance of £1.075m would be payable. This is not captured within the current financial position and poses a significant financial risk to the CCG which has been recorded in the risk register. It is imperative that action is taken in the months to come to ensure that agreed transformation schemes are implemented to drive down activity to the contracted level. This is in the financial interests of both provider (who have a marginal cost in excess of tariff) and commissioner (who do not have the resource to fund this level of demand). Conversations are being progressed at director level in order to determine how to manage this risk in the best interests of the economy.

4.5 In addition to the direct PbR tariff cost and volume pressures covered in the narrative below and the cross year excess bed days pressure of (£0.178m), the FT have identified cost pressures related to premiums they are paying to the commercial sector (£0.141m).

4.6 In terms of the year to date position elective activity is overspent by (£0.189m) and this is driven by Trauma & Orthopaedics (£0.235m). In order to avoid the premium cost incurred by TFT when making secondary referrals to the private sector, GPs have been encouraged to

refer directly to providers other than Tameside Hospital including private providers where appropriate. In line with this protocol we have seen a decrease in T&O referrals to TFT averaging 35 cases per month in quarter 1 and an increase in the independent sector which is overspent on T&O by (£0.108m) year to date. This planned movement of service was factored into the 2016/17 TFT contracting round and the budget allocation for the reduction of the 2016/17 TFT plan is currently sat within CCG reserves to offset the year to date overspend on the independent sector.

4.7 Emergency Care is over spent by (£0.202m) based on month 3 data which is mainly due to pressures within Ambulatory Care (£0.192m). However, it must be noted that there was an extreme overspend on non-elective emergency within month 1 which has significantly reduced in subsequent months. This was due to a one off "spike" within General Medicine for pneumonia which peaked at (£0.117m) overspent in April and dropped to (£0.040m) overspent in June. In addition, there is a second element to the excess bed days cross year pressure relating to the spells. This equates to an additional pressure of (£0.112m) which has not been removed from the year to date position. Furthermore, the Care Together service redesign focuses on higher utilisation of ambulatory care hence the movement of (£0.192m) mentioned earlier was as expected, however a corresponding reduction in high cost admissions has not yet emerged. In particular, DVTs and Pulmonary Embolism are over spending by (£0.072m) and (£0.088m) respectively. Investigation of the D-Dimer scheme during M03 was unable to verify with any certainty that this initiative has reduced DVTs presenting in the acute setting, however there were indications from the analysis that the scheme is possibly offsetting underlying growth and that the over spend would be significantly higher if the new protocol was not in use. An audit of test outcomes is underway with the commissioning team to measure the performance of the scheme.

4.8 Non-Emergency care is over spending by (£0.133m), which is due to elevated births during May and June. The marked increase in antenatal pathways reported at M3 was investigated and the outcome was the identification of a presentational issue within the monitoring data provided by the FT in terms of unit plan prices. This will be resolved for M5. In addition, maternity data has been validated to alleviate concerns raised regarding duplicate charging of pathways across providers.

4.9 Outpatients are over spending by (£0.134m) year to date, with particular emphasis around first attendances which is over spending by (£0.152m). This is particularly interesting in view of the new Elective Care Pathways around MSK, ENT and Ophthalmology as we would expect to be seeing a reduction in first attendees as GPs aim to only refer patients to the acute setting if surgery is required using the referral guidance criteria. In particular, ENT is and T&O are (£0.02m) and (£0.009m) over spent year to date. This is also true of other GM providers and as such an exercise is underway to provide further referral analysis around DNAs, inappropriate referrals and referral outcomes in order to understand this further for M5.

4.10 Direct Access is over spending by (£0.094m) year to date of which (£0.040m) relates to MRI scans during month 1. The MRI costs significantly dropped from month 2 onwards due to the closure of the mobile unit, however as the unit would have been standing empty for the remaining month of the contract it was utilised for other services, hence the (£0.027m) over spend for M2 on unbundled diagnostics.

4.11 Finally we have an over spend within the independent sector of (£0.240m) which covers a range of services including T&O and MRI scans. As discussed within the elective position, this was a planned movement of service between TFT and the private sector factored into the 2016/17 contract. The expectation for activity levels to reduce at TFT as activity increases with private providers has not yet materialised, hence we are incurring the costs of both providers, plus the pass through premium cost when TFT are internally referring patients to the independent sector. This is clearly not a sustainable nor an affordable scenario for either party. Hence the importance of the Director level conversations to

understand the rationale and factors influencing decisions which are driving the improvement of RTT levels at TFT and how this needs to be balanced with overall financial stability.

4.12 **Central Manchester FT** is overspent by (£0.139m) at M4. The forecast position to year end is an over spend of (0.266m). The main issues are:

- Macular activity continues to overspend having increased to (£0.140m) year to date. The forecast has been adjusted this month to take account of this over performance and to factor in an additional £0.090m for future months. The CCG has recently written to providers about adherence to EUR policies and as such we expect cataract activity to reduce in future months and to broadly come back in line with plan. It was also noted that due to the financial envelope the plan was negotiated down for 2016/17. This area of activity will continue to be closely monitored along with SpaMedica within the Independent Sector where macular activity continues to grow.
- Daycase activity is overspent by (£0.058m). This is largely due to Gastroenterology, and mainly endoscopies, as CMFT reduces the Waiting List backlog.
- Easy Go Renal Dialysis Patient Transport – The forecast has been increased by a further (£0.018m) which represents an additional month's service having been extended again and now due to cease on 30 September. The transfer date to NWAS is now expected to be 1 October 2016.
- The offset to the noted pressures is largely the under spend in drugs costs, currently stating a year to date £0.103m (27%) under plan. The main drivers are Adalimumab and Etanercept, which were drugs that reported significant over-performance in 2015-16, which we reflected in our 206/17 plan.

4.13 **Stockport FT –** Contract is currently under-spending by £0.208m on a year to date basis this is driven by large underspends in Elective Orthopaedics where we have seen underspends of £0.095m. This is currently being offset by bigger increases in activity at Tameside FT and private acute provider BMI. This trend at Stockport is expected to continue for the remainder of 2016/17.

4.14 The other main area where we are recognising a significant under performance of £0.066m is within the Stroke pathway where we have seen activity significantly below plan in Months 1 & 2 but assume this will return to expected levels at M3.
The forecast outturn for Stockport FT is an under performance £0.198m.

4.15 **University Hospital South Manchester –** Contract currently overspending year to date by (£0.108m) which is driven by over-performance in Critical Care and Day-cases but being partially off-set by a significant under performance in Non Elective of £0.093m.

4.16 Critical Care saw a significant over performance in the M2 position from a single patient who required organ support care and a significant stay in hospital equating to costs of (£0.070m). No activity was recorded in M3 so the decision to forecast the position back to plan for the remainder of 2016/17 is considered appropriate.

4.17 Long term ventilation support has seen a year to date overspend of (£0.021m) with the majority of this activity concentrated in M1 but M2 & 3 are still over-spending but with a lower cost impact. This trend is predicted to continue so has been reflected within the forecast position.

4.18 Implantation cardiac devices and stent procedures have been a key driver of increased day case costs. It is expected that these procedures will be in line with plan for the remainder of the year. Non elective procedures have reduced and particularly within Geriatric medicine for angiograms and angioplasty procedures.

4.19 **Salford Royal FT Contract** currently overspending by (£0.054m) in the year to date position which is mainly driven by Day cases and Non Elective activity. Neuro Rehab is under-spending against plan by £0.033m.

4.20 Overspends in Day cases are within pain management and clinical haematology. Further detail is being sought to try and understand the reason for this trend.
Non elective activity has seen increases in unplanned dermatology procedures and the provider is being contacted to gain a better understanding of what is driving this change. Stroke activity has increased also and these additional pressures are reflected in the forecast position.

4.21 There have been month on month reductions in neuro surgery and slow stream rehab but for prudence the forecast is reported to be in line with plan at this stage.

4.22 **Mental Health** budgets continue to forecast an overspend of (£0.135m) at year end. This is largely due to additional placements within the Non CHC service which were not included within the baseline budget. As with the CHC placements this continues to remain and area of volatility and risk. A patient level review has taken place between the Finance and CHC teams in July and work is continuing in August. A more robust methodology of data analysis is currently in development and this will ensure a much more streamlined process with more effective forecasting.

4.23 As notified to NHSE we continue to meet, if not exceed (due to additional costs being incurred within Non CHC) the 2016/17 Parity of Esteem. This continues to be one area that will be monitored on a monthly basis both internally and externally by NHSE.

4.24 **Primary Care** Month 4 Primary Care is forecast to overspend by (£0.590m) driven mainly from pressures in Prescribing.

4.25 The CCG also has a cross year pressure from Prescribing of £0.216m. At this early stage in the financial year, the PPA profile is used to estimate the forecast for the remainder of the year. The Medicines Management team are providing intense support to individual practices to reduce prescribing costs.

4.26 The CCG has a £1m QIPP target for prescribing in 2016/17. As referenced above, the Medicines Management team continue to work with GP practices in managing their prescribing costs, repeat orders and elimination of waste, but until a reduction in prescribing expenditure is reported in the Prescribing Monitoring Document (PMD), a forecast position of (£0.500m) overspend is felt to be realistic at this stage. Therefore, in order for the CCG to achieve the prescribing QIPP target in 2016/17 the CCG would need to implement schemes that actually achieve savings of £1.5m compared to the current forecast.

4.27 Delegated Co-Commissioning expenditure shows a forecast overspend of £0.059m compared to a previously reported underspend of £0.067m. This represents an adverse movement of £0.126m. This is attributable to three main areas:

- GMS – The national global sum rate is much higher than the 1% increase anticipated at budget setting. Furthermore, this overspend has increased by £0.073m in month following the adjustment to list sizes at quarter two. For prudence, a further increase based on 0.4% growth has been included for the remaining two quarters of the year. There is a possibility of some additional funding becoming available to CCGs which may mitigate this pressure however this has yet to be confirmed.
- QOF – The final achievement of the 2015/16 QOF is not available until formally signed off in July; this is then used to update the 2016/17 forecast. At month 3 an estimate of the 2015/16 position was used which together with the change in list size has seen a £0.067m increase in the estimated position for 2016/17.
- Premises Cost Reimbursement – The 2 pressures outlined above are offset slightly by a reduction in the forecast for premises cost reimbursement. This is the impact of a national

recalculation of GP premises rateable values. Where practices have submitted invoices for reimbursement, any financial benefit has been reflected in the position reported, however where rates' invoices are still to be received this will be realised in future months.

4.28 The financial position in respect of Delegated Co- Commissioning budgets is discussed in in detail at the Primary Care Committee and the CCG and GMH&SCP colleagues work closely under the principles of the Memorandum of Understanding in place with NHS England.

4.29 **Continuing Care** The month 4 forecast outturn position for CHC remains an overspend of (£0.207m). A patient level review has taken place between the Finance and CHC teams in July and this review is continuing throughout August.

4.30 Initial findings from the review indicate that there has been an increase since last year on Long Term patients with a CHC care package. July 2015 reported 229 Long Term patients in the system compared with 245 patients in July 2016. This upward trend is an indication that more patients in T&G are requiring longer term CHC packages as people are living longer with more complex needs. On average each package of care costs the CCG £0.052m per annum.

4.31 The findings also confirm that there is a significant increase in Fast Track patients compared with last year. In July 2015 there was an average of 25 Fast Track patients in the system compared with an average of 47 in July 2016. Fast Track Patients have a shorter length of stay but the increase in demand could pose a risk to the financial position if this upward trend continues.

4.32 Detailed work in August will concentrate on the analysis of the invoicing for CHC. Currently patients are forecast to receive packages of care until the end of the financial year, unless they are clearly identified as a Fast Track patient. This detailed review will identify if there has been a cross year financial benefit from the accrual that was included at the end of 2015/16

4.33 **Funded Nursing Care.** In July the Department of Health announced an increase in Funded Nursing Care (FNC) rates payable by CCGs for 2016/17. The rate paid by the NHS to nursing homes for eligible patients will rise with effect from 1 April 2016 to £156.25 per week from the current standard rate of £112 per week. This equates to circa 40% increase but only a 2% increase was estimated in the budget setting process. This will generate an estimated financial pressure on the CCG of around £0.600 m. This is currently being evaluated and will be confirmed and reflected in financial values at month 5.

4.34 **CCG Running Costs** The CCG running cost allocation has been reduced in 2016/17 by £0.040m in line with NHS England guidance. The annual budget in 2016/17 is £5.162m. The CCG is forecast to under spend on running costs by £0.425m at the year end. Table 6 below shows the running costs by directorate.

4.35 QIPP savings of £0.116m have been found within Running Costs due to natural attrition.

4.36 The cost of repairing the air conditioning unit in New Century House (£0.295m) is reflected in the Month 4 position. However, this pressure is partly off-set by a cross year benefit in telecommunications of £0.130m within the IM&T budget. The single commission's estates and legal team are currently reviewing the terms of the lease for New Century House to explore if this pressure could be mitigated.

Table 6 – CCG Running Costs 2016/17

Directorate	WTE Estab	£000's Budget	£000's Forecast	£000's Variance
Commissioning	15.36	747	757	(10)
Finance	13.03	750	673	77
CEO / Board Office	2.28	688	547	141
Chair / Non Execs	0.60	218	218	0
Communication & PR	5.00	233	184	49
Corporate Governance	9.80	455	449	6
Human Resources	1.50	45	38	7
IM&T	3.00	259	224	35
IM&T Projects	0.00	175	176	(1)
Nursing Directorate	2.00	115	113	2
Contract Management	4.40	323	251	72
Estates	0.00	430	430	0
Corporate / Other	1.00	724	696	28
TOTAL	**57.97**	**5,162**	**4,756**	**406**

4.37 **Tameside MBC** Additional Council resource of £5.172m to contribute to in year cost pressures is included in the month 4 figures. This is subject to Executive Cabinet approval on 31 August 2016. The narrative below details additional service pressures.

Adult Social Care (Including Early Intervention)

4.38 **Better Care Fund** - Removal of payment for the performance element of BCF has resulted in changes to national conditions around NHS commissioned out of hospital services. There is a minimum requirement in 2016/17 to invest £4.4m of the overall BCF allocation into these services which represents an increase of £1.12m on the previous year's figure. Consequently this has resulted in a £1.12m reduction in the BCF resource available to fund Adult Social Care

4.39 **CCTV -** The service has a projected deficit of £0.060m. A service review is underway in this area to reduce expenditure where appropriate. Further updates will be provided in future reports.

4.40 **Residential & Nursing Care –** The current net cost of placements is projected to be £0.387m in excess of budget for the financial year. This is as a result of increased placement numbers and a reduction in client contributions due to individual financial circumstances. Changes to the FNC contribution rate will potentially reduce net expenditure in this area by c £0.600m. This will be confirmed and reported at month 5.

It should be noted that the Council are mid-range compared to other NW Local Authorities in terms of placement numbers into Residential & Nursing care for over 65s but will seek to improve the position to be top quartile performers as new models of care are implemented.

4.41 **Homecare** - The 2016/17 budget takes account of the increased fees payable to providers and was set based on March 2016 activity levels. Current data suggests that the number of commissioned hours has reduced therefore current projections are that spend for the year will be under budget by £0.195m.

4.42 There have been instances of provider failure over the last 18 months which has led to capacity concerns across the homecare market.

4.43 The Care Together Single Commissioning Board approved an increase to the hourly rate payable to providers on 7 June 2016 (backdated to 1 April 2016) as a result of the implementation of the National Living Wage from 1 April 2016.

4.44 The service continues to review existing commitments in line with statutory responsibilities to deliver a balanced budget by the end of the financial year. Associated progress will be included within further monitoring reports during 2016/17.

Childrens' Services (including Strategy and Early Intervention)

4.45 **Looked After Children (LAC) -** The current number of LAC supported by the Council is 445. This includes Fostering and Adoption placements as well residential care homes. Numbers have increased by 10 since April 2016 with some individual external residential placement costs in excess of £0.200m per annum. Current estimates are that spend will be in excess of budget by £0.401m by the end of the financial year. It should be noted that the service is exposed to the risk of further unexpected and complex needs placements.

Public Health

4.45 Current proposals to reduce the fee payable to Active Tameside for management and operation of the leisure estate will materialise during 2016/17. This will result in a cost saving to the Council of £0.350m per annum (as a minimum from 2017/18) as Active Tameside improves its financial self-sufficiency via capital investment by the Council in the estate.

4.46 The Directorate have negotiated a reduction of £0.169m in the Community Services contract with Tameside FT.

4.47 Temporary resourcing of the Active Tameside capital investment prudential borrowing repayments is currently under consideration. The temporary resourcing arrangements will be replaced in future years via the recurrent savings achieved from a significant reduction to the annual management fee payable. Currently a borrowing repayment of £0.186m is included within the month 4 projected outturn estimate.

5 ADDRESSING THE LOCAL HEALTH ECONOMY GAP

5.1 Considerable work is ongoing to ensure the Economy is investment ready by the end of August when the Greater Manchester Strategic Partnership Board will consider the Tameside and Glossop proposals for Transformational Funds. A revised sum of £23.2m has been requested over the period to 2019/20, £5.2m of which has been requested in 2016/17. It is envisaged a decision on the proposals will be known by 31 August 2016.

6 RISKS

6.1 The key financial risks facing the Commissioners and THFT within the Economy at 31 July 2016 (month 4) are detailed in Table 7.

Table 7 : Schedule of Key Financial Risks – Month 4 2016-17

Risk	Probability	Impact	Risk	RAG	Detail of Risk	Mitigation
The achievement of meeting the Financial Gap recurrently.	4	4	16	R	£12.992m of savings have been identified, of which £7.499m have been risk rated red. £8.508m remains unidentified. We expect that some of this funding gap will be met by a combination of new schemes which will be brought forward, together with the implementation and acceleration of schemes which are included in the table but are not currently quantified. These schemes are unlikely to resolve the total gap meaning we have significant risk of non-delivery against the financial savings target in 2016/17. It is therefore essential that this risk is widely understood across the economy and all efforts channelled in addressing this problem to ensure the provision of clinically safe and sustainable services for our residents.	As part of the Commissioning Improvement Scheme (CIS), GP's along with Commissioners are developing schemes to improve care for patients and achieve the required financial gap in 2016/17.
Over Performance of Acute Contract	3	4	12	A	3 months SLAM data is available for 2016/17, however based on historic data and trends this is one area that is potentially volatile and could therefore create an additional pressure on the ICF in 2016/17. Despite £0.7m of year to date overspend we are currently forecasting that the TFT contract will be in line with plan by year end. If there is an over performance on the TFT contract a 50% premium will be paid.	Both finance and activity data when available for 2016/17 will be monitored and challenged where necessary. The CCG has a 1% uncommitted reserve and a 0.5% contingency that have been set aside as per NHSE guidance. The initial plan would be to utilise this funding to offset such pressures, but confirmation from NHSE would be required. It is anticipated transformational funding will be received which will enable investment in areas to redesign services that will provide savings and better services for patients.
Not receiving Transformation funding	2	4	8	A	It is anticipated transformational funding will be received in 2016/17. A decision is anticipated by 31st August.	There is the potential to use some LA funding to bridge the gap temporarily with the remainder of the £49m to follow later. The CCG, TFT and TMBC are working closely with the GM Health and Social Care Partnership team and confirmation of how much funding will be received will be confirmed in August 2016.
Over spend against GP prescribing budgets	3	5	15	R	Despite a QIPP scheme of £1m being set for 2016/17 for prescribing, the costs in the final quarter of 2015/16 increased considerably more than planned. The CCG has incurred a cross year pressure of £216k on prescribing and is forecasting a year end over spend of £500k. Therefore there is a significant financial risk on prescribing in 2016/17.	A number of practices have or are looking to use a practice based pharmacist to review prescriptions, along with the ongoing work with the Medicines Management team. This will hopefully drive costs down and identify additional areas for savings.
Over spend against Continuing Health Care budgets	2	3	6	A	CHC was a cost pressure in 2015/16 to the CCG. Budgets have been set based on outturn plus a level of growth.	Budgets have been set at outturn plus and an element of growth and there is a provision on the balance sheet for potential restitution claims. A full detailed analysis of the Non CHC and CHC database is taking place in July 2016 between finance and the CHC team. This should ensure a robust forecast is produced and all known information recorded accurately.

Operational risk between joint working.	1	5	5	A	The Integrated Commissioning Fund and integrated working is a new way of working and reporting, bringing together different cultures and different methods of accounting, which therefore bring with it an element of risk.	Working relationships between the CCG and TMBC are very good. There are numerous meetings, and committees which both members regularly attend, contribute and make decisions. Therefore this should mitigate any risk with joint working.
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	4	4	16	R	If the QIPP target and risks stated above are not mitigated the CCG would fail to achieve its mandated 1% surplus.	If all of the above risks are mitigated as explained then by default the CCG would achieve a 1% surplus and the ICF would have a balanced budget.
In year cuts to Council Grant Funding	2	3	6	A	In 2015/16 the Public Health grant was reduced by £1m part way through the financial year. The Council had to fund committed expenditure through use of existing reserves.	The Council maintains earmarked reserves, although these should not be viewed as a long term solution. Discussions are ongoing about more flexible contractual arrangements to enable easier withdrawal to mitigate the effect of similar reductions in the future.
Care Home placement costs are dependent on the current cohort of people in the system and can fluctuate throughout the year	3	4	12	A	Expenditure on Residential and Nursing care home placements accounts for a significant proportion of Adult Social Care spend. The Council aims to manage placement profiles by offering community based services as an alternative wherever possible. In some cases however this is not possible due to the complexity of individual needs.	Continued development of the community based offer and use of technology where appropriate to support self-management of care. It is accepted however that it is not possible to fully mitigate the risk of additional placements.
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A	The current number of LAC supported by the Council is 445. This includes Fostering and Adoption placements as well residential care homes. Numbers have increased by 10 since April 2016 with some individual placement costs in excess of £0.200m per year. The service is also exposed to the risk of unexpected and complex needs placements.	Multi-agency approach around Troubled families as part of GM approved model in order to intervene earlier in the child's life and prevent the need for costly interventions (such as care home placements). Incentives of the fostering service to increase placements via this route rather than costlier residential placements,
Unaccompanied Asylum Seekers	4	3	12	A	There will be a financial impact on the Tameside Economy as unaccompanied Asylum Seekers are accommodated within the borough. There is a risk that associated Central Government funding does not equate to related expenditure incurred by the Council and CCG.	Central Government funding will be received to support related expenditure. The economy will need to ensure services are delivered within resource allocations received.
Provider Market Failure	2	5	10	A	The economy commissions services from the private provider sector e.g. Homecare, Residential and Nursing Care, Children's Residential placements. Internal intelligence suggests that some providers are anticipating financial strain due to the impact of delivering services within commissioned payment rates (e.g. impact of national living wage etc).	A review is underway to reconfigure service delivery requirements from the private sector market to ensure it aligns with the strategic commissioning objectives of the Integrated Care Organisation. The associated fee structure aligned to the revised market provision will also be considered within this review to ensure stability within the market.
Underperformance on Trust Efficiency Savings programme	4	5	20	R	The Trust has a £7.8m savings programme, with c.£1.5m of high risk schemes. The Trust forecast assumes delivery of the total value of the savings.	There is a rolling programme of identification of new schemes. The Trust is also working with other GM organisations involved in the national NHS Financial Improvement Programme to identify further savings.
Independent sector	3	4	12	A	The Trust has incurred £480k of expenditure with the	The Trust is having ongoing discussions with the

expenditure not funded by commissioners					independent sector to July 2016. The Trust does not have budget for this. The 2016/17 contract was reduced to enable commissioners to contract directly with the IS. If this expenditure continues at the same rate, it is estimated the full year expenditure will be £1.1m.	commissioners to agree a financial position with relation to use of the independent sector. Internally, there is ongoing review of the activity required to deliver the performance targets. The Trust Efficiency programme will also potentially support this.
Total proposed value of Sustainability and Transformation Funding (STF) not received	3	5	15	R	It is anticipated the £6.9m STF will be received in full. This is dependent on achieving the planned financial control total and delivering the trajectories for A&E, RTT and Cancer.	A number of action plans are in place to support delivery of the performance targets (A&E action plan, RTT/Cancer monitoring and mitigation in place). Performance is monitored and challenged at all levels of the organisation from operational teams to the Board.
Additional unplanned expenditure due to winter pressures	4	4	16	R	The Trust has traditionally incurred additional expenditure over the winter period due to unplanned for pressures.	Several prior year schemes to reduce the impact of winter pressures have been funded an implemented. The Trust's winter resilience plans are also continuously monitored through the SRG. The Trust also has a de-escalation plan in progress to free up bed capacity, and the IUCT workstream will also support winter resilience.
Additional investment decisions agreed without identified funding	2	4	8	G	All the Trust's budget is allocated against planned expenditure and there is no contingency funding available for new investments.	The Trust has enhanced the governance process for approving additional investment and financial control. The Executive Management Team have communicated the recognition of the organisation's financial deficit position, and commitment of all budgets in 2016/17.
Unmitigated divisional overspends.	3	4	12	G	There are several areas of overspend within the Trust. Currently these overspends are offset by benefits relating to vacancies. However, recruitment to the vacancies are ongoing so this is not a sustainable position for the remainder of the year.	The Trust Efficiency programme supports the delivery of cash releasing savings schemes, to reduce expenditure and bring into line with budget. The Divisions report against a divisional performance framework to monitor and challenge overspending areas.

7 RECOMMENDATIONS

7.1 As stated on the report cover.

APPENDIX A

Summary of CCG Financial Position

NHS Tameside & Glossop CCG 2016/17 Financial Position									
	Year to Date (M4)				Year End			Movement	
	£000's	£000's	£000's		£000's	£000's	£000's	£000's	£000's
Description	Budget	Actual	Variance		Budget	Forecast	Variance	Previous Month	Movement in Month
Funding									
Programme Allocation	116,690	116,690	0		345,457	345,457	0	0	0
Admin Allocation	1,497	1,497	0		5,162	5,162	0	0	0
PC Co-Commissioning Allocation	10,307	10,307	0		30,922	30,922	0	0	0
Total Allocation	**128,494**	**128,494**	**0**		**381,541**	**381,541**	**0**	**0**	**0**
Expenditure									
Acute	66,044	66,788	(744)		198,348	198,622	(274)	(185)	(89)
Mental Health	9,699	9,732	(33)		29,096	29,300	(203)	(134)	(69)
Primary Care	26,908	27,461	(553)		80,379	80,969	(590)	(437)	(153)
Continuing Care	4,864	4,927	(63)		14,236	14,442	(206)	(207)	1
Community	9,125	9,122	2		27,357	27,362	(5)	0	(5)
Other	9,194	7,686	1,508		23,471	22,688	783	557	226
QIPP	0	4,500	(4,500)		0	12,893	(12,893)	(13,010)	117
Total Programme Costs	**125,833**	**130,216**	**(4,383)**		**372,888**	**386,276**	**(13,388)**	**(13,416)**	**28**
Running Costs	**1,497**	**1,614**	**(117)**		**5,162**	**4,737**	**425**	**406**	**19**
Total Costs (Admin + Programme)	**127,330**	**131,830**	**(4,500)**		**378,050**	**391,013**	**(12,963)**	**(13,010)**	**47**
Surplus / (Deficit)	**1,164**	**(3,336)**	**(4,500)**		**3,491**	**(9,472)**	**(12,963)**	**(13,010)**	**47**

APPENDIX B

Summary of TMBC Financial Position (ICF Fund Only)

Directorate	Work Group	Revenue Budget total	Actual	Projected outturn	Variance
		£'000	£'000	£'000	£'000
Adult Social Care	Adults Budget Strategy	(12,614)	(3,477)	(11,062)	(1,552)
Adult Social Care	Adults Performance & Development	1,326	357	1,226	100
Adult Social Care	Adults Senior Management	531	199	539	(8)
Adult Social Care	Supporting People	3,141	3,025	3,140	1
Adult Social Care	Adults Transport	335	92	333	2
Adult Social Care	Assessment & Care Management Contracts	742	279	714	28
Adult Social Care	CCTV	232	117	292	(60)
Adult Social Care	CHC Funding	27	19	27	0
Adult Social Care	Community Support	871	(410)	892	(21)
Adult Social Care	Dowries	169	(14)	169	0
Adult Social Care	FNC	0	148	18	(18)
Adult Social Care	Homecare	3,939	1,008	3,744	195
Adult Social Care	Localities	6,812	2,361	6,781	31
Adult Social Care	Long Term Support	3,818	1,040	4,017	(199)
Adult Social Care	Mental Health	2,290	712	2,233	57
Adult Social Care	Residential & Nursing Care	14,080	5,329	14,467	(387)
Adult Social Care	Occupational Therapy & Sensory Services	1,016	312	967	49
Adult Social Care	Residential and Day Services - Day Services	1,244	424	1,266	(22)
Adult Social Care	Residential and Day Services - Homemakers	5,049	1,016	4,890	159
Adult Social Care	Supported Accommodation	6,492	1,031	5,973	519
Adult Social Care	Urgent Care	2,480	743	2,617	(137)
Total		**41,980**	**14,311**	**43,243**	**(1,263)**
Public Health	Adult Pooled Treatment Budget	0	(27)	0	0
Public Health	Public Health Contracts	0	1,933	0	0
Public Health	Public Health Manager	(13,938)	(7,513)	(13,633)	(305)
Public Health	Public Health Non Prescribed	12,254	2,212	11,983	271
Public Health	Public Health Prescribed	2,019	173	2,036	(17)
Public Health	Sport	1,304	880	1,490	(186)
Total		**1,639**	**(2,342)**	**1,876**	**(237)**
Childrens Social Care	Adoption	1,060	432	1,056	4
Childrens Social Care	Assistant Executive Director - Children's	128	60	133	(5)
Childrens Social Care	Children with Disabilities	2,237	715	1,982	255
Childrens Social Care	Childrens - Safeguarding	448	76	479	(31)
Childrens Social Care	Children's Centre Services	0	168	(39)	39
Childrens Social Care	Childrens Home	1,181	462	1,390	(209)
Childrens Social Care	Childrens Legal Fees	228	88	227	1
Childrens Social Care	Children's Services Administration	1,004	273	894	110
Childrens Social Care	Childrens Social Work	2,416	832	2,603	(187)
Childrens Social Care	Early Help Contracts	130	46	106	24
Childrens Social Care	Early Help Services	1,081	498	1,010	71
Childrens Social Care	Early Years Team	160	53	160	0
Childrens Social Care	Fostering Services	600	189	587	13

Childrens Social Care	LAC Support Teams	1,089	329	1,054	35
Childrens Social Care	Local Safeguarding Children's Board	123	87	123	0
Childrens Social Care	Participation and Partnerships	47	0	24	23
Childrens Social Care	Placements Costs	13,322	4,677	13,723	(401)
Childrens Social Care	Social Work Child In Need	0	1	3	(3)
Childrens Social Care	Strategy & Early Intervention Management	374	85	340	34
Childrens Social Care	Troubled Families	0	(599)	0	0
Childrens Social Care	Young Carers	113	44	122	(9)
Childrens Social Care	Youth Offending Team	136	196	208	(72)
Total		**25,877**	**8,712**	**26,185**	**(308)**
TMBC Total		**69,496**	**20,681**	**71,304**	**(1,808)**

APPENDIX C

Reconciliation of the Integrated Commissioning Fund

Description	Value	Notes
	£000's	
Original ICF Value	**435,519**	**Based on 8th February Submission**
Amendment to CCG Surplus	1,239	Reduce from £4,730k to £3,491k
TMBC Adjustment	1,798	Includes inclusion of CCTV Operations
Final Adjustments	1,830	Confirmation of final contract values and amendments to BCF values
Month 1 ICF Budget	**440,386**	**Based on Final 11th April Submission**
CCG Allocation Correction	(31)	Tier 3 Specialist Wheelchairs Correction
TMBC M2 Budget Adjustment	175	Severance Budget Allocation & CCTV Adjustments
Month 2 ICF Budget	**440,530**	**As per month 2 Integrated Single Finance Report**
CCG Allocation	141	eating disorder service Q1
CCG Allocation	53	Pain management immunosuppressants
CCG Allocation	18	Supporting Primary Care and LCPO development
CCG Allocation	807	7 day access funding
CCG Allocation	(24)	GM Stroke risk share
CCG Allocation	(40)	GM CHC Risk share
CCG Allocation	890	MH Stocktake
Month 3 ICF Budget	**442,375**	**As per month 3 Integrated Single Finance Report**
TMBC Cost Pressures Funding	5,172	Subject to Executive Cabinet approval on 31 Aug 2016
Month 4 ICF Budget	**447,547**	**As per month 4 Integrated Single Finance Report**

ICF Budget Reference	ICF Budget	CCG Net Budget 2016/17	TMBC Net Budget 2016/17	Total Net Budget 2016/17
		£m	£m	£m
A	**Section 75 Services**	**190.216**	**42.244**	**232.460**
B	**Aligned Services**	**156.183**	**27.252**	**183.436**
C	**In Collaboration Services**	**31.650**	**0.000**	**31.650**
		378.05	**69.496**	**447.547**

APPENDIX D

Glossary

Abbreviation	Description
AQP	Any Qualifying Provider
BCF	Better Care Fund
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CIP	Cost Improvement Programme
CIS	Commissioning Improvement Scheme
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
CT	Care Together
DC	Daycase
DDRB	Doctors and Dentists Review Body
DES	Direct Enhanced Service
EL	Elective
GM	Greater Manchester
GMSS	Greater Manchester Shared Service
GP	General Practitioner
IAT	Inter Authority Transfer
ICF	Integrated Commissioning Fund
ISFE	Integrated Single Financial Environment
MfA	Manual For Accounts
MH	Mental Health
MMC	Medicines Management Committee
NEL	Non Elective
NHSE	National Health Service England
NMP	Non Medical Prescribing
ODN	Operational Delivery Network
OP	Outpatient
PBR	Payment By Results
PES	Paramedic Emergency Services
PMD	Prescribing Monitoring Document
PPA	Prescription Pricing Authority
PRG	Professional Reference Group
QIPP	Quality, Innovation, Productivity, Prevention
QOF	Quality and Outcomes Framework
RADAR	Rapid Access Detoxification Acute Referral
SCB	Single Commissioning Board
SFT	Stockport Foundation Trust
SHMI	Summary Hospital Level Mortality Index
SLA	Service Level Agreement
SLAM	Service Level Agreement Monitoring
TFT	Tameside & Glossop Foundation Trust
UHSM	University Hospital South Manchester Foundation Trust
WTE	Whole Time Equivalent
WWL	Wrightington, Wigan and Leigh Foundation Trust

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Report to: **SINGLE COMMISSIONING BOARD**

Date: 6 September 2016

Reporting Member / Officer of Single Commissioning Board Angela Hardman Executive Director, Public Health and Performance

Subject: **DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**

Report Summary:

This paper provides an update on CCG assurance and performance, based on the latest published data (at the time of preparing the report). The June position is shown for elective care and an August "snap shot" in time for urgent care.

Also attached to this report is a CCG NHS Constitution scorecard, showing CCG performance across indicators.

This month's update includes referral data and a section on care homes.

The assurance framework for 2016/17 has been published nationally however; we are awaiting the framework from GM Devolution.

Performance issues remain around waiting times in diagnostics and the A&E performance.

	RTT Incomplete	52WW	Diagnostic	A&E
Standard	**92%**	**0**	**1%**	**95%**
Actual	**92.4%**	**0**	**2.36%**	**89.09%**

The number of our patients still waiting for planned treatment 18 weeks and over continues to decrease and the risk to delivery of the incomplete standard and zero 52 week waits is being reduced.

Cancer standards were achieved in June apart from 62 day screening. Quarter 1 performance achieved.

Endoscopy is still the key challenge in diagnostics particularly at Central Manchester.

A&E Standards were failed at THFT.

Financial Year to 07th August16	April 2016/17	May 2016/17	June 2016/17	July 2016/17	August to 07th 2016/17
89.09%	92.46%	92.16%	86.61%	84.98%	84.99%

Attendances and NEL admissions at THFT (including admissions via A&E) have increased.

The number of Delayed Transfers of Care (DTOC) recorded remains higher than plan.

Ambulance response times were not met at a local or at North West level.

Recommendations:	Note the 2016/17 CCG Assurance position. Note performance and identify any areas they would like to scrutinise further.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.
Legal Implications: (Authorised by the Borough Solicitor)	It is critical to raising standards whilst meeting budgetary requirements that we develop a clear outcome framework that is properly monitored and meets the statutory obligations and regulatory framework of all constituent parts.
How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.

Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17
Access to Information :	The background papers relating to this report can be inspected by contacting Ali Rehman Telephone: 01613663207 e-mail: alirehman@nhs.net

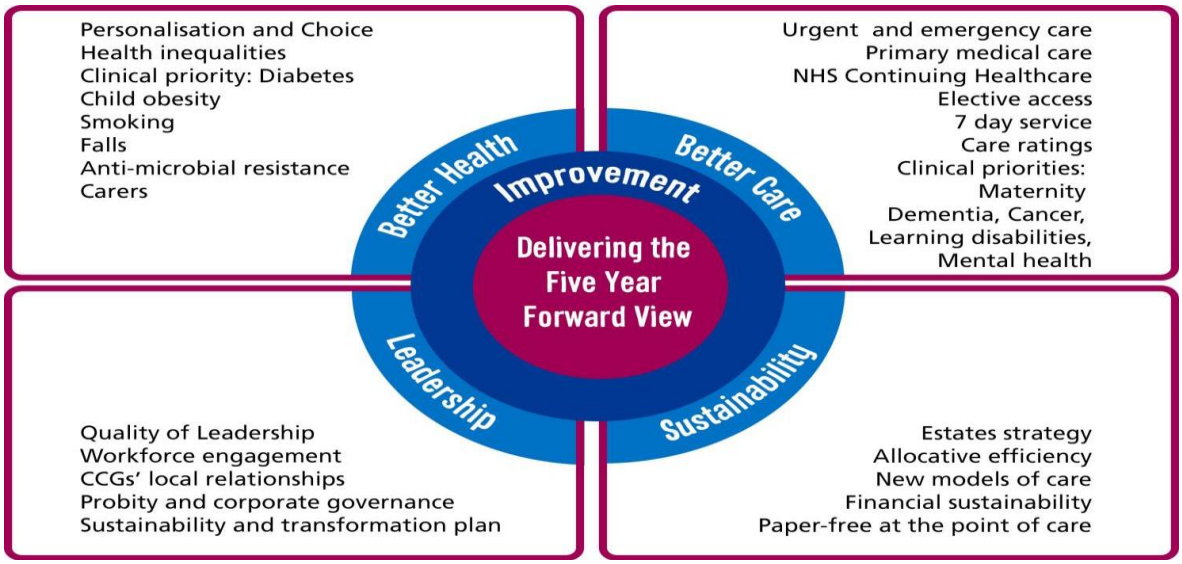
1. INTRODUCTION

1.1 This paper provides an update on CCG assurance and performance, based on the latest published data (at the time of preparing the report). The June position is shown for elective care and an August "snap shot" in time for urgent care. It includes a focus on current waiting time issues for the CCG.

1.2 It should be noted that providers can refresh their data in accordance with national guidelines and this may result in changes to the historic data in this report.

2 CCG ASSURANCE

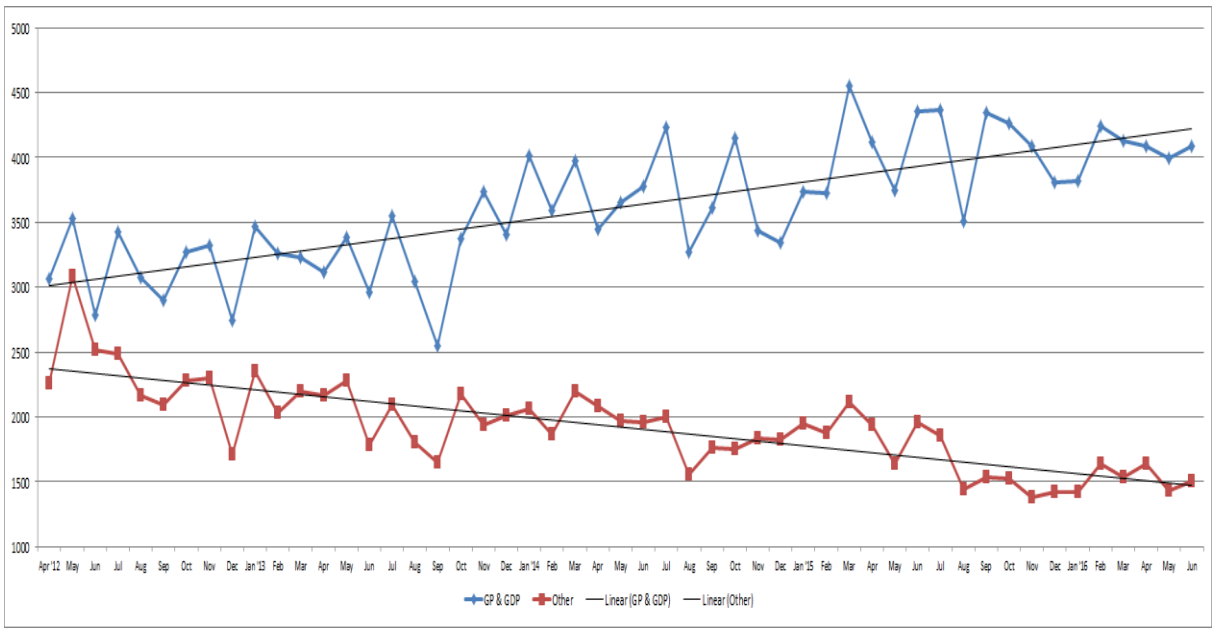
2.1 The assurance framework for 2016/17 has been published nationally however, we are awaiting the framework from GM Devolution. A recent WebEx led by NHS England provided further info on the new assessment framework for 16/17. CCGs will be assessed in relation to four key areas of their functions and responsibilities, health, care, sustainability and leadership. The overall rating for 2016/17 and metrics will be transparent and published on My NHS. Six clinical priorities will have independent moderation to agree an annual summative assessment. Below is the framework NHS England intend to use.

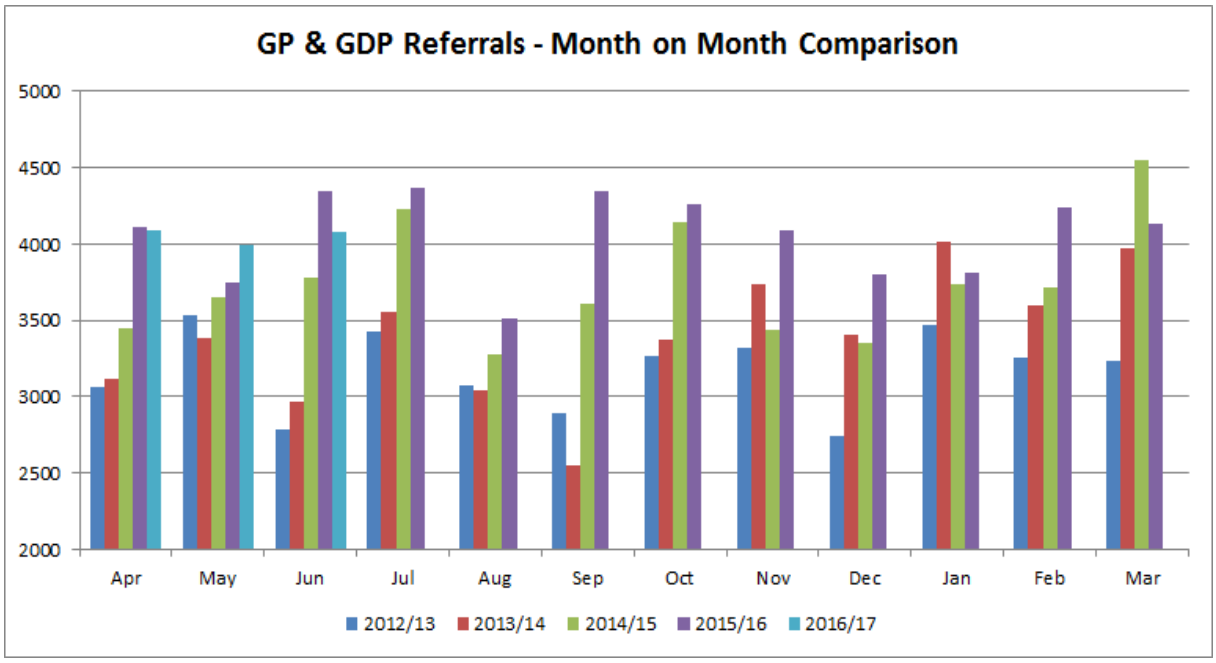


3 CURRENT CCG PERFORMANCE

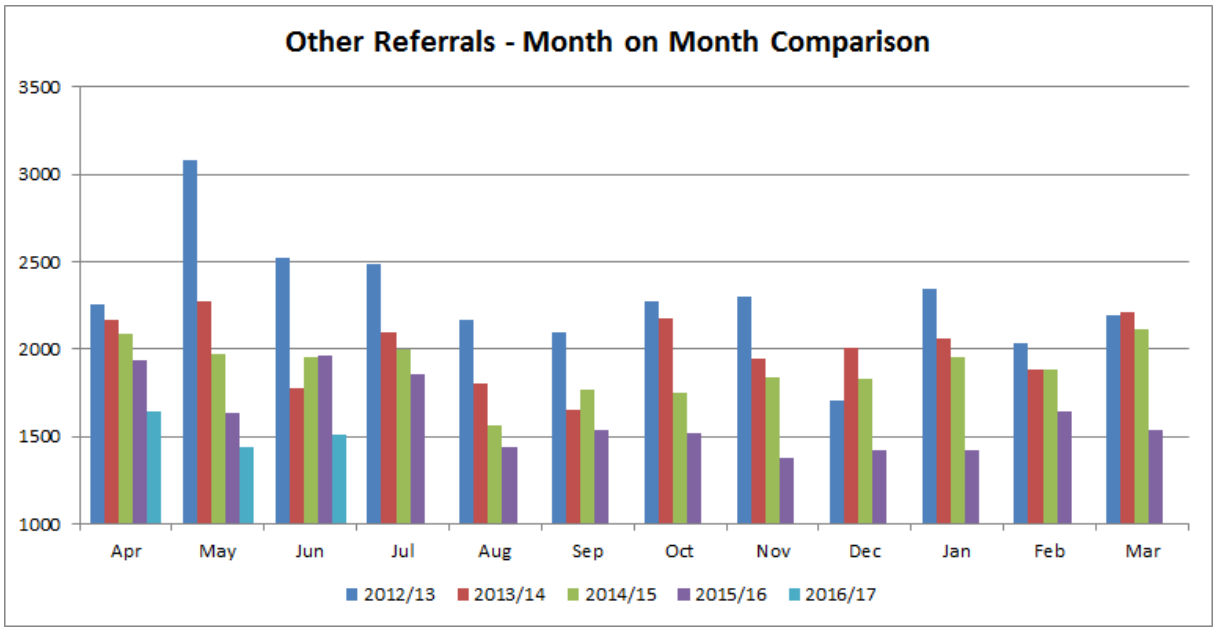
Referrals

3.1 GP/GDP referrals to TFT only have decreased during the month of June compared to the same period last year, however referrals have been on upward trend. Referral data is analysed at practice and specialty level and shared with practices.



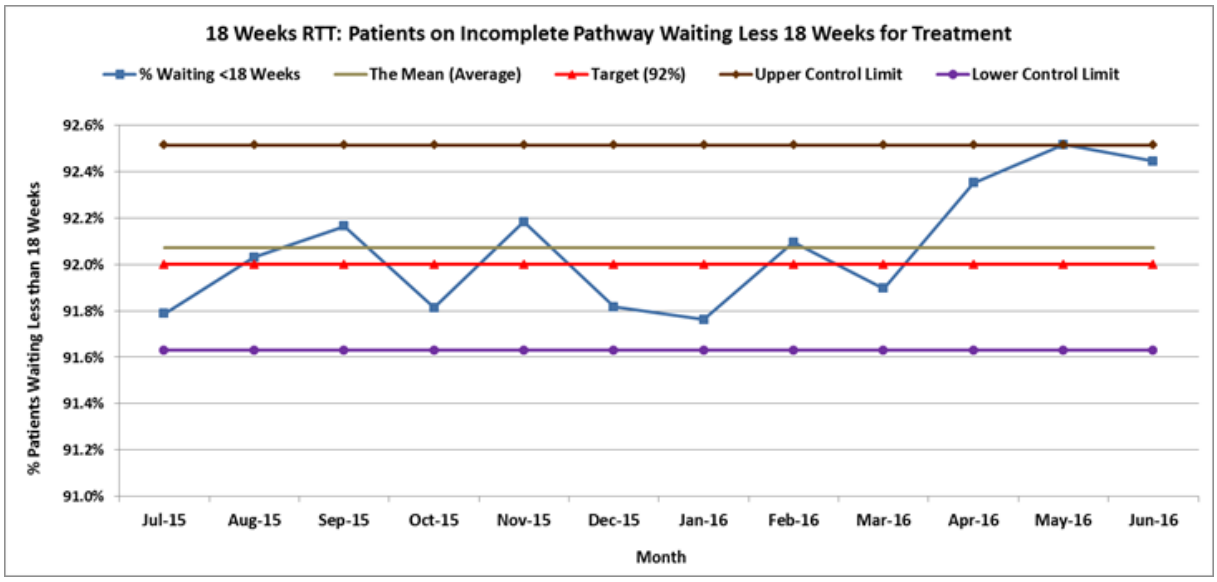


3.2 Other referrals (TFT only) have decreased during the month of June compared to the same period last year. This is a continuing trend.



Elective Care – please note the June position is the latest available data.

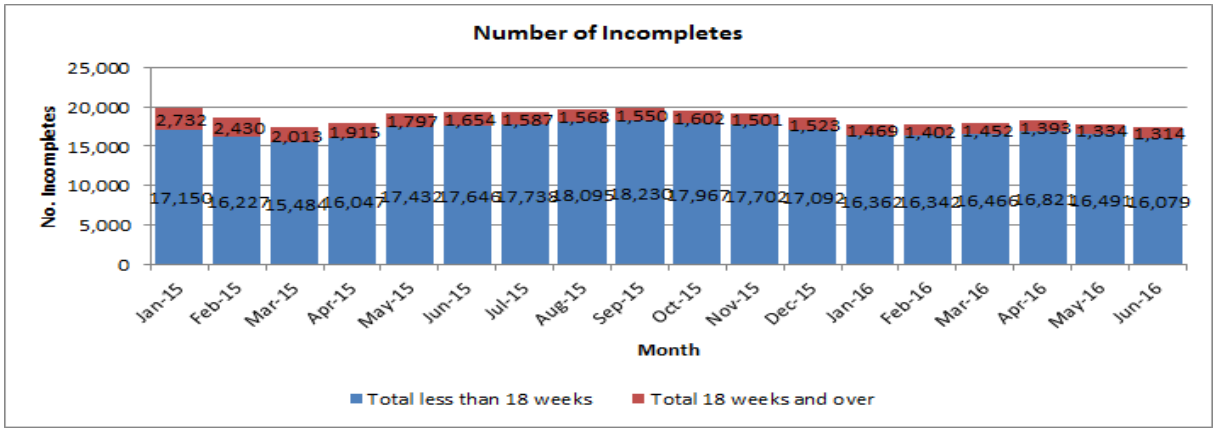
3.3 In June the CCG achieved the incompletes standard at 92.45% and THFT continued to achieve at 93.03%. The National RTT stress test demonstrates the trust are continuing to reduce the risk of failing RTT, this will have a positive impact on CCG performance.



	Incomplete (Standard 92%)	
	CCG Actual	**THFT Actual**
Apr	89.34%	87.50%
May	90.65%	89.30%
Jun	91.44%	90.70%
Jul	91.79%	91.30%
Aug	92.03%	92.10%
Sep	92.16%	92.22%
Oct	91.81%	92.2%
Nov	92.18%	92.8%
Dec	91.8%	92.2%

Jan	91.8%	92.7%
Feb	92.1%	92.4%
Mar	91.9%	92.5%
Apr	92.4%	92.9%
May	92.5%	92.9%
June	92.4%	93.0%

3.4 The total number of incompletes for the CCG has stabilised and slightly decreased this is primarily due to the decrease in under 18 weeks. The over 18 weeks has decreased slightly. There has been a decrease in over 40 week waiters and the 28 to 40 waits have increased.



	T&G Patients at all Providers																	
Weeks Wait	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
52+ Weeks	29	18	6	6	5	1	1	0	1	2	0	1	0	2	0	1	0	0
40+ Weeks (inc. 52+	149	118	90	126	101	92	61	45	39	30	28	42	47	51	49	34	31	24
28-40 Weeks	680	642	512	525	486	422	307	300	307	272	295	341	339	255	245	265	274	251
18-27 Weeks	1903	1670	1411	1264	1210	1140	1219	1223	1204	1300	1178	1140	1083	1096	1158	1094	1029	1039
14-17 Weeks	2395	1959	1884	1254	1828	1987	1890	2039	2242	2288	2038	2051	2191	1930	1836	1424	1670	1591
0-13 Weeks	14755	14268	13600	14793	15604	15659	15848	16056	15988	15679	15664	15041	14171	14412	14630	15397	14821	14488
Total	19882	18657	17497	17962	19229	19300	19325	19663	19780	19569	19203	18615	17831	17744	17918	18214	17825	17393

3.5 There were no patients waiting more than 52 weeks for treatment.

3.6 Tameside expects to report zero 52-week waits for June. However the risk of 52 week waiters remains with ten patients at 43 to 47 weeks. Also there are 47 patients waiting over 36 weeks without a decision to admit. Earlier this year the University Hospitals of South Manchester FT identified a data quality issue of patients who had been waiting >52 weeks not being identified. UHSM, NHSE, Monitor, and SMCCG have been addressing this matter. Following identification of this issue earlier this year, intensive validation work was carried out at the Trust and are still finding new >52 week pathways. As of 1 August 2016, five patients had been waiting longer than 52 weeks when treated. These were patients that we were not aware of when the last report was provided. We are being updated regularly on the position and are keeping a close eye on the issue.

	# of Patients Waiting by Specialty									% of Incomplete at 28
	0-18 Weeks	18-22 Weeks	23-27 Weeks	28-32 Weeks	33-37 Weeks	38-42 Weeks	43-47 Weeks	48-51 Weeks	52+ Weeks	
Cardiology	963	53	15	8	5	3	1	1	0	1.7%
Cardiothoracic Surgery	34	3	1	2	0	0	0	0	0	5.0%
Dermatology	838	18	7	2	5	0	0	0	0	0.8%
Ear, Nose & Throat (ENT)	1390	47	21	6	4	3	1	0	0	1.0%
Gastroenterology	706	26	7	3	1	1	0	0	0	0.7%
General Medicine	844	38	5	6	3	0	0	0	0	1.0%
General Surgery	2045	94	27	20	11	4	1	0	0	1.6%
Geriatric Medicine	7	1	0	0	0	0	0	0	0	0.0%
Gynaecology	1190	89	27	19	4	2	0	0	0	1.9%
Neurology	5	0	0	0	0	0	0	0	0	0.0%
Neurosurgery	32	0	0	1	0	0	0	0	0	3.0%
Ophthalmology	1182	17	6	2	4	0	2	0	0	0.7%
Oral Surgery	0	0	0	0	0	0	0	0	0	
Other	2662	84	53	27	9	3	4	0	0	1.5%
Plastic Surgery	148	7	5	0	2	0	0	0	0	1.2%
Rheumatology	260	11	3	4	2	0	0	0	0	2.1%
Thoracic Medicine	161	7	6	0	2	0	0	0	0	1.1%
Trauma & Orthopaedics	2482	170	67	41	17	6	1	1	0	2.4%
Urology	1130	86	38	23	5	3	0	0	0	2.4%
Total	**16,079**	**751**	**288**	**164**	**74**	**25**	**10**	**2**	**-**	**1.6%**

3.7 The specialities of concern with regard to current performance or Clearance Rate (how long to treat the total waiting list assuming no more were added and the number completed each week stays the same) are shown on the right. Clearance Rate is used as an indicator of future performance with 10 to 12 weeks usually being seen as the maximum to deliver performance however with specialities with low numbers this is less accurate. The clearance rates have recently improved.

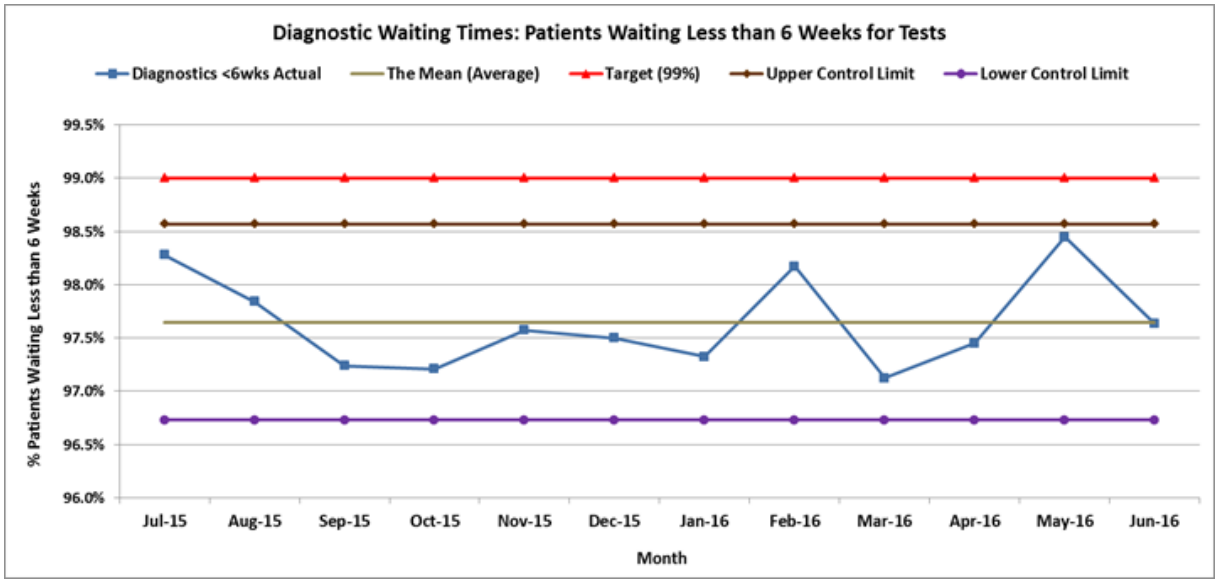
% of Patients waiting less than 18 weeks, by speciality, from All	Incomplete	Clearance Rates	
	Threshold 92%	Threshold 10-12 weeks	Change from last month
Cardiology	91.80%	15.37	⇧
Cardiothoracic Surgery	85.00%	5.52	⇩
Dermatology	96.32%	11.05	⇧
Ear, Nose & Throat (ENT)	94.43%	10.20	⇧
Gastroenterology	94.89%	7.69	⇧
General Medicine	94.20%	12.32	⇩
General Surgery	92.87%	7.34	⇩
Geriatric Medicine	87.50%	4.00	⇩
Gynaecology	89.41%	7.72	⇩
Neurology	100.00%	20.00	⇧
Neurosurgery	96.97%	8.80	⇩
Ophthalmology	97.44%	9.51	⇩
Oral Surgery			
Plastic Surgery	91.36%	8.42	⇩
Rheumatology	92.86%	9.91	⇩
Thoracic Medicine	91.48%	11.17	⇩
Trauma & Orthopaedics	89.12%	9.88	⇩
Urology	87.94%	13.35	⇩
Other	93.67%	10.42	⇩
Total	**92.45%**	9.73	⇩

3.8 Five of these are the specialities where THFT also failed the standard and still have a backlog. Whilst reducing the backlog for Gynaecology and Dermatology there appears to be a small backlog in Urology and Neurosurgery and Orthopaedics has increased. Overall the backlog at THFT has decreased by 5.

Specialty	Incomplete Performance	> 18 Weeks	< 18 Weeks	Total	June Backlog	May Backlog	Apr Backlog	Mar Backlog	Feb Backlog	Jan Backlog	Dec Backlog	Nov Backlog	Oct Backlog	Sept Backlog	August Backlog	July Backlog	June Backlog
General Surgery	94.38%	119	1967	2116									10	40	70	90	130
Urology	90.83%	70	693	763	9	7	7	30	30	40	20	5	25	10			
Orthopaedics	86.78%	251	1647	1898	100	100	89	120	130	140	160	150	180	210	210	190	240
ENT	94.47%	56	956	1012													
Ophthalmology	99.49%	3	580	583													
Oral Surgery	93.26%	41	567	608													
Neurosurgery	89.66%	3	26	29		2	1										
Plastic Surgery	89.09%	6	49	55	2	1						7	30	15			
CT Surgery	100.00%	0	18	18					5			1					
Adult Medicine	93.54%	51	738	789													
Gastroenterology	95.59%	32	694	726							6	30				10	35
Cardiology	94.36%	50	837	887							6		10	40	40	100	110
Dermatology	96.31%	34	887	921			9										
Rheumatology	94.44%	11	187	198													
Gynaecology	88.04%	132	972	1104	44	50	70	60	25								
Other	95..98%	59	1408	1467													
Trust	**93.03%**	**918**	**12256**	**13174**	155	160	176	210	190	180	192	193	255	315	320	390	515

Diagnostics- please note the June position is reported in this update.

3.9 In June we failed the diagnostic standard at 2.36% against 1.0% Standard for waiting 6 or more weeks. This was primarily due to Central Manchester Trust. This month we have seen increases in over 6 week waiters at Care UK and Pioneer Healthcare. Both of these providers have been contacted to understand the issues and what actions are being taken to rectify the problem.



Financial Year	2016	-	2017	Reporting Month	June	Choose Trust	All

Diagnostic Waiting - All Providers

All Providers		April 2016				May 2016				June 2016			
		# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks
Endoscopy	THFT	505	0	0	0.0%	452	0	0	0.0%	579	0	0	0.0%
	CMMC	40	12	38	55.6%	44	4	16	31.3%	28	3	3	17.6%
	Pennine Acute	8	3	0	27.3%	7	3	0	30.0%	9	3	0	25.0%
	Salford	6	0	0	0.0%	6	0	0	0.0%	3	0	0	0.0%
	South Mc.	6	0	0	0.0%	7	0	0	0.0%	5	0	0	0.0%
	Stockport	16	0	0	0.0%	15	0	0	0.0%	18	0	0	0.0%
	Ashton Primary Care Centre	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Care UK	4	0	0	0.0%	7	0	0	0.0%	7	0	0	0.0%
	Other	11	0	0	0.0%	4	1	0	20.0%	2	0	0	0.0%
	Total	596	15	38	8.2%	542	8	16	4.2%	651	6	3	1.4%
Non-Endoscopy	THFT	2448	28	0	1.1%	2622	29	0	1.1%	2654	28	0	1.0%
	CMMC	331	14	5	5.4%	332	7	6	3.8%	340	16	5	5.8%
	Pennine Acute	68	1	0	1.4%	86	0	0	0.0%	69	0	0	0.0%
	Salford	141	0	0	0.0%	146	0	0	0.0%	131	0	0	0.0%
	South Mc.	78	0	0	0.0%	84	2	0	2.3%	100	0	0	0.0%
	Stockport	149	0	0	0.0%	174	0	0	0.0%	204	1	0	0.5%
	Ashton Primary Care Centre	25	0	0	0.0%	54	0	0	0.0%	54	0	0	0.0%
	Care UK	456	0	0	0.0%	636	6	0	0.9%	709	50	0	6.6%
	Other	108	14	0	11.5%	81	1	0	1.2%	91	12	0	11.7%
	Total	3804	57	5	1.6%	4215	45	6	1.2%	4352	107	5	2.5%
	Overall Position	4400	72	43	2.55%	4757	53	22	1.55%	5003	113	8	2.36%

3.10 This means we failed every month last year and continue to fail this year, but there has been an increase in performance in April and May. June's performance deteriorated due to Care UK.

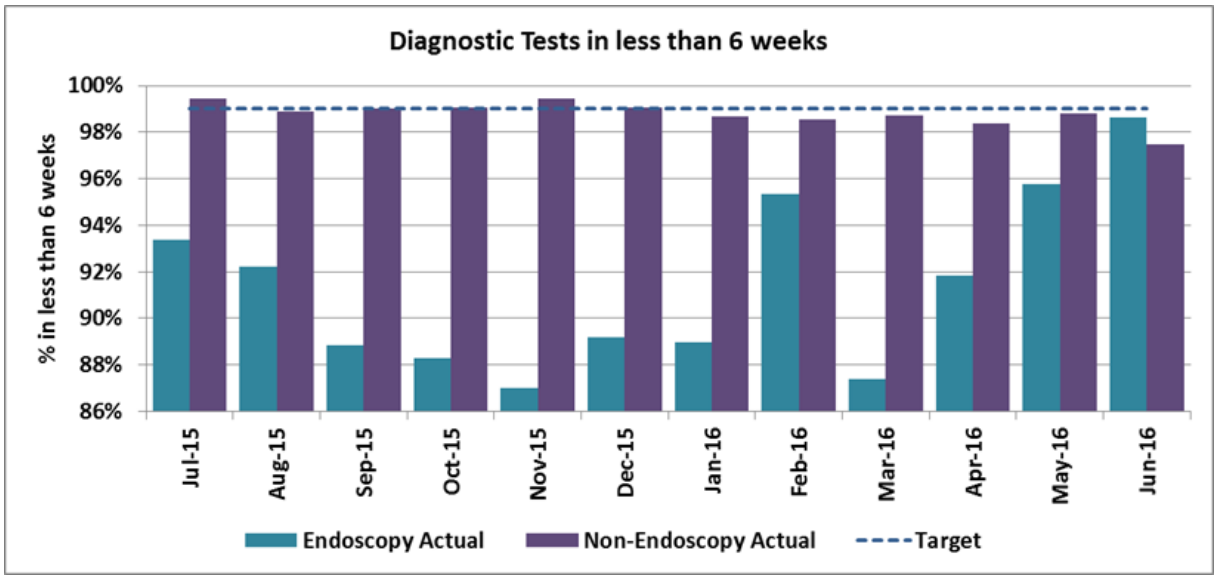
3.11 At the end of June 121 patients were waiting 6 weeks and over for a diagnostic test, eight of which were over 13 weeks. 27 were at Central Manchester Trust. Requests are continued to be made to obtain a copy of the action plan and trajectory from Central Manchester Trust including discussions with NHS England as their role as assurers of Lead CCGs.

Provider	Test	Total 6-13 weeks	Total13+ Weeks
CMMC	Cardiology - echocardiography	7	4
	Colonoscopy	2	3
	Gastroscopy	1	0
	Magnetic Resonance Imaging	8	0
	Urodynamics - pressures & flows	1	1
	Total	**19**	**8**
Pennine Acute	Colonoscopy	2	0
	Gastroscopy	1	0
	Total	**3**	**0**
Stockport	Cardiology - echocardiography	1	0
	Total	**1**	**0**
THFT	Audiology - Audiology Assessments	20	0
	Computed Tomography	2	0
	Neurophysiology - peripheral neurophysiology	5	0
	Non-obstetric ultrasound	1	0
	Total	**28**	**0**
Care UK	Audiology - Audiology Assessments	1	0
	Magnetic Resonance Imaging	49	0
	Total	**50**	**0**
Other	Magnetic Resonance Imaging (RGT Cambridge University Hospitals FT)	2	0
	Neurophysiology - peripheral neurophysiology (NEY Pioneer Healthcare Limited)	10	0
	Total	**12**	**0**
	Grand Total	**113**	**8**

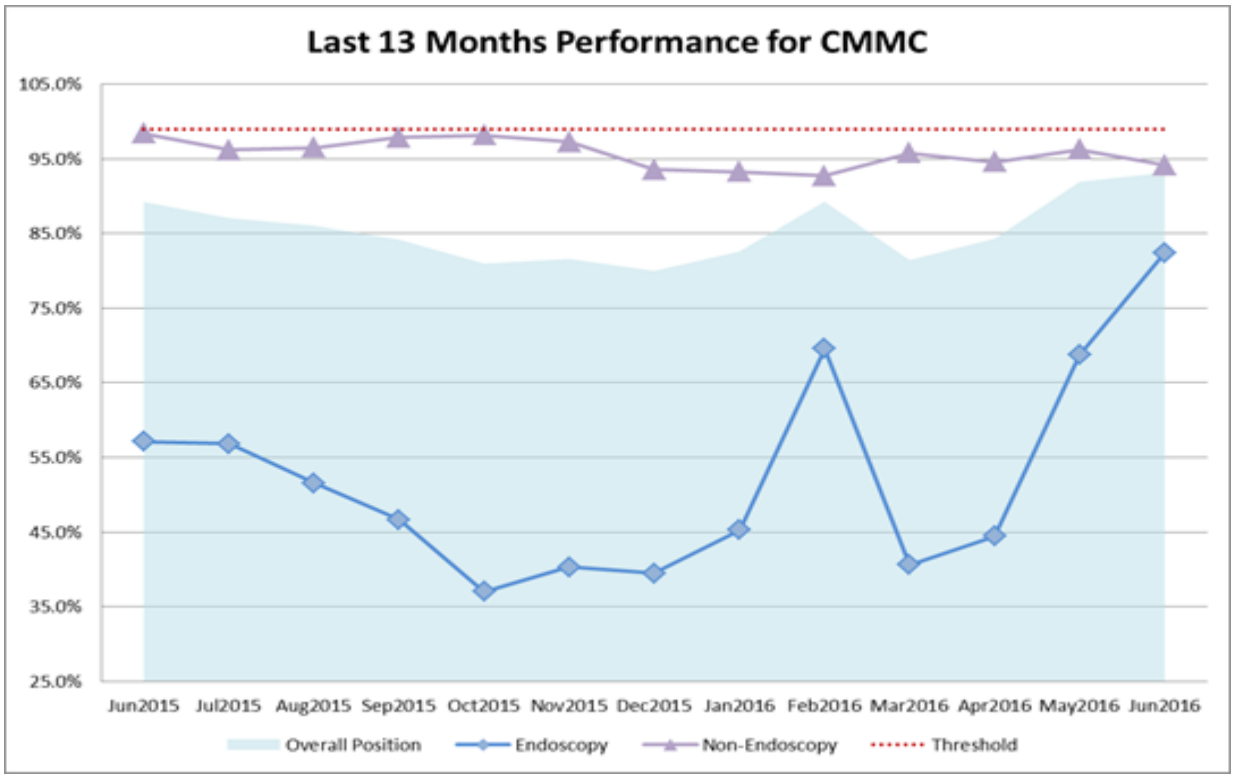
3.12 The backlog in endoscopy appears to have decreased and now accounts for 7% of breaches. Central Manchester Trust has agreed with a private provider to undertake additional activity to help with the backlog clearance. They expect to clear the backlog by the end of July 2016.

Diagnostic Waiting - All Tests for All

	All Providers	April 2016				May 2016				June 2016			
		# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks	# Waiting < 6 weeks	# Waiting 6-13 weeks	# Waiting >13 weeks	% Waiting > 6 weeks
Endoscopy	Colonoscopy	263	7	21	9.6%	228	3	10	5.4%	281	4	3	2.4%
	Cystoscopy	57	0	0	0.0%	46	0	0	0.0%	52	0	0	0.0%
	Flexi sigmoidoscopy	46	3	3	11.5%	8	3	3	42.9%	61	0	0	0.0%
	Gastroscopy	230	5	14	7.6%	260	2	3	1.9%	257	2	0	0.8%
	Total	**596**	**15**	**38**	**8.2%**	**542**	**8**	**16**	**4.2%**	**651**	**6**	**3**	**1.4%**
Non-Endoscopy	Audiology - Audiology Assessments	372	13	0	3.4%	306	20	0	6.1%	329	21	0	6.0%
	Barium Enema	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Cardiology - echocardiography	458	1	3	0.9%	579	2	3	0.9%	515	8	4	2.3%
	Cardiology - electrophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Computed Tomography	737	2	0	0.3%	797	1	0	0.1%	831	2	0	0.2%
	DEXA Scan	84	0	0	0.0%	105	0	0	0.0%	108	0	0	0.0%
	Magnetic Resonance Imaging	1035	14	0	1.3%	1289	8	1	0.7%	1320	59	0	4.3%
	Neurophysiology - peripheral neurophysiology	165	27	0	14.1%	128	12	0	8.6%	158	15	0	8.7%
	Non-obstetric ultrasound	919	0	0	0.0%	972	0	0	0.0%	1059	1	0	0.1%
	Respiratory physiology - sleep studies	27	0	0	0.0%	34	1	0	2.9%	30	0	0	0.0%
	Urodynamics - pressures & flows	7	0	2	22.2%	5	1	2	37.5%	2	1	1	50.0%
	Total	**3804**	**57**	**5**	**1.6%**	**4215**	**45**	**6**	**1.2%**	**4352**	**107**	**5**	**2.5%**
	Overall Position	**4400**	**72**	**43**	**2.55%**	**4757**	**53**	**22**	**1.55%**	**5003**	**113**	**8**	**2.36%**



3.13 THFT performance in endoscopy has stayed the same as last month and Central Manchester showing a slight increase in performance.



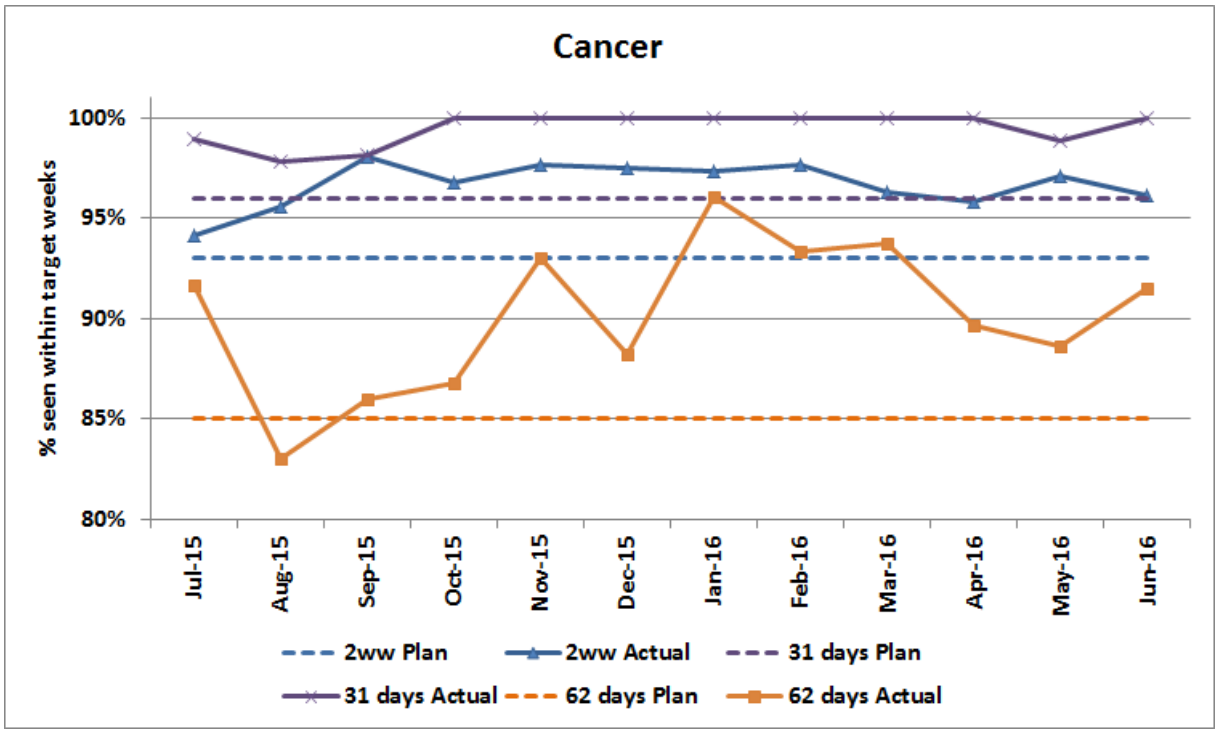
3.14 The latest update received from CMFT as at 21 April 2016 is as follows. The trust has undertaken a clinical validation of the entire endoscopy waiting list, the outcome of this validation is that 714 patients (Trust total) were identified that required transferring to the active list, and 170 of which are priority. To address the back log the trust has taken the following steps:

- The trust is transferring patients from the planned list to the active list and will report them in the next submission.
- An extension to the arrangement with the independent sector for extra capacity.
- The balancing of waiting lists across the MRI and Trafford Endoscopy units continues.
- The director of performance now heads up a weekly meeting to review all aspects.
- Administrative and reporting routines have been improved/adapted.

The trust expect that they will be able to ensure resolution by end of June 2016. They are developing a weekly trajectory in the next few weeks.

Cancer- please note the June position is reported in this update

3.15 We achieved all the standards In June apart from 62 day screening but achieved all standards in Quarter 1.



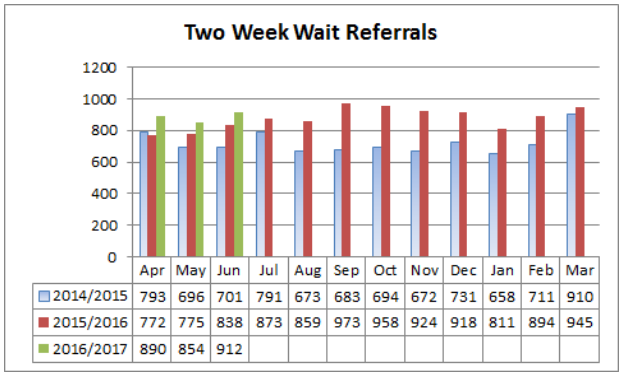
3.16 Our full performance is shown below with all standards achieved apart from 62 day screening. Quarter 1 standards achieved.

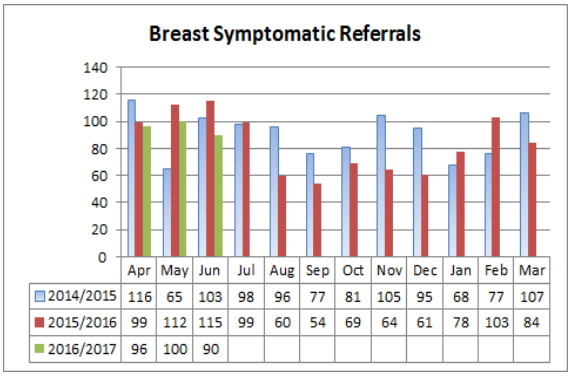
		Performance					No. of patients not receiving care within standard in Apr
Indicator Name	**Standard**	**March 15/16**	**April 16/17**	**May 16/17**	**June 16/17**	**Q1 16/17**	
Cancer 2 week waits	93.00%	96.3%	95.82%	97.07%	96.12%	96.34%	33
Cancer 2 week waits - Breast symptoms	93.00%	98.88%	93.88%	98.00%	95.79%	95.92%	4
Cancer 62 day waits – GP Referral	85.00%	93.75%	89.66%	88.64%	91.49%	90.00%	4
Cancer 62 day waits - Consultant upgrade	85.00%	88.24%	83.33%	86.67%	94.44%	88.24%	1
Cancer 62 day waits - Screening	90.00%	100%	100%	100%	60.00%	87.50%	2
Cancer day 31 waits	96.00%	100%	100%	98.89%	100%	99.65%	0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	0

3.17 Tameside achieved all the standards.

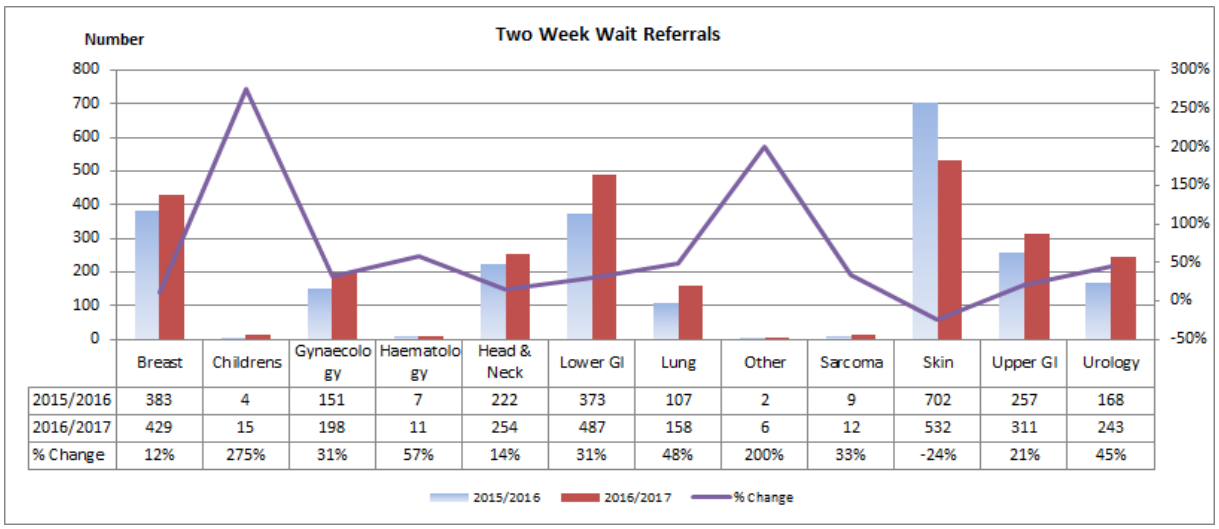
Indicator Name	Standard	Performance					No. of patients not receiving care within standard in Apr
		March 15/16	April 16/17	May 16/17	June 16/17	Q1 16/17	
Cancer 2 week waits	93.00%	95.8%	95.8%	97.1%	96.6%	96.5%	31
Cancer 2 week waits - Breast symptoms	93.00%	98.8%	93.8%	98.0%	94.4%	95.5%	5
Cancer 62 day waits – GP Referral	85.00%	95.9%	91.3%	87.7%	91.0%	90.2%	4
Cancer 62 day waits - Consultant upgrade	85.00%	87.1%	89.5%	84.6%	93.5%	89.5%	1
Cancer 62 day waits - Screening	90.00%	100%	N/A	N/A	100%	100%	0
Cancer day 31 waits	96.00%	100%	98.6%	100%	100%	99.5%	0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	N/A	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	0

3.18 The increase in two week wait referrals continues. Breast however, have recently been close to 2015/16 levels.





3.19 The year to date increases in referrals continues compared to the same period last year with Haematology, Urology, Lower GI, Head and Neck, breast and lung showing the larger increases.



Urgent Care – please note position reported is at 10th July.

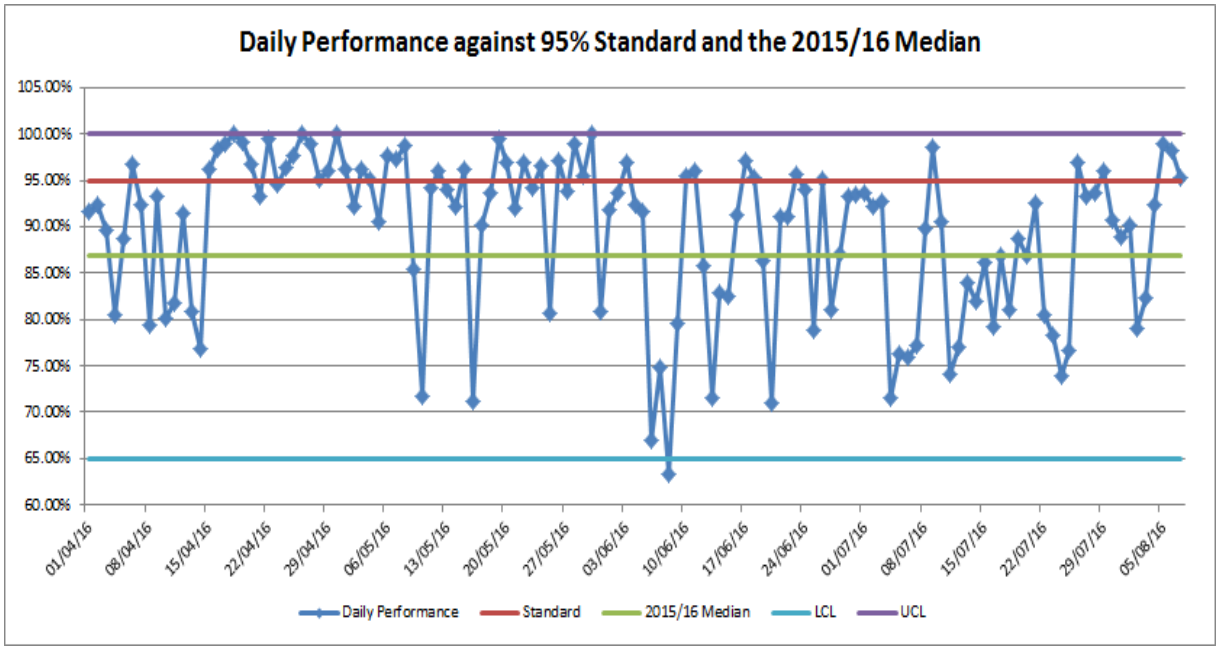
3.20 THFT A&E performance is as below.

Apr-16	May-16	Jun-16	July-16
92.46%	**92.16%**	**86.61%**	**84.98%**

3.21 We are currently the third best performer across the GM trusts YTD, reported through Utilisation Management. Our May and June, July performance and August performance to the 7th has not achieved the standard.

	Financial Year to 07 August 16	April 2016/17	May 2016/17	June 2016/17	July 2016/17	Aug to 07th 2016/17
Wigan	91.75%	92.93%	90.30%	93.87%	89.67%	94.20%
Salford	89.55%	92.52%	90.21%	94.05%	81.69%	90.84%
Tameside	89.09%	92.46%	92.16%	86.61%	84.98%	84.99%
Oldham	86.89%	86.89%	90.39%	86.58%	83.72%	86.63%
Bury	83.40%	82.72%	84.74%	86.35%	82.90%	69.40%
Bolton	82.44%	80.25%	81.29%	85.33%	81.94%	86.83%
Stockport	81.56%	79.31%	81.59%	85.26%	81.51%	74.94%
North Manchester	76.31%	80.20%	77.90%	75.11%	71.24%	81.05%

3.22 Recent performance is on a downward trend. Previous Improvement was being maintained by close monitoring in A&E underpinned by an electronic board. As use of the board becomes embedded it is hoped that senior manager scrutiny can reduce.

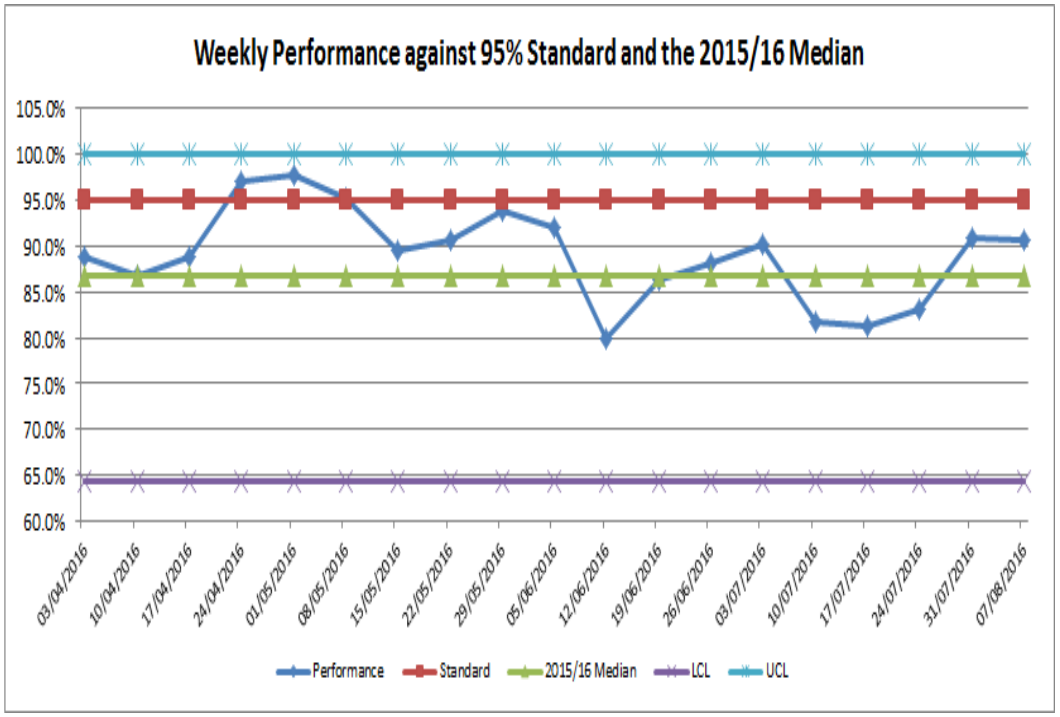


3.23 Activity was well managed during the two day period of junior doctors industrial action. Activity levels were not below normal levels and performance was above the standard.

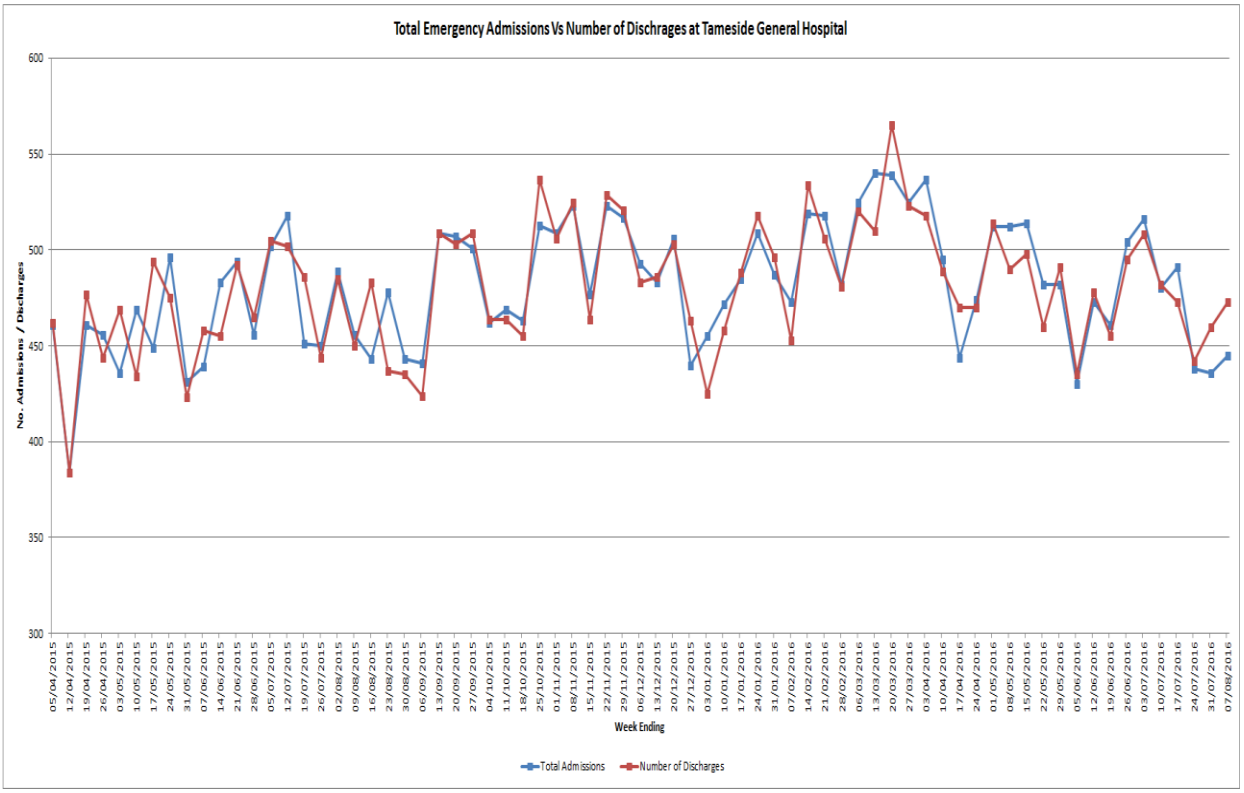
3.24 There has previously been considerable variation on a daily basis with no clear reason, but more recently that has stabilised. During April the standard was achieved but May, June and July has seen a drop in performance.

3.25 During April, May, June and July late first assessment is the main cause of A&E breaches with patients having late assessments as the highest reason for breaches. The patients waiting also impact on cubicle availability which results in breaches due to late first assessments. Previously the main breach reason was awaiting a bed.

Breach Reason (Actual)	w/e 1 May	w/e 8 May	w/e 15 May	w/e 22 May	w/e 29 May	w/e 5 Jun	w/e 12 Jun	w/e 19 Jun	w/e 26 Jun	w/e 7 Jul	w/e 10 Jul	w/e 17 Jul	w/e 24 Jul	w/e 31 Jul	w/e 7 Aug	Cumulative
Awaiting bed	0	6	26	16	26	5	46	37	40	27	51	66	100	24	34	3337
Specialty Delay	1	9	10	2	11	17	21	11	7	18	20	26	21	24	20	1030
Delayed Medical Assessment	0	0	0	105	0	0	0	0	0	0	0	0	0	0	0	510
Other	0	3	5	11	1	3	8	3	2	2	5	5	7	0	8	628
Late First Assessment	28	41	125	4	46	95	151	141	137	94	211	215	146	85	61	4664
Clinical	5	14	17	13	15	14	17	21	11	18	19	15	11	11	9	857
CT Delay	0	2	0	0	2	0	1	1	1	1	0	0	1	1	1	178
Late Referral to Specialty	4	5	6	3	4	0	5	9	8	3	3	3	4	3	0	294
Seen after 4 hours	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23
Awaiting transport	0	2	1	3	1	0	3	5	0	3	0	5	6	5	4	211
Pathology Delay	0	2	0	0	0	0	0	0	0	0	0	0	0	1	0	60
XR Delay	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	21
Unknown	0	0	0	0	0	0	84	0	0	0	0	0	0	0	0	84
Total	38	84	190	157	106	134	336	228	206	166	310	335	296	154	137	11897



3.26 We frequently have fewer emergency discharges than emergency admissions and so routinely have to escalate discharge to manage the daily demand. The loss of the beds at Darnton House has further impacted on our ability to discharge from acute beds recently.


Total Emergency Admissions Vs Number of Dischrages at Tameside General Hospital
No. Admissions / Discharges
600
550
500
450
400
350
300
05/04/2015
12/04/2015
19/04/2015
26/04/2015
03/05/2015
10/05/2015
17/05/2015
24/05/2015
31/05/2015
07/06/2015
14/06/2015
21/06/2015
28/06/2015
05/07/2015
12/07/2015
19/07/2015
26/07/2015
02/08/2015
09/08/2015
16/08/2015
23/08/2015
30/08/2015
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27/09/2015
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28/02/2016
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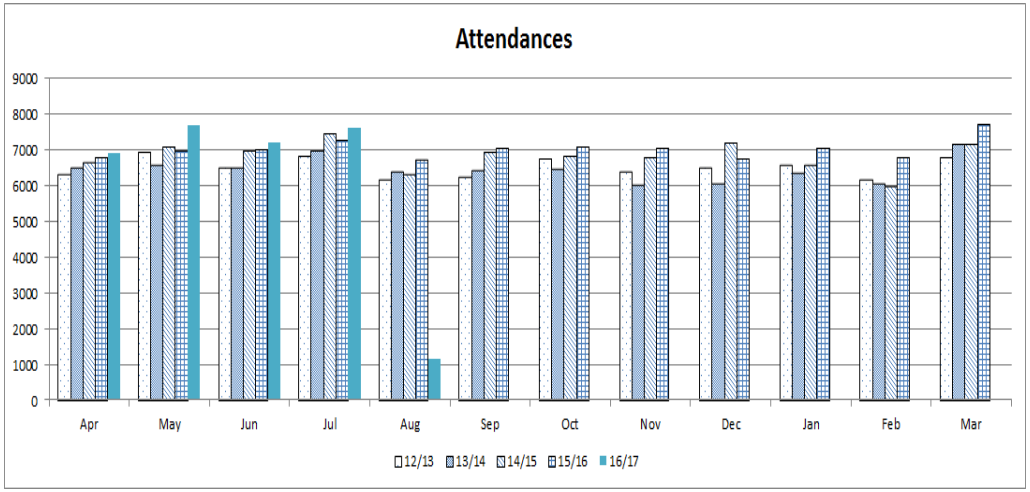
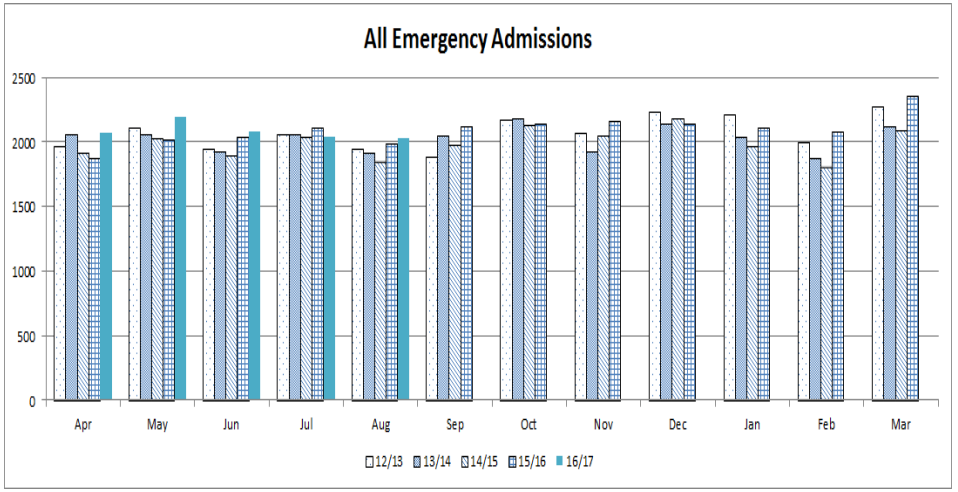
27/03/2016
03/04/2016
10/04/2016
17/04/2016
24/04/2016
01/05/2016
08/05/2016
15/05/2016
22/05/2016
29/05/2016
05/06/2016
12/06/2016
19/06/2016
26/06/2016
03/07/2016
10/07/2016
17/07/2016
24/07/2016
31/07/2016
07/08/2016
Week Ending
Total Admissions
Number of Discharges

3.27 Slight increase in A&E attendances during April with much larger increase during May and slight increase in June. July saw a larger increase in attendances compared to 2015/16 and admissions have also increased. The number of 4 hour breaches has decreased significantly during April but increased in May June and July.

					Variance				% variance			
	Apr-16	May-16	Jun-16	Jul-16	Apr-16	May-16	Jun-16	Jul-16	Apr-16	May-16	Jun-16	Jul-16
A&E Attendances	6890	7680	7182	7609	102	715	155	348	1.5%	10.3%	2.2%	4.8%
4 hour Breaches	523	602	963	1144	-402	157	499	548	-43.5%	35.3%	107.5%	91.9%
% Seen within 4 hours	92.41%	92.16%	86.59%	84.97%								
Admissions via A&E	1764	1885	1773	1776	174	201	53	-15	10.9%	11.9%	3.1%	-0.8%
Other Emergency Admissions	309	309	303	267	16	-30	-19	-58	5.5%	-8.8%	-5.9%	-17.8%
All Emergency Admissions	2073	2194	2076	2043	190	171	34	-73	10.1%	8.5%	1.7%	-3.4%
Discharges	2037	2091	2098	2027	117	83	55	-133	6.1%	4.1%	2.7%	-6.2%



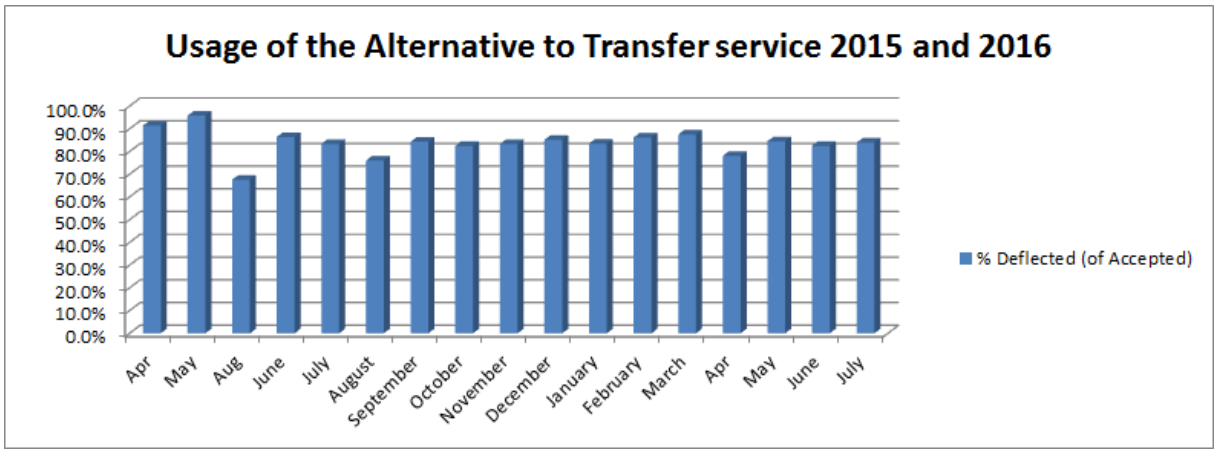


3.28 Since September 2015 there has been considerable variation in the numbers of attendances and admissions and breaches have risen significantly. During April this had stabilised and breaches had reduced, which now look to have increased during May, June and July.

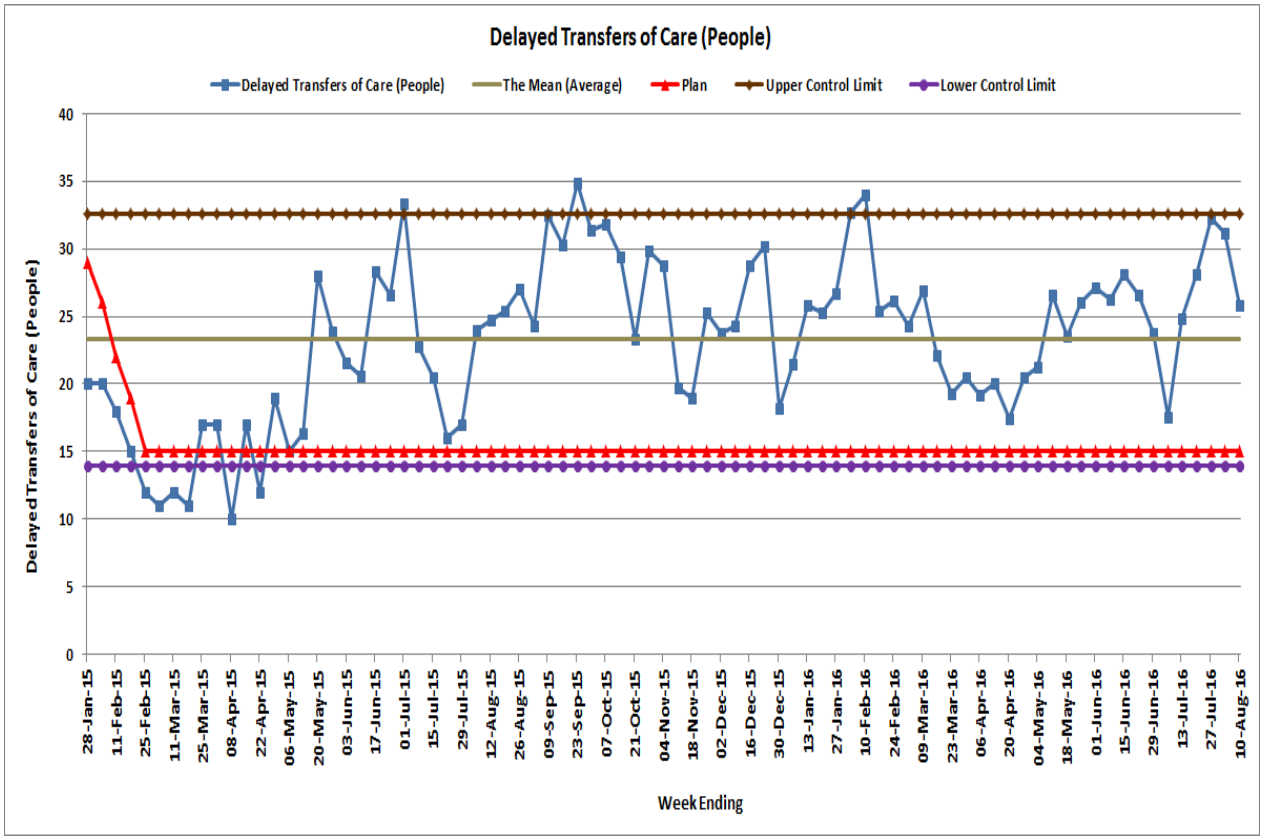
Week Ending	Actual Number of A&E Type 1 Attendances	Actual Number of 4 hour Type 1 breaches	Actual Performance	Number of Emergency Admissions via A&E	Number of Direct Emergency Admissions	Total Emergency Admissions
03 Apr	1787	202	88.7%	453	80	533
10 Apr	1641	217	86.8%	421	85	506
17 Apr	1495	166	88.9%	382	58	440
24 Apr	1639	47	97.1%	406	71	477
01 May	1609	38	97.6%	445	68	513
08 May	1770	84	95.3%	435	74	509
15 May	1797	190	89.4%	450	66	516
22 May	1682	157	90.7%	414	69	483
29 May	1688	106	93.7%	411	75	486
05 Jun	1676	134	92.0%	373	58	431
12 Jun	1673	336	79.9%	413	62	475
19 Jun	1653	228	86.2%	382	78	460
26 Jun	1728	206	88.1%	439	73	512
03 Jul	1686	166	90.2%	443	73	516
10 Jul	1701	310	81.8%	422	59	481
17 Jul	1785	335	81.2%	424	67	491
24 Jul	1752	296	83.1%	378	60	438
31 Jul	1673	154	90.8%	376	60	436
07 Aug	1496	139	90.7%	386	59	445

3.29 Usage of the Alternative to Transfer service continues to be good and the level of deflections remains above 80%.

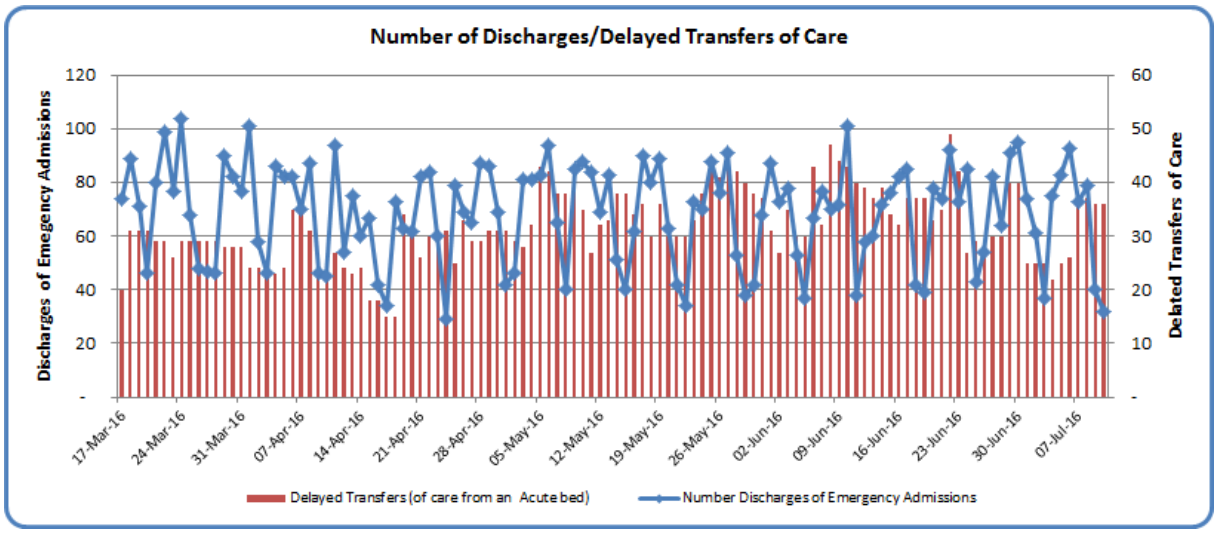
	February	March	April	May	June	July	Aug to 07th
Referrals	207	241	198	183	178	221	37
Accepted	203	223	196	183	177	220	37
Red Refusals to Hospital also seen	29	22	18	15	17	27	11
Deflected	150	189	139	142	132	162	20
Accepted %	98.1	98.8	99.0	100	99.4	99.5	100
% Deflected (of Referrals)	86	88	78.1	85	82.5	83.9	77.0
% Deflected (of Accepted)	**86**	**88**	**78.1**	**85**	**82.5**	**83.9**	**77.0**

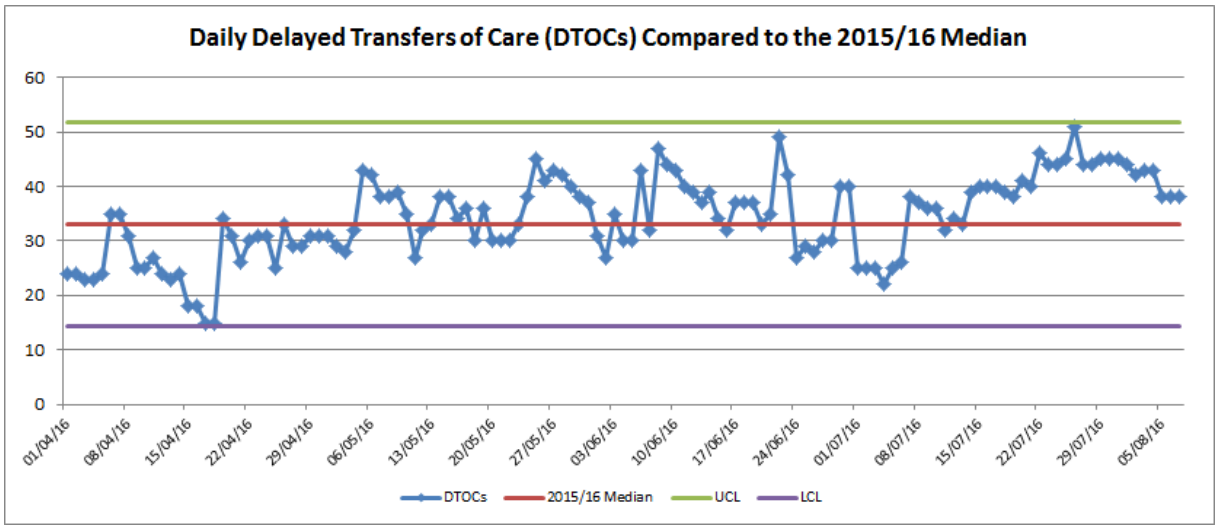


3.30 The number of Delayed Transfers of Care (DTOC) recorded has increased recently.



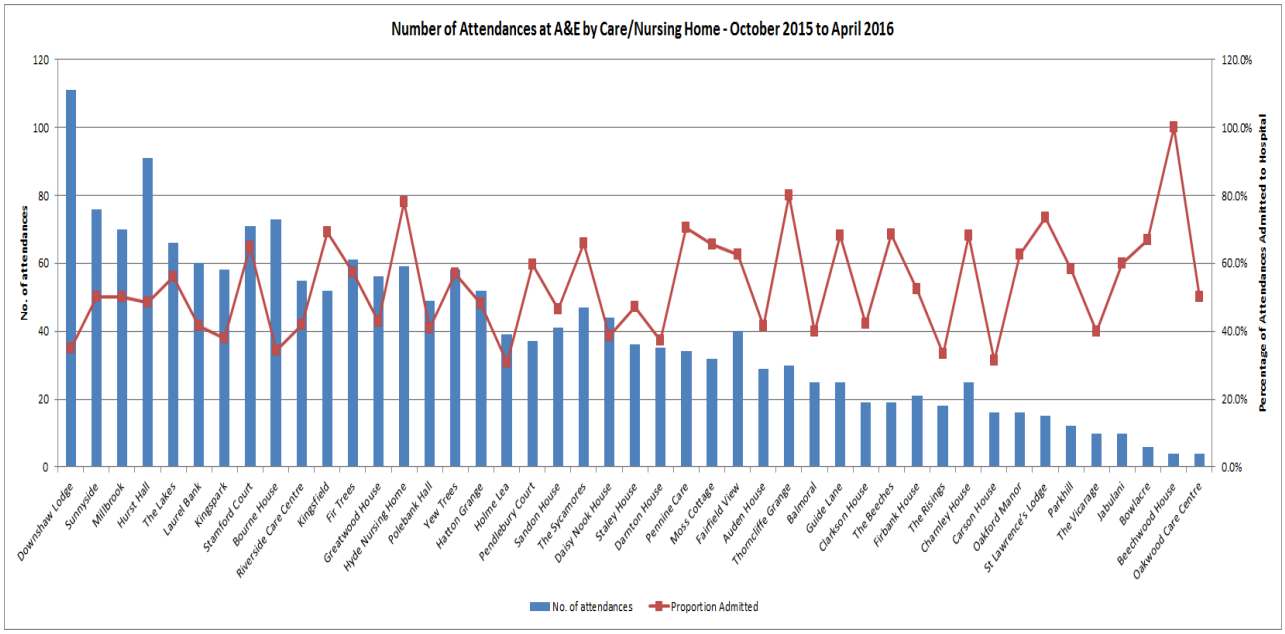
3.31 Reducing DTOC and the level of variation day by day is a key aspect of the improvement plan with Integrated Urgent Care Team designed to significantly impact on bed availability by improving patient flow out of the hospital and avoiding admissions. This should deliver a culture of' Discharge to Assess' which is key to delivering the national expectation that trusts will have no more than 2.5% of bed base occupied by DTOC.


Number of Discharges/Delayed Transfers of Care
Discharges of Emegency Admissions
Delated Transfers of Care
120
100
80
60
40
20
-
60
50
40
30
20
10
-
17-Mar-16
24-Mar-16
31-Mar-16
07-Apr-16
14-Apr-16
21-Apr-16
28-Apr-16
05-May-16
12-May-16
19-May-16
26-May-16
02-Jun-16
09-Jun-16
16-Jun-16
23-Jun-16
30-Jun-16
07-Jul-16
Delayed Transfers (of care from an Acute bed)
Number Discharges of Emergency Admissions

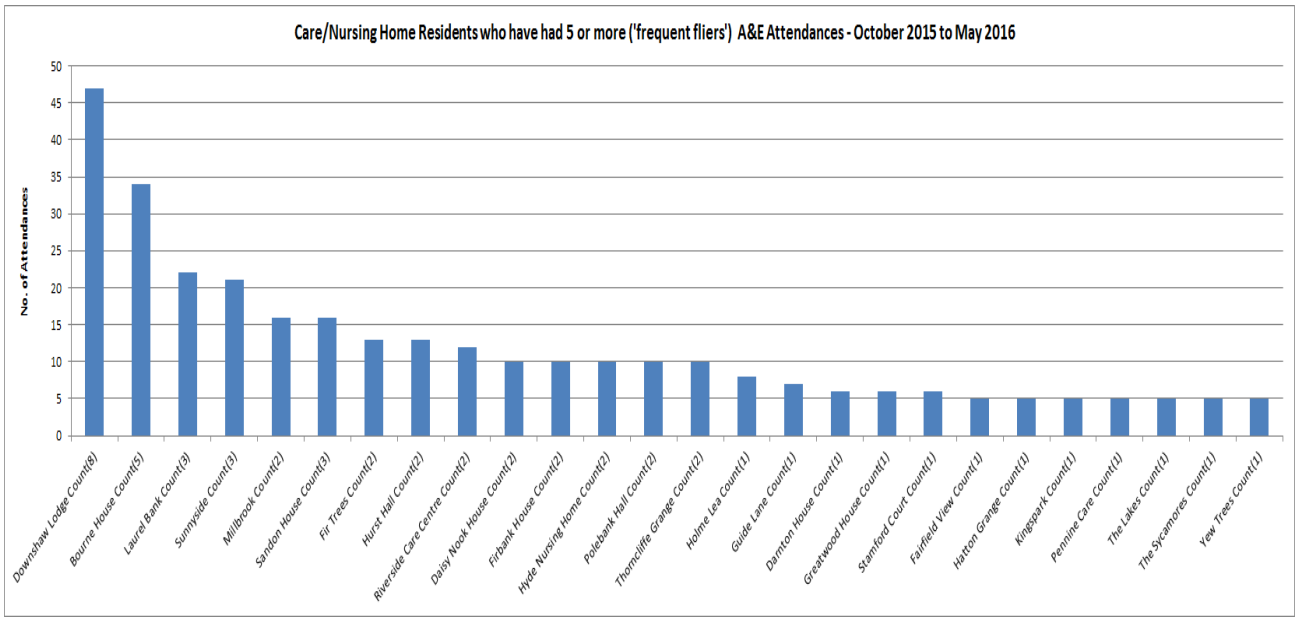

Daily Delayed Transfers of Care (DTOCs) Compared to the 2015/16 Median
60
50
40
30
20
10
0
01/04/16
08/04/16
15/04/16
22/04/16
29/04/16
06/05/16
13/05/16
20/05/16
27/05/16
03/06/16
10/06/16
17/06/16
24/06/16
01/07/16
08/07/16
15/07/16
22/07/16
29/07/16
05/08/16
DTOCs
2015/16 Median
UCL
LCL

Care Homes

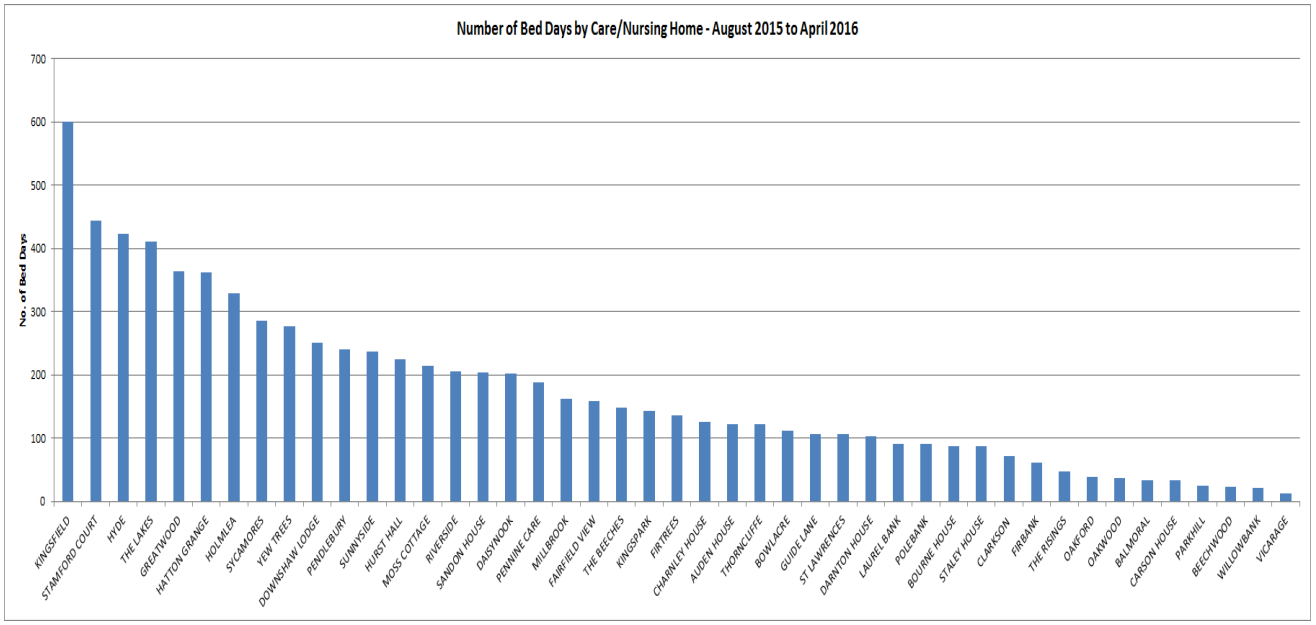
3.38 The decision was made to specifically look at the care homes use of our urgent care systems. This was to allow us to look to see if we can identify themes and trends regarding particular care home providers. In doing this it would allow us to focus support which will be individual to providers. Trying to establish a robust and consistent dataset has been challenging given that we are looking at one specific client group that uses multiple elements of an urgent care system. Data submission remains a challenge, we are working with the relevant urgent care partners to get to a position where we will receive month end live data. The graphs below represent the cumulative activity for the periods detailed above e ach graph. We would aim to deliver a monthly reporting system that would allow health and social care services to interpret the data to develop appropriate support plans. Some examples of the data collected to date used by the care home steering group are shown below.



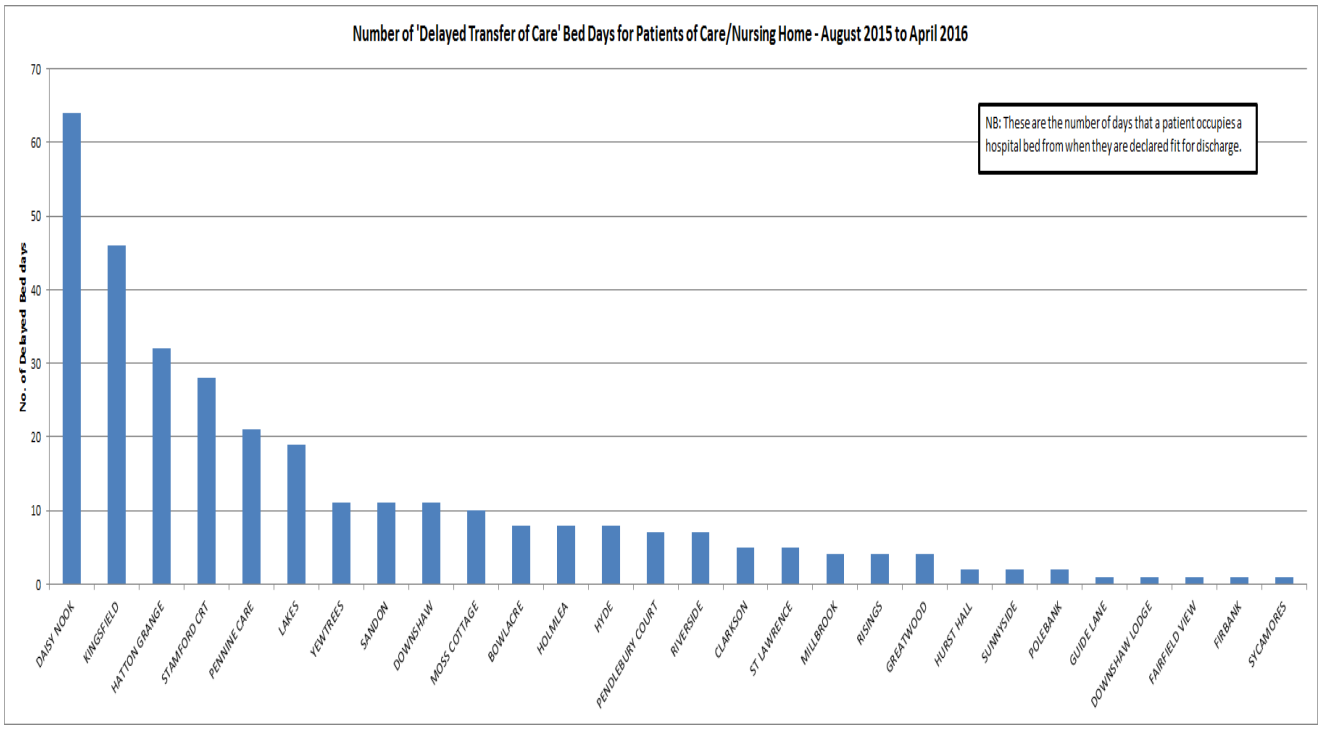
3.39 Work is currently being done to present this graph showing a month on month position. This will allow us to monitor attendances per care home per month giving us the ability to take action in a more timely manner.



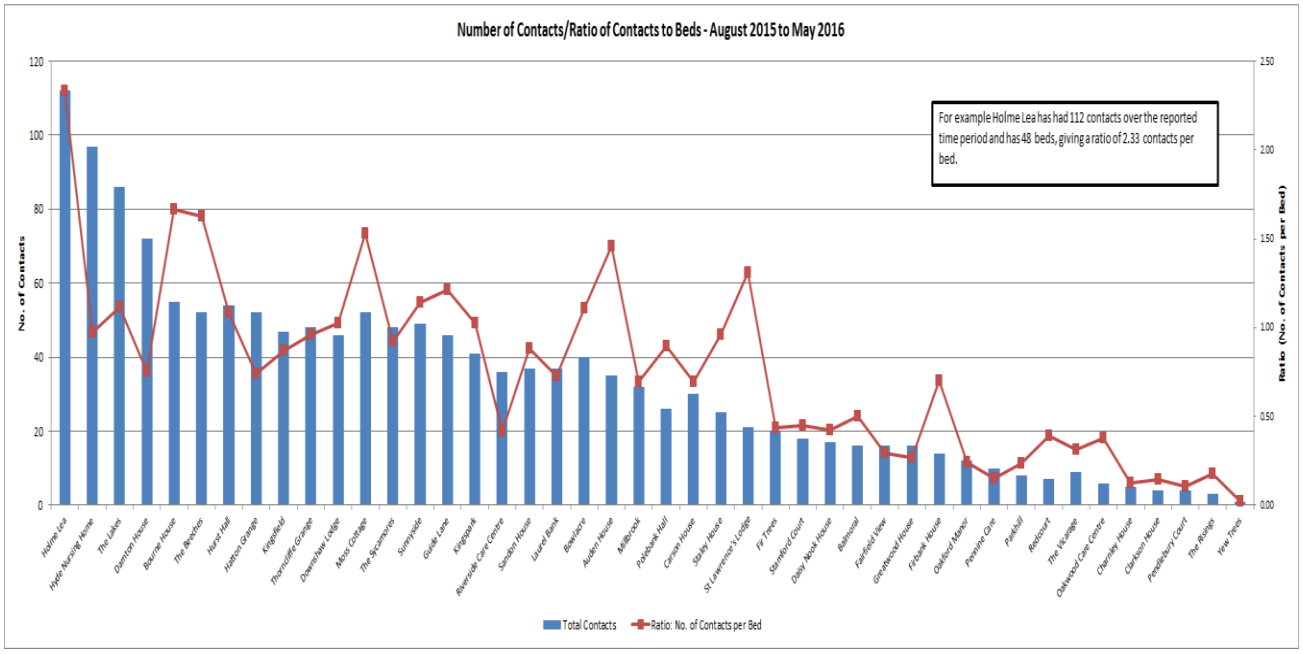
3.40 To enable an MDT to be wrapped around individuals who frequently attend A&E this data also needs to be as live as possible. Early work has already identified that a number of the clients in this category in the above graph had already passed away.



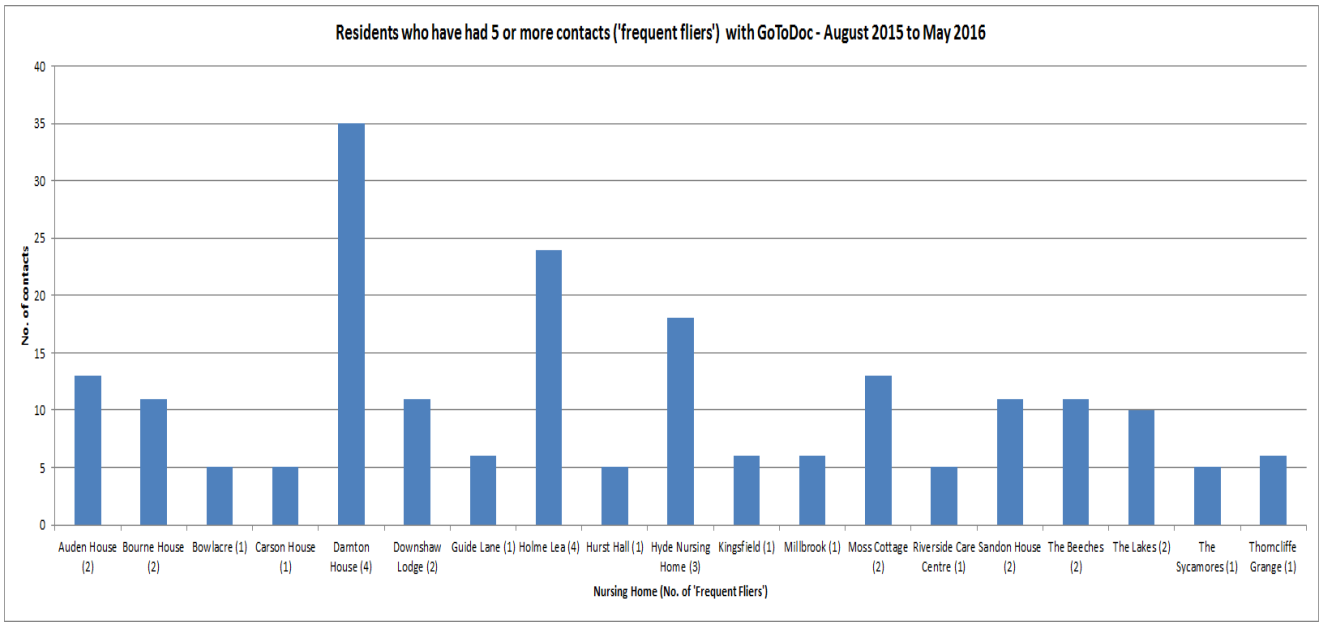
3.41 Once we are able to collate the above data on the number of inpatient bed days per care home on a monthly basis, we need to the correlate the above data with that of A&E attendances in the graph in section 4.1.



3.42 The above graph shows the number of inpatients bed days by care home once an individual is medically ready to be discharged from hospital. Given these individuals are already in receipt of 24 hour care further work has been requested by the care home steering group to understand why these individuals remain in hospital once ready to leave.



3.43 The CCG has secured the extension of the GTD professional help line to care home nurses as a pilot which did commence on the first of August. The CCG will review on a monthly basis with the lead from GTD the details of the calls made to the helpline from care homes allowing us to see if there are any themes or trends.

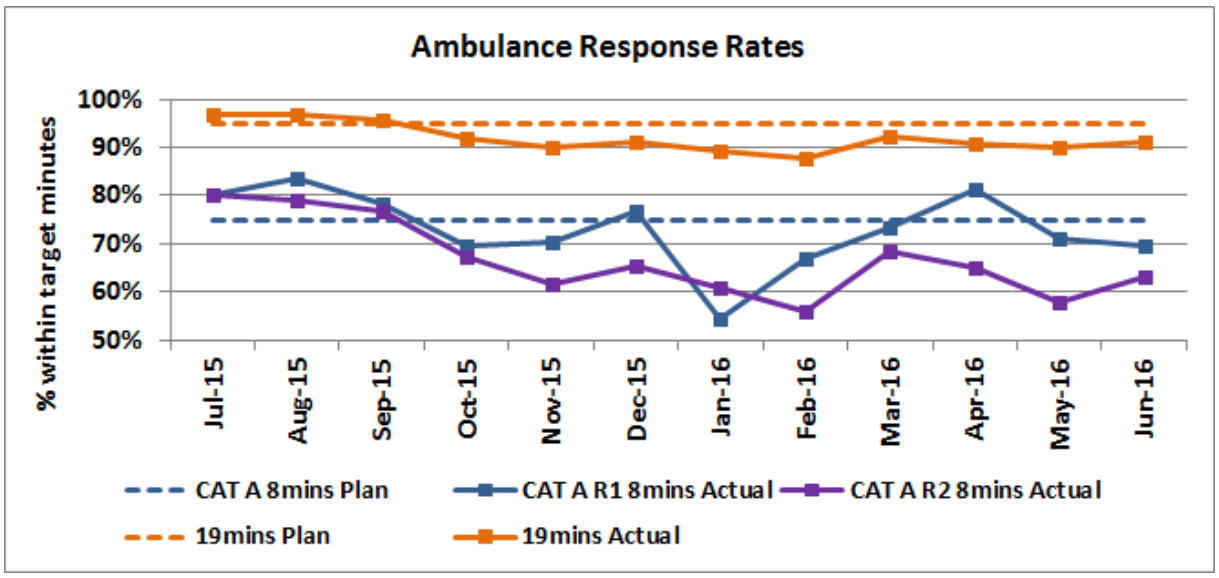


3.44 We need to move to a position where this data is reported monthly to allow us to mobilise an MDT in a more timely manner.

3.45 The care home steering group meets monthly and has access to the full dataset from the urgent care partners. This section will be subject to review as the care home steering group identifies where the priorities within the urgent care system that supports care homes.

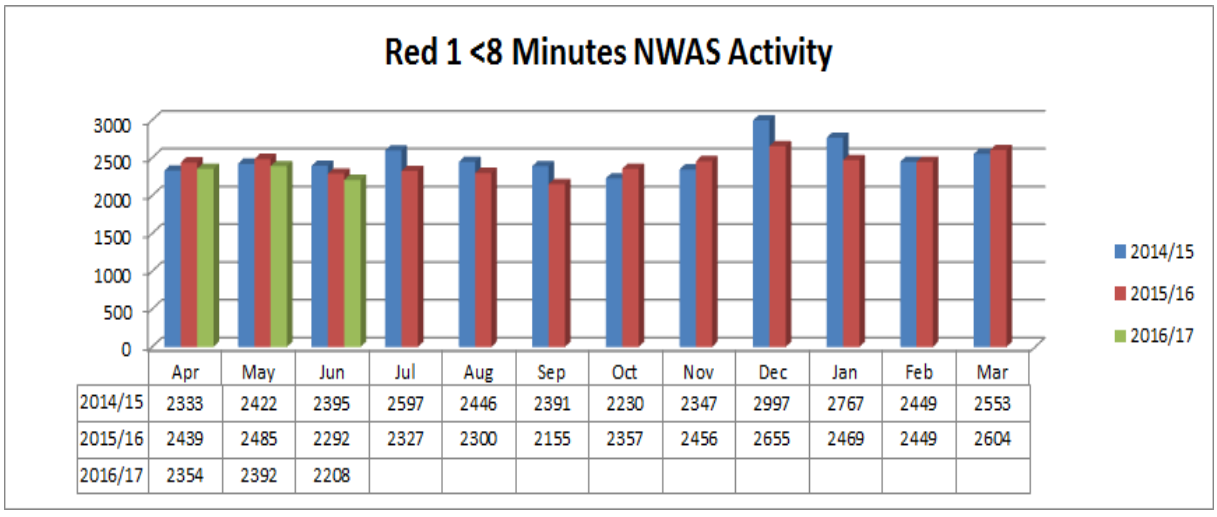
Ambulance – please note position reported is June

3.46 In June 2016 the CCG failed to achieve the response rates locally with 69.50% for CAT A 8mins Red 1, 63.10% for CAT A 8mins Red 2 and 91.10% for CAT A 19 mins Red 2.

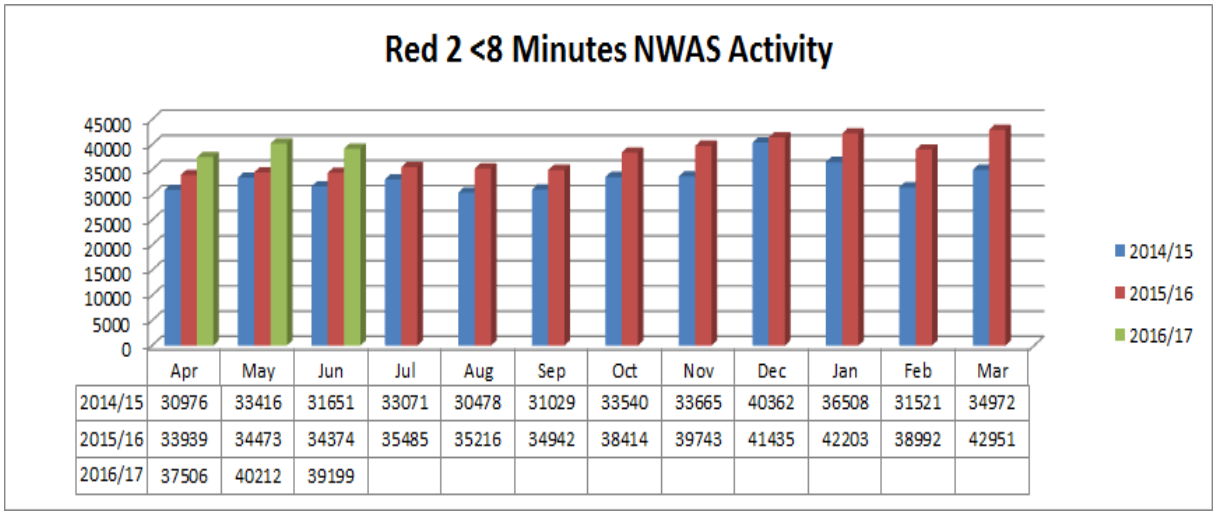


3.47 However, we are measured against the North West position which was 73.06% for CAT A 8mins Red 1; 66.20% for CAT A 8mins Red 2 and 91.49% for CAT A 19mins Red 2 which means none achieved this month.

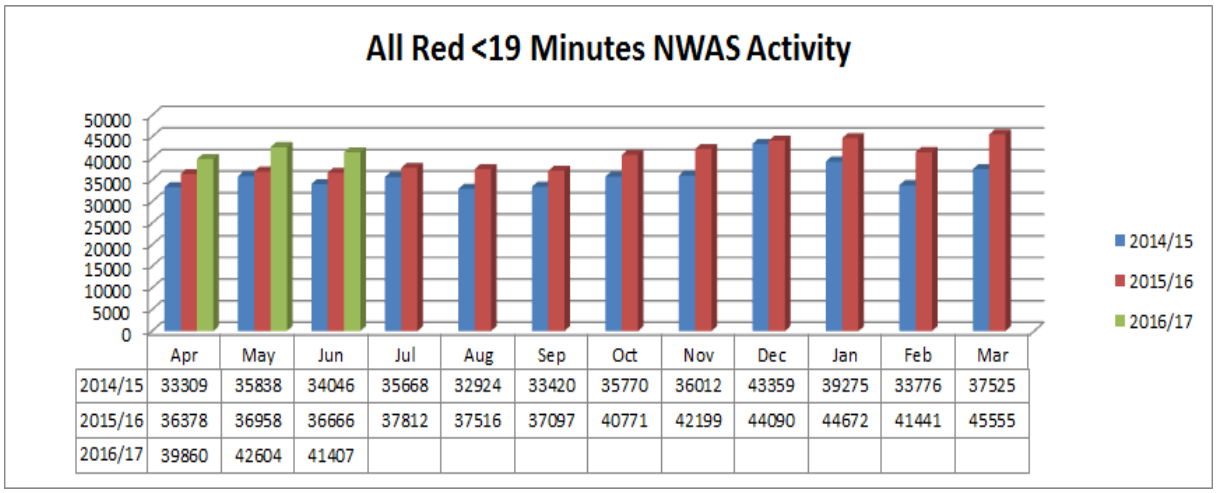
3.48 Increases in activity have placed a lot of pressure on NWAS, which has not been planned for. This is impacting on its ability to achieve the standards.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	2333	2422	2395	2597	2446	2391	2230	2347	2997	2767	2449	2553
2015/16	2439	2485	2292	2327	2300	2155	2357	2456	2655	2469	2449	2604
2016/17	2354	2392	2208									

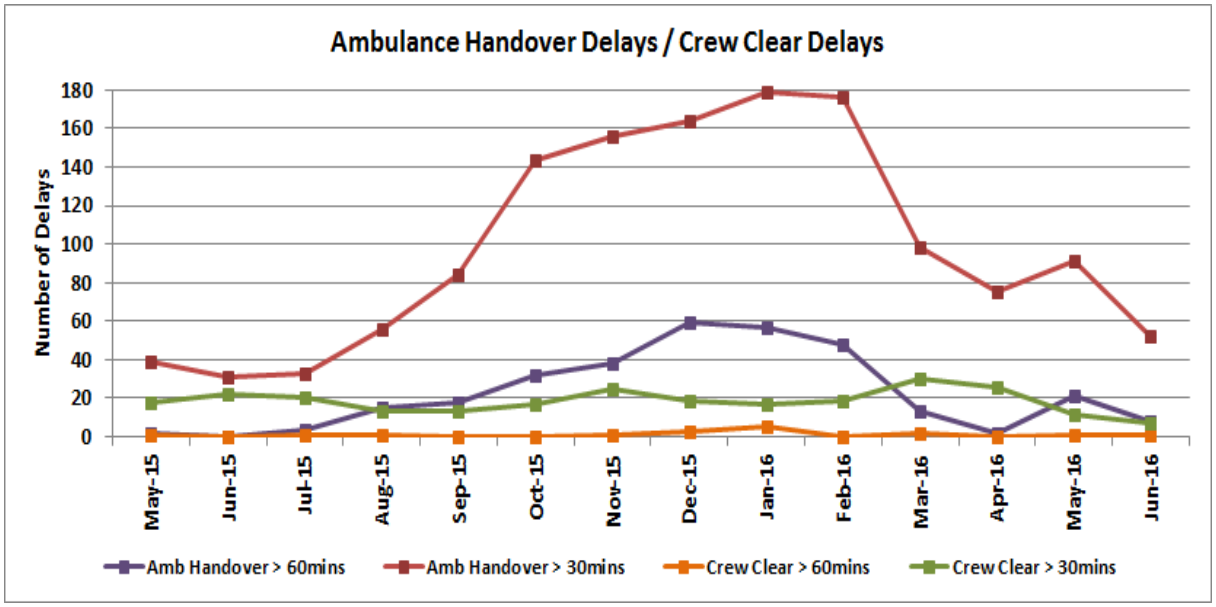


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	30976	33416	31651	33071	30478	31029	33540	33665	40362	36508	31521	34972
2015/16	33939	34473	34374	35485	35216	34942	38414	39743	41435	42203	38992	42951
2016/17	37506	40212	39199									

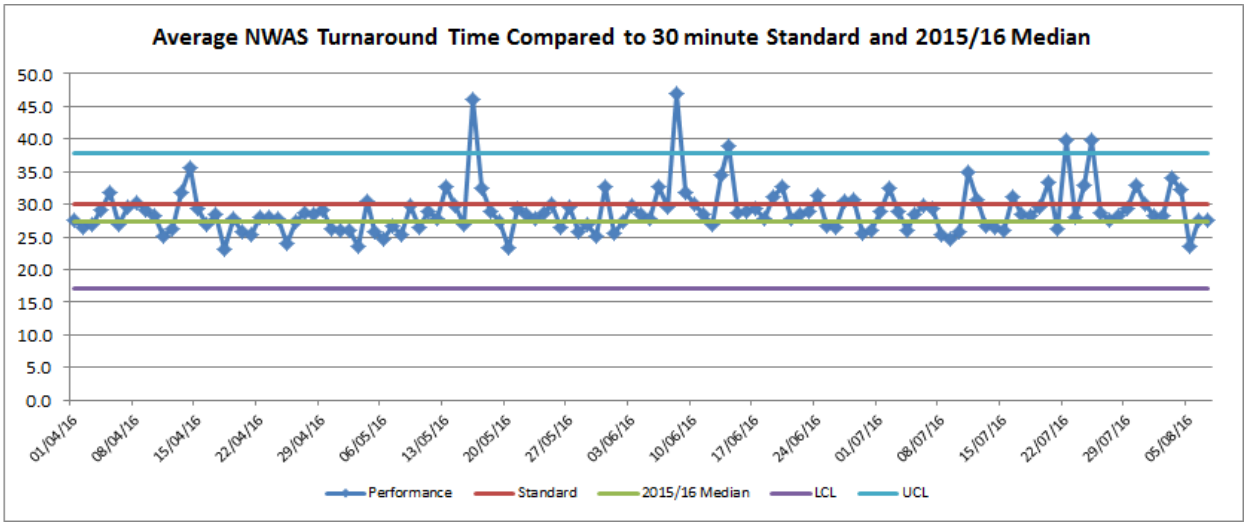


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	33309	35838	34046	35668	32924	33420	35770	36012	43359	39275	33776	37525
2015/16	36378	36958	36666	37812	37516	37097	40771	42199	44090	44672	41441	45555
2016/17	39860	42604	41407									

3.49 The number of ambulances with handover delays decreased in June.



3.50 The trend is however still improving for ambulance turnarounds below 30 minutes.



111– please note position reported is June

3.51 111 went live in GM 10 November so this is the seventh full month reported under the new arrangements.

3.52 Primary KPI performance

- The North West NHS 111 service was offered 150,613 calls in the month, answering 129,266.
- 115,726 (89.53%) of these calls were classified as being triaged.

NWAS has worked closely with Commissioners over recent months to address a known staffing shortfall which has had a significant adverse effect upon call answer performance and calls abandoned in particular. Staffing has continued to increase during June, and attrition has continued to be well managed, leading to an improvement in KPI's in line with our performance trajectory. NWAS continues to apply focus to staffing numbers, especially in the clinician workforce, in order to generate an improvement in the clinical access KPI's.

3.53 The North West NHS 111 service is performance managed against a range of KPI's, however there are 4 primary KPI's which are accepted as common 'currency', reported by each NHS 111 service across England. These are:

	Target	**Reported**
•	Calls answered (95% in 60 seconds)	90.09%
•	Calls abandoned (<5%)	2.05%
•	Warm transfer (75%)	32.23%
•	Call back in 10 minutes (75%)	40.42%

3.54 The level 4 incidents where ambulances were urgently dispatched to patients who did not want to be resuscitated are being followed up (There was 1 case reported in June). It is essential that GPs share DNACPR with Go to Doc through Special Patient Notes to enable 111 staff to see them and avoid distress to patients and families.

3.55 Our use is in line with NW levels.

	15 and Under	16 to 65	65 and Over	Total
Callers Triaged by Age	854	1,945	740	3,539
% Breakdown	24%	55%	21%	100%
Total for NW Region	27,021	64,983	23,722	115,726
% Breakdown NW Region	23%	56%	20%	100%

3.56 Our treatment is generally in line with NW levels.

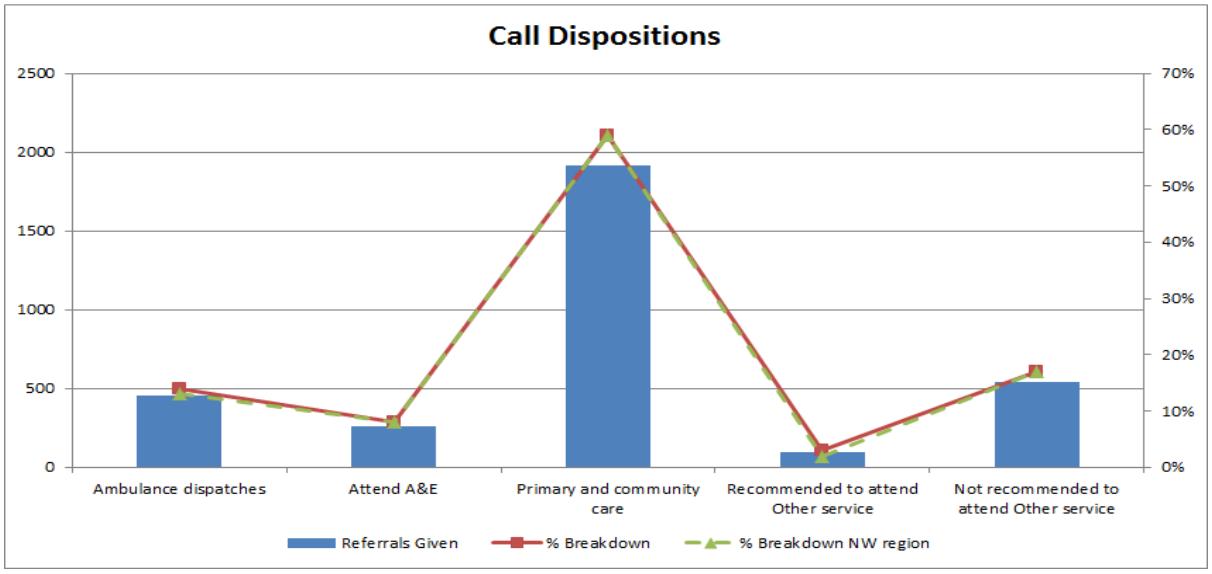
	Calls Triaged	Caller terminated call during triage	Callers who were identified as repeat callers	Triaged Patients Speaking to a clinician	Patients Warm Transferred to a Clinician Where Required	Patients Offered a Call Back Where Required	Call Backs in 10 Minutes
Caller Treatment	3,539	313	226	690	224	466	173
% Breakdown	100%	9%	6%	19%	32%	68%	37%
Total for NW Region	115,726	10,341	4,419	23,505	7,575	15,930	6,439
% Breakdown NW Region	100%	9%	4%	20%	32%	68%	40%

3.57 Our onward referral is generally in line with NW levels.

Calls Triaged	Ambulance Despatches	Attend A&E	Primary and community care	Recommended to Attend Other Service	Not Recommended to Attend Other

						Service
Referrals Given	3,539	501	299	1,874	79	786
% Breakdown	100%	14%	8%	53%	2%	22%
Total for NW Region	115,726	15,661	10,284	64,100	2,637	23,044
% Breakdown NW Region	100%	14%	9%	55%	2%	20%

3.58 Our dispositions are in line with this.



4 RECOMMENDATION

4.1 As set out on the front of the report.

NHS Tameside & Glossop CCG: NHS Constitution Indicators (June 2016)

Description	Indicator	Level	Threshold	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Exceptions
18 Weeks RTT	Admitted patients to start treatment within a maximum of 18 weeks from referral (unadjusted)	T&G CCG	90%	89.0%	84.4%	85.8%	84.2%	83.9%	85.8%	86.0%	87.3%	89.1%	88.3%	88.8%	88.9%	86.8%	89.1%	87.9%	87.7%	CCG target not achieved. Failing specialties are; urology (54.12%), T&O (78.27%), ENT (87.5%), plastic surgery (89.36%), cardiology (82.98%), dermatology (50%), Gynaecology (78.07%). CCG at THFT failing specialities are; T&O (75.48%), ENT (88%), Gynaecology (73.49%).
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	T&G CCG	95%	88.7%	88.5%	87.2%	87.5%	80.3%	86.0%	83.5%	85.8%	85.1%	85.4%	84.9%	86.0%	85.7%	86.0%	88.4%	87.6%	CCG target not achieved. Failing specialties are; general surgery (86.36%), urology (74%), T&O (89.60%), ENT (88.17%), neurosurgery (85.71%), plastic surgery (73.33%), cardiothoracic surgery (88.89%), general medicine (86.72%), gastroenterology (79.75%), cardiology (83.19%), dermatology (92.01%), thoracic medicine (77.36%), rheumatology (92.45%), gynaecology (86.46%), other (89.24%). CCG at THFT failing specialties are; general surgery (86.75%), urology (68.75%), T&O (88.72%), ENT (85.36%), neurosurgery (80%), plastic surgery (62.5%), cardiothoracic surgery (87.5%), general medicine (86.96%), gastroenterology (62.5%), cardiology (84.42%), dermatology (91.64%), rheumatology (92.05%), gynaecology (84.08%), other (89.73%).
	Patients on incomplete non emergency pathways (yet to start treatment)	T&G CCG	92%	89.3%	90.7%	91.4%	91.8%	92.0%	92.2%	91.8%	92.2%	91.8%	91.8%	92.1%	91.9%	91.6%	92.4%	92.5%	92.4%	CCG failing specialties are; urology (87.94%), T&O (89.12%), plastic surgery (91.36%), cardiothoracic surgery (85%), cardiology (91.8%), thoracic medicine (91.48%), geriatric medicine (87.50%), gynaecology (89.41%). CCG at THFT failing specialities are; urology (90.85%), ENT (86.99%), plastic surgery (91.30%), gynaecology (87.94%).
	Patients waiting 52+ weeks on an incomplete pathway	T&G CCG	Zero Tolerance	6	5	1	1	0	1	2	0	1	0	2	0	12	1	0	0	In April 2016 there was 1 patient waiting 52+ weeks an incomplete pathway, 1 patient at UHSM for T&O. It has been confirmed that this patient has now been seen.
Diagnostics < 6 Weeks	Patients waiting for diagnostic tests should have been waiting less that 6 weeks from referral	T&G CCG	1%	1.2%	1.6%	1.7%	1.7%	2.1%	2.8%	2.8%	2.4%	2.5%	2.7%	1.8%	2.9%	2.2%	2.5%	1.6%	2.4%	CCG target not achieved, 121 breaches. Failing for CCG are Central Manchester with 27 breaches for echocardiography, colonoscopy, gastroscopy, MRI and urodynamics. PAHT with 3 breaches for colonoscopy an flexi sigmoidoscopy. South Manchester with 2 breaches for echocardiography and neurophysiology. THFT with 29 breaches for audiology assessments, CT scans and neurophysiology. Care UK with 6 breaches for audiology and MRI. Pioneer Healthcare Limited with 1 breaches for neurophysiology. Leeds Teaching Hospitals FT with 1 breach for flexi sigmoidoscopy.
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	THFT	95%	86.4%	93.6%	93.4%	91.8%	89.2%	87.7%	82.6%	77.2%	73.0%	73.4%	76.0%	93.1%	84.9%	92.4%	92.2%	86.5%	2015-16 performance shows that 12,737 patients waited more than 4 hours (denominator 84,303). Breached by 8,522 patients. June 2016 performance is 86.54% breached by 608 patients. July 2016 performance is 84.98% breached by 763 patients.
Cancer 2 Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	T&G CCG	93%	95.5%	93.9%	95.3%	94.1%	95.5%	98.1%	96.8%	97.7%	97.5%	97.4%	97.7%	96.3%	96.4%	95.8%	97.1%	96.1%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	T&G CCG	93%	94.2%	91.1%	70.7%	93.6%	98.4%	96.7%	94.6%	96.7%	98.4%	96.1%	98.2%	98.9%	93.0%	93.9%	98.0%	95.8%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definative treatment for all cancers	T&G CCG	96%	98.9%	97.7%	98.0%	99.0%	97.8%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	99.1%	100.0%	98.9%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	T&G CCG	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	T&G CCG	98%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100%	99.1%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	T&G CCG	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definative treatment for cancer	T&G CCG	85%	97.7%	87.2%	83.7%	91.7%	83.0%	86.0%	86.8%	93.0%	88.2%	96.1%	93.3%	93.8%	89.9%	89.7%	88.6%	91.5%	
	Maximum 62 day wait from referral from an NHS screening service to first definative treatment for all cancers	T&G CCG	90%	100.0%	100.0%	100.0%	83.3%		82.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.3%	100.0%	100.0%	60.0%	June 2016 performance is below the 90% target, however due to the low numbers the de minimis rule applies. 3 patients breached out of a total of 5 patients.
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	T&G CCG	85%	100.0%	81.8%	94.7%	78.6%	80.0%	81.8%	91.7%	80.0%	85.7%	100.0%	92.3%	88.2%	88.9%	83.3%	86.7%	94.4%	
Ambulance	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	NWAS	75%	71.2%	81.6%	79.8%	79.3%	77.7%	78.4%	75.9%	73.4%	74.9%	69.3%	70.5%	67.3%	74.8%	76.5%	74.3%	73.1%	High levels of demand and lengthening turn around times.
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	NWAS	75%	72.1%	79.4%	78.2%	76.0%	75.4%	74.9%	72.5%	68.5%	69.5%	63.5%	61.1%	58.9%	70.4%	67.5%	66.3%	66.2%	High levels of demand and lengthening turn around times.
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes	NWAS	95%	93.3%	96.4%	95.9%	94.6%	95.1%	94.6%	94.1%	92.0%	92.7%	89.9%	88.1%	86.7%	92.6%	92.0%	91.5%	91.5%	High levels of demand and lengthening turn around times.
Mixed Sex Accommodation	MSA Breach Rate	T&G CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.1	Total of 1 breach in June 2016 for T&G CCG. This is an unjustified mixing in relation to sleeping accommodation.
Cancelled Operations (Elective)	The number of last minute cancelled elective operations in the quarter for non-clinical reasons where patients have not been treated within 28 days of last minute elective cancellation	THFT	0	6			0			4			2			12	2			Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85
Care Programme Approach (CPA)	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	T&G CCG	95%	94.2%			100%			96.3%			100%			96.7%	94.5%			16-17 Q1 52 patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care out of a total of 55 patients = 94.5%

IAPT

Access		3.75%	4.00%	4.50%	4.30%	4.41%	
Recovery		50%	38.20%	36.92%	44.00%	40.14%	
Wating times less than 6 weeks		75%	57.83%	54.81%	52.60%	60.14%	
Wating times less than 18 weeks		95%	90.50%	91.11%	89.61%	90.54%	

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Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INTEGRATED NEIGHBOURHOOD BUSINESS PROPOSITION**
Report Summary:	The Neighbourhood Development workstream leads the design and delivery of an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. This system will work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector. This report is the Care Together Business Proposition for our Integrated Neighbourhood model. There will be five Integrated Neighbourhoods across the Tameside and Glossop CCG footprint. Four of the Neighbourhoods are co-terminous with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective. The development of INs will build upon the recent development of place based hubs in Tameside, and the public sector prevention agenda which went live in May 2016. These hubs bring together front line providers from across a range of agencies to focus resource where it is needed most and responding to issues in a holistic rather than single agency way. Agencies currently include social services, police, housing, mental health, fire and the voluntary and community sector.
Recommendations:	SCB are asked to approve the attached report to proceed to the implementation stage as part of the Care Together programme.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	Funding to implement this model has been requested as part of our £23.2m bid from GM Health & Social Care Partnership. An extraordinary TFOG (Transformation Fund Outcomes Group) has been arranged for 23 August to consider our bid again. Over the long term this project will deliver significant financial savings (on-going savings of £10.1m p.a.) and is congruent to the Care Together strategy. Approval of this business case needs to be made conditional pending the outcome of the GM funding decision. The GM funding will be contingent on meeting agreed performance metrics. Failure to deliver these targets would result in future funding being withdrawn, therefore the PRG decision also has to be linked to delivery against targets.
Legal Implications: (Authorised by the Borough Solicitor)	This report outlines at a strategic level a model for future service delivery. Once funding is approved there will need to be clear governance to spend the funding to ensure delivery of outcomes, vfm and a clear project plan to ensure delivered expediently and

	a clear understanding of risks that will need to be managed and how. It will be necessary before there are any specific service delivery changes that there is clear consultation and engagement with the public about those proposals to meet necessary legal requirements.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health & Wellbeing Strategy, and are priorities for the Integrated Neighbourhood model
How do proposals align with Locality Plan?	The development and implementation of the Integrated Neighbourhood model is a key part of our Locality Plan. The vision to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home is in line with the vision for Integrated Neighbourhoods.
How do proposals align with the Commissioning Strategy?	Integrated Neighbourhoods are key to the delivery of our commissioning strategy. The strategic commissioning priorities of a focus on the ***wider determinants*** of health and wellbeing, early intervention and prevention across the life course to encourage ***healthy lifestyles*** and promote, improve and sustain population health, creating a care model so that people with ***long term conditions*** are better supported and equipped with the right skills to manage their conditions more effectively, and supporting positive ***mental health*** in all that we do are clearly delivered by the model outlined in this paper.
Recommendations / views of the Professional Reference Group:	The paper was accepted by PRG with the following recommendations: • That the work is aligned with that of the Healthy Lives workstream • Joint work with our public (including a focus on carer engagement) must be an integral part of the Integrated Neighbourhoods' further development and implementation • That the outcome measures are reviewed to include 2 additional 'I' statements: – I am confident that my experiences of the services I have used will help inform the improvement of the services offered in my neighbourhood – I know that I am actively able to contribute to the development of health and social care services in my neighbourhood.
Public and Patient Implications:	The model outlined in this paper has been developed with the engagement of patients / public. We will continue to engage with our patients in the implementation phase. The model outlined will deliver improvements to our public / patients by achieving the following objectives: • Proactively identify people at high risk of requiring access to services, through early intervention and prevention • Help people live as independently as possible whilst managing one or more long term conditions

- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Neighbourhoods
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely
- Focus on improved condition management to avoid admissions
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to.

Quality Implications:

The delivery of this model will improve the quality of life of our population, improve the quality of interactions with health & social care professionals, and deliver improvements in our population's ability to be resilient and self-manage, on an individual and community basis.

How do the proposals help to reduce health inequalities?

Delivering a model of care around the needs of our 5 neighbourhoods, with a core offer and neighbourhood specific priorities (based on robust risk stratification data and local intelligence) will enable us to target the delivery of interventions in a way that will reduce health inequalities.

What are the Equality and Diversity implications?

Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.

What are the safeguarding implications?

All providers included in the Integrated Neighbourhood model are bound by safeguarding standards and policies. Will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.

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

Information governance is included as an element of the core offer for Integrated Neighbourhoods, and will be addressed via the Care Together IG and data sharing agreement work. All partners in the neighbourhood work will be bound by the necessary guidelines.

Risk Management:

Risks related to the INs will be managed and reported through the Care Together governance.

Access to Information :

The background papers relating to this report can be inspected by contacting Clare Watson, Director of Transformation.

e-mail: clarewatson2@nhs.net

TAMESIDE AND GLOSSOP
Caretogether

Neighbourhood Development

Business Proposition

1. STRATEGIC CONTEXT – CARE TOGETHER

1.1 The Care Together programme has the ambition to significantly raise healthy life expectancy (HLE) in Tameside and Glossop, through the adoption of a place based approach to better prosperity, health and, wellbeing. The Tameside and Glossop Locality Plan sets the bold ambition of raising healthy life expectancy to the North-west average by 2020. For both men and women, this means an increase in healthy life expectancy of 3.3 years over the next five years. Our vision to achieve this ambition is to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home. The Tameside & Glossop Commissioning for Reform Strategy sets out the strategic commissioning priorities for improving population health over the next 5 years, and these are:

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

2. GM PERSPECTIVE TO NEIGHBOURHOOD DEVELOPMENT AND PLACE BASED CARE

2.1 Tameside and Glossop Care Together partners are part of a wider Greater Manchester health and social care system. In February 2015, the 37 NHS organisations and local authorities in Greater Manchester (GM) signed a landmark agreement with the government to take charge of health and social care spending and decisions in the Greater Manchester area; Tameside and Glossop Clinical Commissioning Group and Tameside Council are two of the 37 organisations.

2.2 Greater Manchester Health & Social Care Devolution have outlined what they see are the key features and characteristics of 'Locality Care Organisations'. Scaled, population health and wellbeing management is core to the GM strategy to transform community based care and support. Our Tameside & Glossop models closely reflect the key characteristics set out at a GM level.

2.3 Greater Manchester Public Service Reform (PSR) principles have been agreed, which are to promote:

- A **new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An **asset based approach** that recognises and builds on the strengths of individuals, families and our communities rather than focusing on the deficits.
- **Behaviour change** in our communities that builds independence and supports residents to be in control
- A **place-based approach that redefines services** and places individuals, families, communities at the heart
- Stronger prioritisation of **well-being, prevention and early intervention**
- An **evidence led** understanding of risk and impact to ensure the right intervention at the right time

2.4 In May 2015, Combined Authority members at a GM level agreed to the principles of adopting Place Based Integrated Working as a Public Service Reform workstream. The development of place-based integrated working is an essential feature of the GM whole-system approach to the creation of new Public Service delivery models and is central to the GM Health and Social Care reforms. These new delivery models have been designed to focus on reduction and prevention and building on community capacity. It is intended that these new models will maximise operational effectiveness within the context of reduced budgets and are essential to the sustainability of the neighbourhood policing function and other fundamental neighbourhood services.

2.5 To begin addressing these issues a GM-led project was carried out throughout the latter half of 2015 that delivered 'proof-of-concept' integrated working in a Neighbourhood in Wigan and another in Tameside. The purpose of the proof-of-concept working was to build evidence to demonstrate the benefits that can be realised through working in this way, increase understanding of the extent to which frontline roles can be redesigned and recognise the competencies and powers required to deliver these new roles effectively. The work has also begun to identify blockages created by current system conditions that by being addressed would lead to enhanced effectiveness and future demand reduction. The work in Wigan and Tameside has highlighted the high level of support required locally in terms of leadership and coordination, the importance of a dedicated local Strategic Lead and relevant dedicated project management support.

2.6 Our neighbourhood approach to the design and delivery of a model to deliver scaled population health and wellbeing management is in line with the Greater Manchester Devolution strategy to transform community based care and support. This paper sets out the Neighbourhood Development and Place Based Care elements of the Tameside & Glossop approach to "Neighbourhood Care Organisations" and is consistent with the GM proposed scope and features of such a model.

3. TAMESIDE & GLOSSOP NEIGHBOURHOOD DEVELOPMENT

3.1 The following vision statement was developed in Tameside and Glossop for the Care Together Programme:

"Our vision is to significantly raise healthy life expectancy in Tameside and Glossop through a place-based approach to better prosperity, health and wellbeing and to deliver a clinically and financially sustainable health and social care economy within 5 years"

3.2 To support the delivery of the Care Together programme, four key Workstreams have been established, with senior Executive, Professional and Clinical leadership. The Neighbourhood Development Workstream will act as a significant enabler to the realisation of this strategic ambition. The model represents a fundamental shift in thinking, blending evidence based approaches and interventions, robust workforce development, and place-based community approaches.

3.3 The Neighbourhood Development workstream will design and deliver an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. This system will work to improve health and social care outcomes, increase healthy life expectancy, reduce duplication, improve patient/service user satisfaction and reduce dependency on the acute sector. This system will be developed over the next 3 -5 years and in full partnership with patients, staff, voluntary sector, residents and regulators to ensure the model achieves its aims, is well understood and meets the needs of the population. Key objectives for the workstream are to:

- Define ambitious outcomes which will demonstrate delivery of the workstream's aims

- Design the models of care for each of the 5 Neighbourhoods to deliver these outcomes
- Agree how each Neighbourhood can incorporate additional services also required to meet the specific needs of their population
- Determine the scope and cost envelope for the Neighbourhood model
- Lead the transformation of Primary Care services, and deliver closer alignment and joint working of general practices within the Neighbourhood model
- Determine if new categories of staff are required to support the new ways of working and if so, to liaise with the Human Resource Enabling workstream to ensure these can be created/sourced
- Agree and prioritise a work programme to deliver these objectives
- Challenge and drive the progress of the work programmes
- Clarify interdependencies with the other workstreams, agreeing where each starts and ends
- Consider emerging Greater Manchester Devolution programmes and incorporate relevant work within the overall Neighbourhood Development programme
- Lead the commissioning/decommissioning of services to deliver the new model of care, turning it into 'business as usual' by 2018/19
- Harness opportunities for innovation and new ways of working to improve the health and well-being of people in Tameside and Glossop.

3.4 We have aligned our Neighbourhood Development work with the Health Lives workstream to ensure the neighbourhood model is a robust delivery vehicle for our system wide self-care, social prescribing and 3rd sector offer.

4. INTEGRATED NEIGHBOURHOODS

4.1. **The Neighbourhoods**
There will be five INs across the Tameside and Glossop CCG footprint. Four of the Neighbourhoods are co-terminus with the Tameside Metropolitan Borough Council Neighbourhoods. Glossopdale will be supported by Derbyshire County Council from a social care perspective.

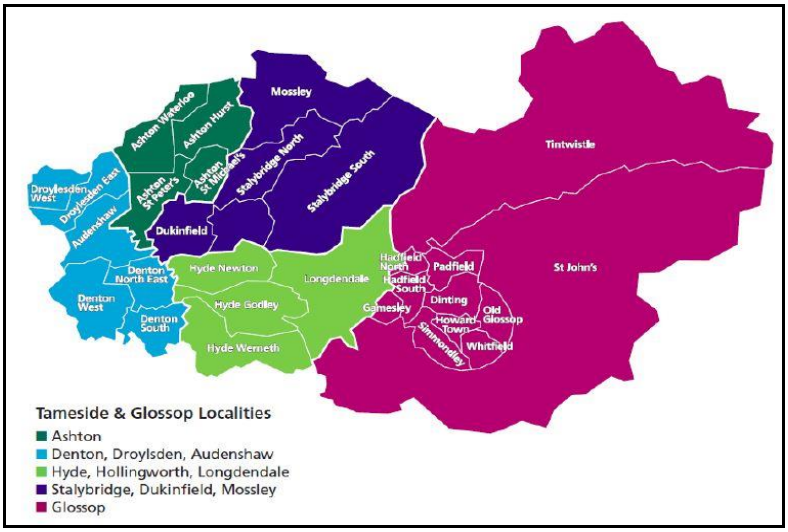
4.2 The development of INs will build upon the recent development of place based hubs in Tameside, and the public sector prevention agenda which went live in May 2016. These hubs bring together front line providers from across a range of agencies to focus resource where it is needed most and responding to issues in a holistic rather than single agency way. Agencies currently include social services, police, housing, mental health, fire and the voluntary and community sector.

4.3 We are working with colleagues in the Glossopdale neighbourhood to ensure we build on the existing links with Derbyshire Constabulary, NWAS and Derbyshire Fire & Rescue Service when implementing our model. Examples of good practice in relation to joint working in Glossopdale include the MAPs forum (a Glossop forum consisting of Police safer neighbourhood team, housing and Adult Care to manage anti-social behaviour, protect vulnerable citizens and reduce offending in the community), and the DCC work with Police Community Support Officers and Persons Susceptible to Harm Officers (with regular face to face contact and hot-desking agreements). DCC are also involved in the Vulnerable Adult Risk Management approach (VARM).

4.4 As a single commission we will continue to work with Derbyshire County Council on issues relating to the commissioning of services for the Glossopdale neighbourhood.

4.5 INs will bring wider health and social care teams into these place based hubs to deliver a wide range of services that not only treat illness but promote wellness and behaviour change. This will involve a comprehensive response from community services, social and primary

care, outreach from hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach.



	GP Practices	Registered Population
North Neighbourhood: Ashton –U-Lyne	10	56,596
South Neighbourhood: Hyde / Hattersley / Hollingworth / Longdendale	8	62,662
East Neighbourhood: Stalybridge/Dukinfield/Mossley	10	43,817
West Neighbourhood: Denton/Droylsden/Audenshaw	7	49,696
Glossopdale Neighbourhood	6	32,000

The Integrated Neighbourhood Principles and Objectives

4.6 Integrated Neighbourhoods will facilitate provision of / access to bespoke person centred solutions, working to the following principles of place based care:

- Integrated local services responsive to local need
- Services that build on assets of the community & intervene early in an emerging problem
- One team, knowing their area & each other
- Person centred approach within the context of family & community
- Services delivered within the community, close to home from a flexible asset base

4.7 The Integrated Neighbourhood vision is to support neighbourhoods to deliver asset rich, high quality and connected services which look after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing.

The key objectives are to:

- Proactively identify people at high risk of requiring access to services, through early intervention and prevention
- Help people live as independently as possible whilst managing one or more long term conditions
- Co-ordinate delivery of services from all providers, with teams of multi skilled professionals based in each of the Neighbourhoods
- Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely

- Focus on improved condition management to avoid admissions
- Help prevent people from having to move to a residential or nursing home (24 hour care) until they really need to

4.8 The INs will achieve the aims and objectives outlined above as follows:

- Focus on wellbeing, wellness and preventing illness and longer term health improvement and proactive self-care
- Provide high quality safe and sustainable services centred around the individual
- Provide short term interventions to maximise independence and self-management of illness/condition
- Work closely with partners to ensure smooth and seamless support during periods of crisis and the transition to / from hospital based care
- Use a Multi-Disciplinary case management approach to co-ordinated consistent care and support in the person's own home
- Provide high quality, holistic person centred care and support – to ensure individual choice and control
- Where appropriate, conduct Multi-Disciplinary Team meetings to review people at high risk of admission to longer term care
- Provide long term Care-Coordination to maintain stability of illness/condition
- Identifying people who may benefit from care co-ordination by a lead professional to improve individual outcomes, reduce repetition, duplication and 'hand offs' between services
- Ensuring people receive the right level of care and support at the right time and in the right place, therefore reducing the need for crisis interventions
- Support individuals and their families towards self-reliance and away from being dependent on services
- Enable carers to have a life outside of their caring role
- Consider how accessing employment and skills provision could support the patients continual health condition management and refer to specialist services and co-case manage as appropriate.

4.9 The fundamental principle of the IN proactive approach to care is that individuals are assessed for the level of care they require. Depending on the level of risk an individual has at any given point, they would be managed/signposted within the relevant framework of the model. The model takes a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need.

Integrated Neighbourhood Outcomes

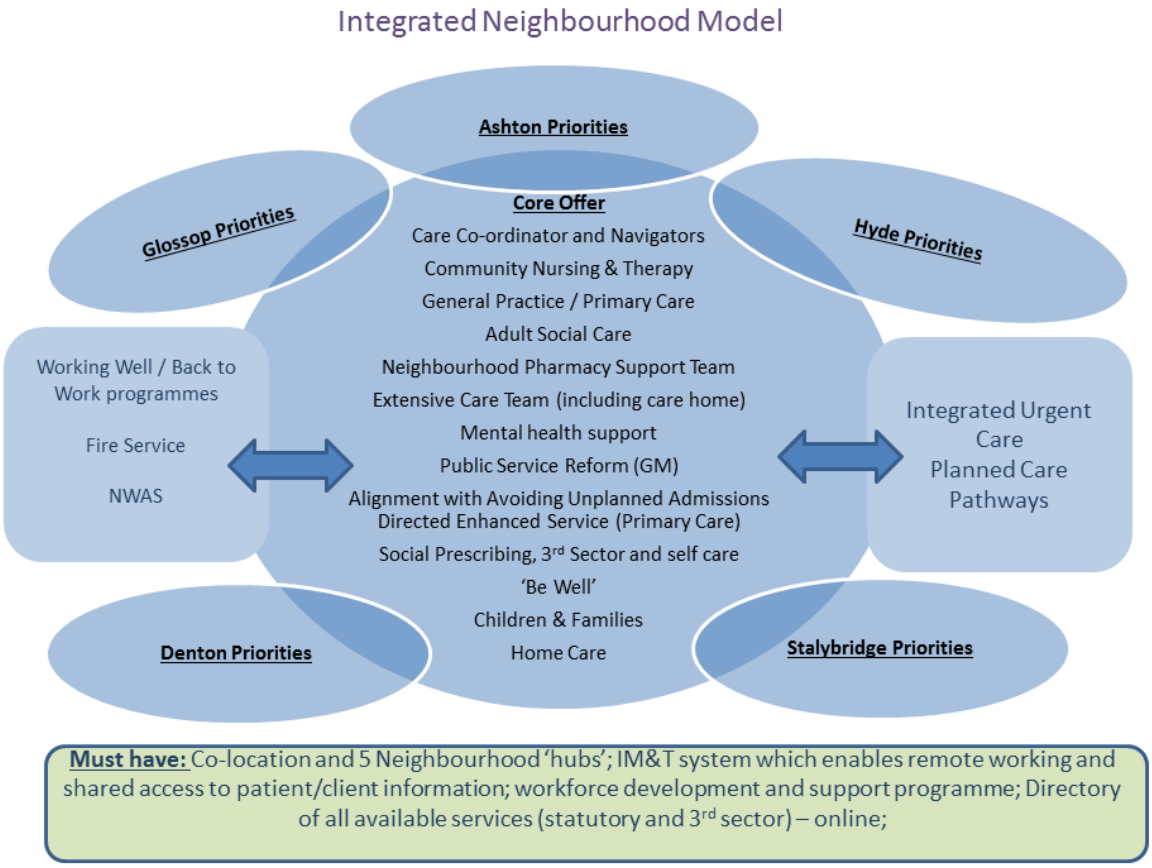
4.10 During the development of the IN model we have produced proposed metrics and outcomes in the form of 'I statements'. These have been presented to the Care Together Programme team to ensure they are included in the overall Care Together metrics, and are refined if required to ensure they are in line with the programme approach. The latest version is attached at **appendix 1**. We will continue to work with the programme team on the refinement and development of these to ensure we have robust outcome measures to take into the implementation phase of INs. We are working with Tameside Hospital NHS Foundation Trust as the shadow ICO on a set of contractual outcome measures to support delivery of our IN model.

The Model for INs in Tameside & Glossop

4.11 Our model for Integrated Neighbourhoods has been developed over a number of months, building on the previous 'Local Community Care Team' proposals, and taking into account the local progress made through the 'Public Service Reform' agenda. This is the model which all 5 neighbourhoods will work towards delivering through the implementation processes outlined in section 6 of this paper.

4.12 Through consultation with stakeholders and detailed engagement with our 5 neighbourhoods, using the vision and objectives outlined above, we have developed a model which includes a 'core offer' – an offer which is available to all 5 neighbourhoods – and local priorities which are specific to meet the needs of neighbourhood populations. Each of the five INs will look different and will eventually be staffed according to the local needs and demands, though they will share the same objectives, goals and outcomes.

4.13 The initial work has been focused on the population aged 18 years and over, but the Integrated Neighbourhood model is an 'all age' model, and as illustrated below will increasingly include the delivery of support for our children and families.



The Core Offer

4.14 As already cited in this proposal, each Neighbourhood will have a 'core offer' – an offer which is available to all 5 neighbourhoods – and local priorities which are specific to meet the needs of neighbourhood populations. The level of intervention delivered by the INT will be determined by the need of the individual. Needs will be met by a range of people with the appropriate skills from community health and social care providers, 3rd sector, General Practice (and wider primary care, e.g. pharmacy), and wider public sector teams (e.g. fire service, police service, council provided support). The core offer has been developed through consultation with stakeholders and members of the developing integrated neighbourhoods, and currently includes the functions outlined below.

4.15 The proposal is that the transformation funding requested from GM will be used to support any developments in the core offer which require additional funding. These are highlighted below *

4.16 Lists of existing staff and teams have been produced at a neighbourhood level to facilitate the development and redesign of the IN model.

4.17 **Care Co-ordinator and Navigators** The Integrated Neighbourhood Model is based upon the principle of care co-ordination and navigation. The initial proposed staffing structure includes 'care navigator' roles to support people to access the support they require, encouraging and enabling self-care and supported self-management. Key to the success of the INs will be the delivery of effective care co-ordination and key worker roles from within the existing multi-disciplinary teams, delivering the clarity and support required across what can at times be a complex system.

4.18 **Community Nursing & Therapy** The community nursing services provided by Tameside NHS Foundation Trust have been aligned/allocated to the 5 neighbourhoods to ensure delivery of core community nursing services as part of this model. The District Nursing teams have been allocated to neighbourhoods, with named members of other teams (e.g. the Macmillan palliative care team, and Long Term Conditions team) allocated to neighbourhoods whilst continuing to work as part of a CCG-wide team.

4.19 **General Practice / Primary Care** The Integrated Neighbourhood model is based on the inclusion of our member practices as part of the multi-disciplinary team / offer to our residents. Primary Care is at the heart of integrated care and our GPs have a unique opportunity to contribute to and lead the development of the ICFT. The evolving agenda requires leadership and engagement to ensure that the pathways, models of care, quality and performance are designed with primary care at the centre, working as a fully integrated partner in the new delivery models/provider.

4.20 The recently published NHSE 'General Practice Forward View' gives legitimacy and credibility to the work already underway in Tameside & Glossop to work with our practices in a new way: offering support to improve quality of care, recognising the pressures some of our practices are under and working with them to alleviate this, and working increasingly at a Neighbourhood (place) based level.

4.21 **Adult Social Care** Both Tameside Metropolitan Borough Council and Derbyshire County Council have confirmed the inclusion of their Adult Social Care teams in the Integrated Care model for the 5 neighbourhoods. The INs will therefore be responsible for the delivery of the assessment and delivery models for core adult social care. Tameside MBC have also included their Health & Wellbeing Advisors in the INs.

4.22 **Neighbourhood Pharmacy Support Team *** All 5 neighbourhoods have cited primary care based pharmacy as a priority for their neighbourhood model therefore the proposal is that this is included in the core offer for all neighbourhoods. The 'offer' from a neighbourhood pharmacy support team could include:

- Discharge facilitation: In-reach to liaise with ward based pharmacist teams
- Clinical medication reviews with patients with LTC and polypharmacy issues (including care home and domiciliary / house-bound patients)
- Support for a case load of patients from the upper two strata of the Risk Profile, intervening pro-actively to reduce likelihood of crisis, in effect conducting a community based ward round.
- Deliver training programmes to other members of the IN team.
- Pharmacist support to GP practices: Working across a neighbourhood the practice pharmacist team would help relieve some of the pressure on General Practice as indicated in the five year forward view and 'The future of primary care ; creating teams for tomorrow'
- Repeat Systems: Produce and implement a practice repeat prescribing policy.
- Undertake changes to medicines (switches) designed to save on medicine costs where a medicine or product with lower acquisition cost is now available.

- Medicines Information: Answers all medicine related enquiries from GPs, other practice staff, integrated neighbourhood members and patients, suggesting and recommending solutions and providing follow up for patients to monitor the effect of any changes
- Medicines Quality improvement: Undertake audits of prescribing in areas directed by the GPs and INs, feedback the results and implement changes
- Implement changes to medicines that result from MHRA alerts, product withdrawal and other local and national guidance.
- GMMMG: Monitor T&G community prescribing against the GMMMG formulary

4.23 **Extensive Care Team ***All neighbourhoods have highlighted the need for improved support for the 'at risk', frail, elderly, care home residents, and people with complex needs and / or multiple long term conditions. Requests were also made for improved communication and links with the elderly care physicians currently working in the acute sector, with some proposing an 'outreach' model for the care of the elderly.

4.24 Models of extensive care exist in other areas of the country and have already been considered as an approach for Tameside & Glossop. The INs will include a proposed model for extensive care / extensivists which will be designed and developed under the auspices of the Neighbourhood Development workstream and the Model of Care Steering Group. This piece of work will encompass the existing care homes work, will be aligned with the 'home first' model and proposals for intermediate care, and will take into account the existing Better Care Fund 'over 75s' resource and schemes. The work which has already commenced on proposals for an internal hospital model for the assessment and management of frailty will be aligned with this work in the community.

4.25 **Mental Health Support *** One of the commissioning priorities included in the Tameside & Glossop Commissioning for Reform Strategy is 'Supporting positive mental health in all that we do'. The IN model will include support for the mental health needs of our population. Our existing mental health services are aligned with our neighbourhood model, which means from an operational perspective each neighbourhood will know the resource available, who the people are, and how services can be accessed. Going forward we will work with our neighbourhoods, mental health commissioners and providers to address any gaps or areas for development, including support for people with dementia, and access to psychological support for people with long term conditions. This has been identified as a priority for ALL neighbourhoods through our consultation, therefore will be taken forward through the implementation phase, with proposals being developed for additional resource from across all 5 neighbourhoods' allocation of any GM transformation funding.

4.26 **Public Service Reform (Tameside Neighbourhoods)**
From 9 May 2016 the Public Service Reform model in Tameside has been rolled out across all 4 neighbourhoods. Through the implementation phase for our IN model we will ensure we align the functions and processes to bring these approaches together.

4.27 Within the Public Service Reform offer wider determinants of health such as work will be considered when supporting a patient. Referrals into specialist employment and skills services (such as Working Well) or closer integration with Jobcentre Plus services will ensure that residents who are unemployed or in work with low pay with a health condition can access support to access further opportunities into work. The core offer will provide a mechanism to further integrate health and employment and skills services centred around the resident.

4.28 The Glossopdale approach to working with the wider public sector, as it sits outside the Tameside footprint, is included in the local priorities section below.

Alignment of the Avoiding Unplanned Admissions Directed Enhanced Service

4.29 The Commissioning Team will work with primary care and the IN implementation team to ensure the DES criteria and specification is aligned with the IN approach. A proposal has

been prepared for the Professional Reference Group (reporting to the Single Commissioning Board) which recommends that we continue with the AUA as it stands but implement the IN alignment recommendations as soon as possible, latest by Autumn 2016. The national service specification is in line with our approach to Integrated Neighbourhoods therefore does not need to be reviewed or amended. However, practices have not to date been supported with the delivery or to engage with partner organisations in its delivery. This can be remedied within the current specification by aligning with our IN model.

Social Prescribing, 3rd Sector and Self Care *

4.30 The involvement of the 3rd sector is key to the success of integrated neighbourhoods, as are the use of 'social prescribing' and the development of a non-medical model. The alignment of our IN model with the Healthy Lives workstream will ensure we have the pathways and services available to deliver our social prescribing and 3rd sector access effectively across all 5 neighbourhoods. The 'Healthy Lives' GM transformation funding proposal will support this element of the IN model.

4.31 One of the key approaches to creating a sustainable economy will be supporting the population to manage their health more effectively, adopt healthier behaviours and choose appropriately when accessing support from health and social care. We will adopt a system wide approach to self-care and supported self-management, where self-care becomes our default and something promoted by all parts of the health system.

4.32 Underpinned by a proactive risk stratification approach and the use of the Patient Activation Measure, we will identify people who are at greatest risk of poor health and high levels of unplanned activity. We will focus on the development of social prescribing at scale and combine it with an asset based community development approach seeking to unlock the potential of communities and individuals.

4.33 **'Be Well' Service (Tameside Neighbourhoods only)** This team provides support for multiple lifestyle issues, e.g. improving the quality of diet and nutrition, stopping smoking, reducing alcohol intake, increasing physical activity etc. The service welcomes anyone over the age of 16 and the advisors also offer all clients a holistic 'wellbeing' assessment. The assessment will include asking about: clients overall health, feeling connected to other people, affordable warmth concerns, money, emotional health and work/training. Clients will then be supported to achieve their goals and to navigate the system and access appropriate services. The 'Community Liaison' approach will be to work with residents, groups and organisations to promote Health and Wellbeing and encourage greater access to Be Well Tameside services. Be Well Tameside offers a health and wellbeing a training programme to enhance and develop the competencies and skills of the wider public health workforce across organisations and the community.

4.34 **Children & Families** The Integrated Neighbourhoods will provide support to the whole population of Tameside & Glossop. Initial work has focused on a model for adults (18yrs+) but the existing programme of work relating to children & families is now being aligned with our neighbourhood model, to ensure seamless delivery of support to our population. Further detail of the services deemed 'in scope' for neighbourhood level delivery will be identified from July 2016 onwards and included in the implementation of the IN model. This work will include alignment with the Public Service Reform agenda and the GM children & families reform agenda.

4.35 **Home Care** Using a holistic approach to service delivery, we will redesign the current homecare model to ensure it is focused on individual strengths and capabilities. Homecare workers and providers will form an integral part of the INs. We will place an emphasis on moving away from time and task, to high quality contact with people that utilises a wide range of community assets, technology and the range of community and primary health available to remain safe, secure and independent at home. The new service will deliver a sustainable

care home market with significant more capacity and which pays its staff at levels commensurate with the expected role.

4.36 **Accessing the Integrated Neighbourhoods** Through the implementation phase a detailed process and pathway will be developed to ensure the access to support from our Integrated Neighbourhoods is clear to all – professionals and public. This will need to align with the Integrated Urgent Care Team pathways, assessments and points of entry. It has been agreed, through the development of the draft Operational Procedures for INs (see section 4.7 below) that there will be three main points/routes of access to the IN:

i. New and urgent presentation

This will be made via the single point of contact, where an assessment / triage will be undertaken, based on the information provided by the "referrer". This will ensure the first assessment is responsive, holistic and multi-professional

ii. Known cases / clients requiring review of existing intervention / package of care

These cases will be picked up via the internal INT communication channels and relationships developed by working as a neighbourhood team and/or via the statutory trigger points for review where applicable. No new referral will be required, but the new need will be highlighted via internal messaging and communication.

iii. Case finding (including from risk stratification data – see below)

Appropriately nominated members of the INT will be responsible for the analysis of the risk stratification data, including the identification of individuals who would benefit from intervention and/or case management. New / Known client routes of access (see points i and ii above) would be applied to cases identified via risk stratification

Work has commenced on the development of clear access points, including the assessment and triage processes, to enact the approach outlined above. This work will ensure alignment with the urgent care pathways and processes.

4.37 **Expanding the Neighbourhood Model** The Neighbourhood Development workstream will work across the Care Together programme to identify the priority pathways for redesign and delivery via / in support of the Integrated Neighbourhoods during 2016-17 and beyond. Services currently delivered at a CCG level will also align themselves to our Neighbourhood model, to ensure that whether via electronic referral, "advice and guidance" or face to face presence in the Neighbourhoods, our INs have access to the specialist input and support needed. Initial priorities identified include pathways for people with respiratory disease, diabetes, cardiovascular disease, support for people with a learning disability, and those in need of palliative / end of life care. This will also ensure the necessary links are made with the Planned Care and Urgent Care workstreams.

4.38 **Enabling Projects and Priorities** The Integrated Neighbourhood Project Steering Group have identified 12 key enablers to the development and implementation of the Integrated Neighbourhood model, and are working across the Care Together programme to facilitate the achievement of these tasks:

Agreed outcome measures and "I statements" for the Integrated Neighbourhoods: The IN Project Steering Group defined a set of metrics in the early stages of the project, and expanded these to the level of detail seen the draft document at appendix 1 of this document. The Care Together Programme are now developing metrics which will cover all elements of the programme, including INs. The IN project steering group will continue to engage in this piece of work to ensure the workstream's priorities are included.
Clear points of entry into the INs defined and communicated: As described in section 4.5 of this document, the IN steering group are leading a project to determine the detail of the access points for the INs.

A co-ordinated offer for prevention, health and wellbeing support in the 5 localities: The work of the IN and Healthy Lives workstreams is aligned to ensure the healthy lives 'offer' is included in the IN model, and that INs are established to deliver and support people into the defined offer.
Ensure information on the wellness offer is accessible and clear with in the localities: The IN Project Steering Group through the Care Together Programme Office are taking this work forward to ensure delivery of the information and support requested and specified through our programme of engagement.
Clear plan in place for the co-location of core LCCT staff: The development of the IN model has informed our Strategic Estates planning, in particular the development of the proposal for 5 neighbourhood 'hubs'. Input to this planning will continue.
IM&T plan in place to support LCCT project, to reflect the work to date with Liquid Logic and EMIS, and to include plans for community nursing and mental health systems: The IN project steering group work closely with the IM&T enabling workstream to ensure the IM&T requirements of the IN model are addressed by the wider IM&T plans. We are working with the IM&T team on the re-procurement of a community system, and work to develop and implement a system which enables viewing of records across health and social care.
Development of a clear HR/OD/Workforce plan: A 'People Task & Finish Group' has been established, led by the HR/OD leads from the ICO and TMBC, to support the development of a workforce plan for the IN model.
Clear plan for information sharing (Long term strategy and ensure safe and secure working in the interim): Working with the wider Care Together programme to ensure safe practice in relation to information sharing.
Full Standard Operating Procedure developed and agreed: A draft 'operating model' has been developed which will be picked up and developed further as required in the implementation phase of the IN work.
Review of the Admissions Avoidance Directed Enhanced Service to be completed, to ensure alignment with the Integrated Neighbourhood model: A proposal for the alignment of the AUA DES and the IN model has been developed for consideration by the Professional Reference Group and Single Commissioning Board, as described in section 4.4.9 above.
Clear plan in place for support for Carers: Through the single commission, an approach for the support for carers as part of the IN model is in development
Confirmation of the dedicated resource for each IN: A summary of the resource allocated to each IN from the existing service providers has been developed (general practice, THFT community services, adult social care DCC and TMBC) to inform the implementation phase of this project.

4.39 **Neighbourhood Priorities** During the development of our initial Local Community Care Team model, which developed into the Integrated Neighbourhood proposal, we have engaged extensively with a wide range of local stakeholders, including patients and public representatives. This engagement has provided the detail of the model described in this paper, and the detail of our core offer. This engagement has included numerous workshops, regular discussions at the existing neighbourhood meetings, presentation to and discussions with Patient Participation Groups, and the formation of a multi-agency Integrated Neighbourhood Steering Group.

4.40 To ensure we gained consensus on our proposals for the IN model and the 'core offer', and to ensure we captured the local priorities, the 5 Neighbourhoods have held workshops during June and July 2016 to identify their key priorities for delivery. The IN workshops, or 'lock-ins' were each attended by between 40-60 (varied between neighbourhoods) representatives from a range of statutory and public sector services / teams (including general practice), 3rd sector organisations and Patient Participation Groups. The sessions were facilitated by members of the Single Commission and shadow Integrated Care Organisation, and gave all stakeholders the opportunity to participate in the design process. The write up of the

sessions has been shared widely to ensure those attending and those unable to attend could confirm their support for the model and their agreement with the declared local priorities.

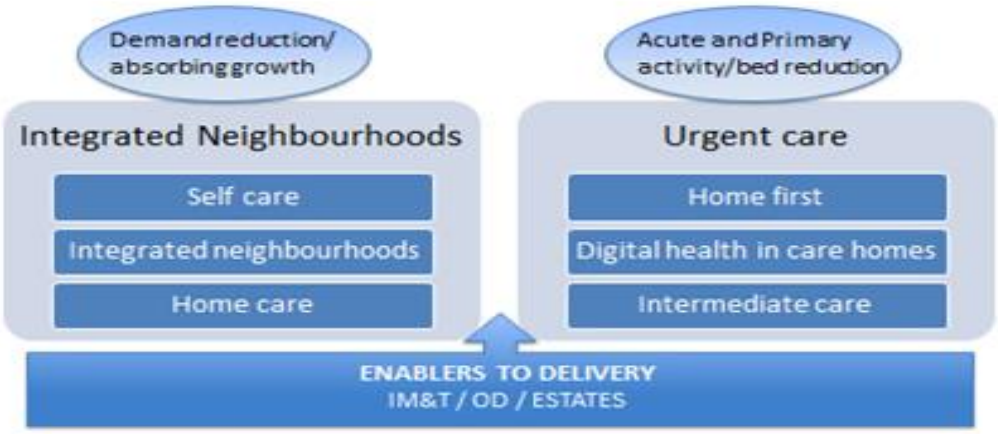
4.41 Some priorities arising from the workshops were identified in more than one neighbourhood, and have therefore been included in the 'core offer' as developments to take forward across the locality. The Neighbourhood specific priorities, for consideration and development over and above the core offer, currently stand as:

North Neighbourhood (Ashton)	Campus approach to delivery of services and support Upskill volunteers in the community Consistency in primary care offer Increased resources in IAPT
West Neighbourhood (Denton)	Telecare/medicine - expand use of assistive technology in the community Community patient transport Additional / enhanced support for care homes Community paramedic
Glossopdale Neighbourhood	Retain community paramedic role in Glossop Access to work / employment schemes Build on / develop further the strong links with the voluntary sector in Glossop Childhood mental health and 'school readiness'
South Neighbourhood (Hyde)	Care Navigation & 'Alice' role - Community resilience and development Improvements in early intervention and proactive support / case finding Improved links between health and education / school age children and their families Improved dementia care
East Neighbourhood (Stalybridge)	Support and action groups for young families Support to care home sector Proactive multi-agency case finding – neighbourhood 'case conference'

4.42 There will be further work within the neighbourhoods during July and August to refine and confirm these priorities, taking us into the implementation phase which will commence from August 2016 onwards.

5. COST BENEFIT ANALYSIS & GM TRANSFORMATION FUNDING

5.1 The Care Together investment case to GM comprises a series of interdependent transformation schemes that together help Tameside & Glossop deliver a financially and clinically sustainable health and care economy and improve the healthy life expectancy of the local population. The schemes are broadly split into two groups focusing on demand reduction/absorbing growth and reducing acute and primary activity as illustrated by Diagram 1 below.



5.2 An effective integrated neighbourhood model will impact on the demand on our urgent care system, non-elective pathways, and traditional models of elective care (including hospital based outpatient services). In order to deliver this model, we have proposed investment in the neighbourhood infrastructure and have submitted plans to GM for transformation funding to this effect. The funding model below is an extract from the GM submission, but further work will be required prior to allocation once the Care Together programme receive feedback and a decision from GM.

Neighbourhood Development

36 month non recurrent support required from start date. Assumed funding granted on 30 June with 2/3 months mobilisation. Therefore funding required September/October

Neighbourhood Specific Offer	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Ashton	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Denton	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Hyde	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Stalybridge	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Glossop	0	0	100	100	200	100	100	100	100	400	400	200	0	1,200
Total	0	0	500	500	1,000	500	500	500	500	2,000	2,000	1,000	0	6,000

Staffing of new structures	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Ashton	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Denton	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Hyde	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Stalybridge	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Glossop	0	0	38	38	75	38	38	38	38	150	150	75	0	450
Total	0	0	188	188	375	188	188	188	188	750	750	375	0	2,250

Total Neighbourhood Development	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
	0	0	688	688	1,375	688	688	688	688	2,750	2,750	1,375	0	8,250

5.3 The neighbourhood costs above cover £750k additional pay costs in relation to the creation of neighbourhood managers and care co-ordinators who will ensure that all services are wrapped around the person. In addition to this a further £2m per annum has been identified to ensure that services appropriate to the neighbourhood's needs are developed to ensure that growth is stemmed.

5.4 In order to support this it will be necessary to improve home care services within the area to upskill staff to provide a broader range of support for individuals than is currently offered and to ensure that that support is integrated into the neighbourhood and forms part of the wrap around services offered. The details of the financial investment proposals to support this are outlined below.

Home Care

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Training	0	0	0	20	20	0	24	36	26	86	0	0	0	105
Supervision & Support	0	0	21	62	83	62	62	62	62	248	0	0	0	331
Increased Pay costs	0	0	0	56	56	56	125	227	302	710	1,210	605	0	2,581
Total	**0**	**0**	**21**	**138**	**158**	**118**	**211**	**325**	**390**	**1,044**	**1,210**	**605**	**0**	**3,017**

5.5 The proposed investment in the 'Living Well / Healthy Lives' initiatives – summarised below – will also support the delivery of an effective IN model in T&G and support our work to reduce demand and stem growth.

Living Well

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
Community Navigators	0	0	88	88	175	88	88	88	88	350	350	175	0	1,050
Stimulate Voluntary Sector	0	0	188	188	375	188	188	188	188	750	750	375	0	2,250
Social Prescribing IT	0	0	0	50	50	5	0	0	0	5	5	0	0	60
Primary Care Volunteers Netwo	0	0	0	125	125	0	500	0	0	500	400	200	0	1,225
Social Marketing & Comms	0	0	25	25	50	25	25	25	25	100	100	50	0	300
GP/patient facing dynamic hea	0	0	0	1	1	0	0	0	2	2	4	0	0	7
Total	**0**	**0**	**300**	**476**	**776**	**305**	**800**	**300**	**302**	**1,707**	**1,609**	**800**	**0**	**4,892**

5.6 The table below identifies the benefits associated with the implementation of and investment in Integrated Neighbourhoods. The basis of this model is that we will prevent all growth from Q2 2017-18 as outlined below:

Benefits Realisation

Integrated Neighbourhoods

£000's	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total £000's
A&E	0	0	0	0	0	0	17	35	52	105	390	575	862	1,932
Non Elective	0	0	0	0	0	0	91	181	272	544	2,031	2,990	4,481	10,045
Non Elective XBD	0	0	0	0	0	0	8	17	25	51	190	279	419	939
Elective	0	0	0	0	0	0	29	58	87	173	648	953	1,429	3,204
Outpatients	0	0	0	0	0	0	59	118	176	353	1,317	1,939	2,907	6,516
Total	**0**	**0**	**0**	**0**	**0**	**0**	**204**	**408**	**613**	**1,225**	**4,576**	**6,737**	**10,098**	**22,636**

Activity	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	2016/17 Total	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	2017/18 Total	2018/19 Total	2019/20 Total	2020/21 Total	Total
A&E	0	0	0	0	0	0	147	293	440	880	3,287	4,840	7,191	16,198
Non Elective	0	0	0	0	0	0	55	110	165	331	1,235	1,818	2,701	6,084
Non Elective XBD	0	0	0	0	0	0	38	77	115	231	863	1,270	1,887	4,250
Elective	0	0	0	0	0	0	27	53	80	159	594	874	1,299	2,926
Outpatients	0	0	0	0	0	0	513	1,026	1,539	3,078	11,493	16,921	25,141	56,633

5.7 The information above uses our planned budgets for 2016-17 as a baseline. The plan is to maintain activity over the next 5 years at our 2016-17 planned levels for A&E attendances,

non-elective admissions, emergency excess bed days and outpatients, and to reduce growth in elective and daycase admissions by 50%. In the implementation phase we will develop detailed neighbourhood-level subsets of the plans outlined above. In summary, the INDICATIVE 'split' based on registered population is as follows:

Required saving split by neighbourhood (£000)		2016-17	2017-18	2018-19	2019-20	2020-21
Ashton	24.77%	-	607	1,133	1,669	2,501
Denton	19.90%	-	488	911	1,341	2,009
Glossop	11.37%	-	279	520	766	1,148
Hyde	26.40%	-	647	1,208	1,778	2,666
Stalybridge	17.56%	-	430	803	1,183	1,773
Total	**100%**	**-**	**2,451**	**45,76**	**6,737**	**10,098**

6. IMPLEMENTATION OF THE INTEGRATED NEIGHBOURHOOD MODEL

6.1. **Neighbourhood Implementation Teams** The Neighbourhood Development workstream will support and lead the establishment of 5 Neighbourhood Management Teams to lead the implementation of the model. The Model of Care workstream will provide oversight to a robust governance structure, including the development and approval of 'memoranda of understanding' between the Neighbourhoods and the Care Together Programme and Single Commission.

6.2 To support the implementation of the IN model in each neighbourhood, and to ensure the detailed local requirements are addressed, a full write-up of the sessions held in June 2016 has been produced and will be available to the commissioning and operational teams to enable them to support the neighbourhood in an ongoing programme of development and implementation.

6.3 **Risk Stratification** The Single Commission will ensure the production and distribution of risk stratification data to support the implementation of the IN model, and the identification of 'at risk' patients. The GPs will be the custodians of this data, and through application of the Risk Stratification Policy we will ensure safe use of this information. The Single Commission will work with the INs on the ongoing refinement, analysis and presentation of risk stratification data.

6.4 **Operational Management** Each IN will be led by a senior IN Operational Manager, managed via the shadow Integrated Care Organisation. The post holder will work closely with partners within the neighbourhood, and cultivate and develop close working relationships. Acting as an ambassador for best practice within care planning and problem solving, the post holder will also work closely with external partners. They will assist in ensuring that the Neighbourhood delivers its financial, activity, user experience and clinical and quality outcomes. The post holder will be responsible for the continuing development of the IN to meet the needs of the local population, using and developing the resources available to enable this. Dynamic individuals will need to be recruited to these posts to ensure the IN model reaches its full potential. Recruitment to key posts to support the operational implementation of the Integrated Neighbourhoods is due to commence in July 2016.

6.5 **Commissioning Support**
Each of our neighbourhoods already have dedicated commissioning support from the single commission, including members of our finance team. This resource will support the ongoing implementation and development of our IN model, working closely with the operational managers and team, and our member practices, to lead the effective implementation of our plans as key members of the Neighbourhood Management Teams.

APPENDIX 1

INT Objectives					
Proactively identify people at high risk of needing access to services	**Help prevent people from having to move to a residential or nursing home until they really need to**	**Coordinate delivery of services from all providers, with teams of multi-skilled professionals based in each of the localities**	**Help people to live as independently as possible whilst managing one or more long-term conditions**	**Focus on improved condition management to avoid admissions**	**Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely**
Client Outcomes – possible Outcomes for each INT Objective					
I get help at an early stage to avoid a crisis	I feel safe and supported in my own home	I do not have to speak to lots of different people to get the support I need or There is a single point of contact available to me where there is knowledge and skills to help me	I have the information and support I need in order to remain as independent as possible*	I have considerate support delivered by competent people*	I have access to a range of support that helps me live the life I want and remain a contributing member of my community*
It is recognised that I may need support to help me to keep well and at home	I have the equipment I need to be supported in my own home	I can speak to people who know something about care and support and can make things happen*	I want to feel that services are shaped around my needs and not the other way round**	I can plan ahead and keep control in a crisis*	I have a network of people who support me - carers, family, friends, community and if needed paid support*
The people who know me communicate with each other and let each other know if I have any extra needs that I may need their support with	I know what to do and who to contact in a crisis	I have access to easy to understand information about care and support which is consistent, accurate, accessible and up to date	I am supported to maintain my independence for as long as possible***	I feel safe, I can live the life I want and I am supported to manage any risks	I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities*
I want to get the right type of help, when things	I am supported with both my physical and	I have a clear line of communication, action and	I am happy with the quality of my care and support and I	I have systems in place so that I can get help at	I am in control of planning my care and support *

first start to be a problem, at the right time in the right place and without having to wait until things get worse**	mental health needs so that I can stay in my home	follow-up* or The goals of my rehab are clear, meaningful and measured and there is recognition that my goals may change throughout my life.	know that the person giving me care and support will treat me with dignity and respect ***	an early stage to avoid a crisis*	
I can refer myself to services easily when I need to and as my needs change		I have knowledge of, and access to, joined up rehabilitation services that are reliable, personalised and consistent.	My rehabilitation supports me and gives me confidence to self-care and self-manage, making the best use of available technologies and stops me from being admitted to hospital unnecessarily		I have care and support that is directed by me and responsive to my needs
					I am supported by people who help me make links into the community*
Possible Performance Measures for each INT Objective					
Proactively identify people at high risk of needing access to services	**Help prevent people from having to move to a residential or nursing home until they really need to**	**Coordinate delivery of services from all providers, with teams of multi-skilled professionals based in each of the localities**	**Help people to live as independently as possible whilst managing one or more long-term conditions**	**Focus on improved condition management to avoid admissions**	**Optimise self-care and family/carers support to enable people to stay at home for as long as possible, independently and safely**
Number of people identified at risk of needing access to services (include LD and MH)	No and % people remaining at home 90 days after discharge from hospital (including mental health	No and % people with single, holistic and personalised INT care plan in place	% people advising they have the information and support they need	% people reporting they feel more confident in managing their care at home	% of clients with a personalised and holistic support plan

	and LD)				
No. and % of A&E attendances for INT cohort (baseline vs. 1 year into targeted support	% people in 50% cohort (needs more help; needs a lot of help) being supported in their own home	% of staff completed mandatory training	% people feeling informed of their conditions and able to manage independently with the support provided	No. and % of INT cohort admitted to hospital	% of clients reporting that they are supported by their network - via patient experience measure
Delayed Transfers of Care attributable to INT	Proportion of adults with a learning disability who live in their own home or with their family	% people reporting their care is coordinated	% people feeling their psychological health and well-being is supported	SI Reporting Evidence of triangulation of learning from incidents; complaints, compliments, and other Patient Experience measures - you said, we did approach	% of clients whose care plan is monitored and reviewed regularly (appropriate timings to be agreed and will need to personalised dependent on need level)
? measure re Safeguarding	Proportion of adults in contact with secondary mental health services living independently, with or without support	% Staff FFT			
% clients reporting they know who to contact in a crisis	% people in 50% cohort with named case worker	% Staff feeling valued in their role (may need to complete staff-survey bi-annual; as will not be able to disaggregate INT staff from overall staff group)	% of people reporting improvement in individual Goals	% staff training completed (need to agree any key areas beyond mandatory)	
% of medical outpatient appointments	% people reporting feeling safe and supported in own home	% People knowing who to contact for support	% of people reporting positive impact based on the Session Rating Scale	Case studies – analysis of 10 randomly selected cases per INT of people with a Care Plan to	

				measure impact against a range of indicators including change in admission rate	
% cohort reporting increased well-being	% people admitted to care homes or care homes with nursing in year	Evidence of open and safe reporting culture (STEIS; patient safety incidents; safeguarding)		Outcomes on discharge/case closure	

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Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**CONTRACT FOR THE PROVISION OF INDEPENDENT SERVICES FOR TAMESIDE BIRTH PARENTS AND RELEVANT GRANDPARENTS**
Report Summary:	To present a report outlining the statutory requirement for this service and seek authorisation to extend for a period of up to twelve months (effective from 1 September 2016) where there is provision to do so in the contract.
Recommendations:	That approval is given to extend the contract with Adoption Matters for a period of up to twelve month effective from 1 September 2016.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The value of the proposed extension to the contract for a 12 month period from 1 September 2016) will be £ 0.015m. This will be a cost to the Childrens Service within the aligned budget of the Integrated Commissioning Fund (ICF). Single Commissioning Board members are reminded that the ICF currently has a projected total funding gap of £ 21.119m at 31 March 2017. It is therefore essential that proposals are implemented as a matter of urgency to reduce this projected gap for the 2016/17 financial year and on a recurrent basis thereafter.
Legal Implications: (Authorised by the Borough Solicitor)	The proposed extension was provided for within the procurement exercise and the contract. The extension would not constitute a material variation for the purposes of procurement legislation and therefore it is reasonable to extend the contract for a period of up to twelve months if this is expedient to service delivery.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Developing Well and Living Well programmes for action
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group and Single Commissioning Management Team have recommended this report go to the Single Commissioning Board.
Public and Patient Implications:	None

Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	This service meets the Council's statutory requirement to provide independent services to Tameside Birth Parents and relevant Grandparents advocacy hence ensuring the Birth Parents voice is heard. The service will Provide a named support worker, supporting birth parents to participate in decisions about their child/ren and allowing birth parents to contribute to the making of plans for their future welfare.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding is central to this service
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	The Council will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan
Access to Information :	The background papers relating to this report can be inspected by contacting Nick Ellwood, Planning and Commissioning Officer:  Telephone: 07976931066  e-mail: nick.elwood@tameside.gov.uk

1. BACKGROUND

1.1 Under Regulation 14 of the Adoption Agencies Regulations 2005/389 made pursuant to the Adoption and Children Act 2002 an adoption agency is requirement to provide counselling and information for, and ascertain wishes and feelings of, the parent or guardian of the child and others.

1.2 Feedback from birth parents at the time the service was commissioned indicated that they would like a local service, or a service that is prepared to visit them in their own home, ideally independent of the Local Authority.

1.3 The current contract provided by Adoption Matters commenced on the 1 September 2014 and ends on 31 August 2016. The contract includes an option to extend for a further period of up to one year.

1.4 The purpose of the service is to provide support for birth parents, independent of the child's social worker from the time of adoption when identified as the plan (from the point of a best interest decision).

2. PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

2.1 Under Procurement Standing Order F1.3 permission must be sought to extend a contract even when the provision to extend is included within the contract.

3. VALUE OF CONTRACT

3.1 The value of the contract extension in £0.015 million. The annual contract price has remained the same for the past two years.

4. GROUNDS UPON WHICH WAIVER / AUTHORISATION TO PROCEED SOUGHT

4.1 Under Procurement Standing Order F1.3 permission must be sought to extend a contract even when the provision to extend is included within the contract.

4.2 Robust contract monitoring has been undertaken throughout the length of the contract. The report's author is satisfied that the service is being delivered to an excellent standard. Performance data received each quarter provides good evidence the service was meeting Children's Services objectives. For example :

4.3 During the period 1 April 2015 to 31 March 2016 the supplier has processed 31 Tameside enquiries to the Action line. Of the 31 enquiries:

- Sixteen were from social workers, ten were self-referred, and four were referred by other professionals.
- The enquiries/ referrals included those in relation to the following service users
  Ten birth parents (current), seven adoptive families, one historical birth family, eight professionals (consultation/advice)

4.4 It should be noted that of the 31 enquiries during the period 1 April 2015 to 31 March 2016, 19 new cases were allocated to an adoption support worker. In addition to the 19 cases allocated a worker since 1 April 2015, the supplier has continued to support a further 16

individuals/ couples referred prior to that date, giving a total of 35 ongoing cases during the period. Of the service users supported during this financial year, 13 have received long term / intensive involvement. The contract appears approximately the correct size for level of demand in terms of total number of referrals and provides some capacity for flexibility.

4.5 The service is essential to ensure there is; intervention at an earlier stage with Birth Parents. One of the key benefits of the service is that the staff employed via this contract are experienced Social Workers independent of the Council. This has helped to build a more positive relationship with Birth Parents who otherwise might not engage with the Councils Social Workers due to their experience(s) in relation to the Adoption process.

4.6 The current service provider has shown a commitment to continually improving systems and service delivery to meet the needs of its service users:

4.7 The following options have been considered and discounted for the reasons stated below:-

- **End contract and amalgamate the service with other services/contracts.** Due to the specific nature of this service, it would be extremely difficult to undertake any form of amalgamation with other services/contracts as it was felt that the elements of the service could easily be consumed and the success of the service suffer as a result. It would be difficult to purchase the individual elements of the service for the financial commitment that is already provided by each area, as outlined above.
- **End contract and re-tender**; there is no guarantee that we would be able to find a successful tenderer to provide this service at the price that we currently invest. This course of action would not provide any added benefits to the Council, the service provider or the service users and may create a break in service provision for Birth Parents.
- **Extend contract on renegotiated terms**; the current contract price is very low in terms of the significance of this work to Birth Parent and reflects value for money. To reduce the current contract price would seriously jeopardise the service as the supplier would find it difficult to deliver the same levels of support. The purchaser and supplier agree that the current funding levels meet the required demand for Birth Parent support in Tameside.
- **Extend contract on current terms;** based on the positive performance during this contract to date. This is the preferred option.

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

5.1 The Procurement Standing Orders are being complied with. Under Procurement Standing Order F1.3 permission must be sought to extend a contract even when the provision to extend is included within the contract.

6. RECOMMENDATIONS

6.1 As stated on the report cover.

6.2

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	Tuesday 6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INSPECTIONS OF LOCAL AREAS' PROVISION FOR CHILDREN AND YOUNG PEOPLE WHO HAVE SPECIAL EDUCATIONAL NEEDS AND/OR DISABILITIES (SEND)**
Report Summary:	A new framework for the inspection of local areas' effectiveness in meeting the needs of Children and Young People with Special Education Needs and/or Disability (SEND) has been implemented. It is important to note that this is a local area inspection, not a local authority inspection. The local area includes the Local Authority, CCGs and Public Health. This report outlines the process and exposes the risks that the joint inspection framework may hold.
Recommendations:	1. SCB is asked to note the contents of this report, and to authorise CCG/single commission officers and the clinical lead to continue to take relevant steps, make decisions, and to progress arrangements to further the implementation of the SEND reforms 2. SCB recommended to consider, approve and ensure that: ▪ Action plan based on the findings on the CCG SEND Diagnostic audit tool is developed and approved through the emerging governance structure; ensuring oversight and inspection readiness ▪ The CCG/single commission function seeks that all relevant providers are briefed in relation to the new inspection framework and its requirements ▪ The CCG/single commission function seeks a re-audit applying CCG SEND Diagnostic audit tool in July 2017.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	None noted at this Stage – Main Health SEND service (ISCAN) remains on CCG Risk register
Legal Implications: ***(Authorised by the Borough Solicitor)***	This report sets out a new inspection regime and the actions required in order to ensure such inspections are effective and efficient and that any learning is acted upon in interests of the children and young people who receive the services.
How do proposals align with Health & Wellbeing Strategy?	The Health and wellbeing Strategy is due to be refreshed this year, but has a strong focus on starting and developing well, supporting the most vulnerable in our communities and helping our children and families to reach their full potential. The recommendations in this report would support and strengthen the update.
How do proposals align with Locality Plan?	SEND and the wider children's agenda (arrangements) needs to clarified in relation to the Locality plan(s).

How do proposals align with the Commissioning Strategy?	Seek to ensure that SEND commissioning arrangements are clarified and documented with the Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	Paper Noted and SEND Action plan to be developed and approved through governance structures in September 2016. Single Commission function need to ensure oversight of plans going forward and ensure all relevant providers are briefed in relation to the new inspection framework and its requirements.
Public and Patient Implications:	Seeks to strengthen engagement with children and young people with SEND and their families.
Quality Implications:	Seeks to drive and build on existing arrangements and provision.
How do the proposals help to reduce health inequalities?	Seeks to ensure that required support to the most vulnerable in our communities and helping our children and families to reach their full potential is embedded within commissioning frameworks.
What are the Equality and Diversity implications?	As above
What are the safeguarding implications?	The report has been considered by CCG safeguarding and no implications noted.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The agreement and recommendation for an agreed action plan will ensure/aid the SCB that information relating to SEND is efficiently managed and that appropriate policies, system processes and robust governance framework are in place. Ensuring that SCB effectively and ethically use information within commissioning decisions.
Risk Management:	The CCG SEND Diagnostic audit has been undertaken to highlight areas of potential weakness/risk. The proposed recommendations and actions seek to mitigate the risks of a potential poor inspection.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Commissioning (Alan Ford, Commissioning Business Manager for Children, Young People & Families) Telephone: 0161 304 5300 e-mail: clarewatson2@nhs.net (alan.ford4@nhs.net)

1. INTRODUCTION

1.1 A new framework for the inspection of local areas' effectiveness in meeting the needs of Children and Young People with Special Education Needs and/or Disability (SEND) has been implemented. The new inspection programme began in May 2016, with potentially Tameside and/or Derbyshire (Glossop) assessment likely for the autumn/winter 2016/17.

2. WHO WILL BE INSPECTED?

2.1 All 152 local areas in England will receive a local area SEND inspection over a period of five years. It is important to note that this is a local area inspection, not a local authority inspection. The local area includes the Local Authority, CCGs and Public Health. The new joint inspection framework for SEND will seek to hold the CCG/Single Commission to account and ensure that our commissioning plans are appropriate to meet local demand, and to ensure they have an effective relationship with the key providers to ensure effective arrangements for delivering completed and implemented EHC plans.

3. WHO WILL UNDERTAKE THE LA SEND INSPECTIONS?

3.1 Care Quality Commission (CQC) and Ofsted will jointly carry out the inspections of local areas. Inspection teams will consist of an HMI, a CQC inspector and an Ofsted Inspector (with SEND experience and training).

4. WHAT WILL INSPECTORS LOOK FOR AS PART OF THE INSPECTION?

4.1 Inspectors will evaluate how effectively the local area identifies children and young people who have special educational needs and/or disabilities. Inspectors will also evaluate how effectively the local area meets the needs and improves the outcomes of children and young people who have special educational needs and/or disabilities. How well a local area engages with, and involves children and young people and their parents and carers, both in commissioning services at the strategic level and in assessing individual need will be a key area of inspection focus.

5. HOW WILL INSPECTORS CONDUCT THE INSPECTIONS?

5.1 A wide range of information will be used to evaluate the effectiveness of local area arrangements to identify children and young people who have special educational needs and/or disabilities; and to meet their needs and improve their outcomes. A range of ways will be used during the inspection to obtain the views of disabled children and young people and those who have special educational needs, and their parents and carers. The field work is likely to include discussions with elected members, key local area officers from health, education and social care, and meetings with leaders of early year settings, schools and colleges, and specialist services. Visits will be made to a range of providers and services. Visits will not inspect the provision but focus on their understanding and participation in meeting the local area's responsibilities.

5.2 There will be a strong emphasis on gathering the views of young people, parents and carers, involving:

- Meetings during visits to early years settings, schools and colleges
- Meeting with established young people, and parent and carer groups
- Meeting with any reference groups established by the local area.
- Where possible, a webinar for parents and carers during the inspection.

6. HOW LONG WILL EACH INSPECTION BE?

6.1 Each inspection will include five days of on-site inspection activity. There will also be preparation time for the inspection team and time following the one-site inspection to complete all inspection outputs (e.g. the report).

7. NOTICE IN ADVANCE OF AN INSPECTION?

7.1 Local areas will receive five days' notice in advance of an inspection. This will give those in the local area, notably young people, parents and carers, the opportunity to provide their feedback and contribute their views.

8. PREPARATION

8.1 Within Greater Manchester, Bolton has undergone inspection and has shared experience. As such Bolton CCG and Public Health were requested by CQC to provide the following commissioning and performance data:

- Health Child Programme
- School Nursing Service
- Neonatal Screening Programme
- CAMHS
- SALT, OT, Physiotherapy
- Any commissioned pathways and arrangements for specialist services for children and young people with SEND

8.2 Bolton CCG noted that CQC and Ofsted will view [*require*] completed CCG SEND Diagnostic audit tool as evidence demonstrating an active commitment to and interest in implementing the reforms

8.3 The CCG SEND Diagnostic audit tool pulls together in one place the key pieces of evidence that the CCG will wish to assure itself on in terms of its progress in implementing the 2014 Children and Families Act reforms in relation to disabled children and young people and those with SEN.

8.4 Tameside and Glossop CCG audit was completed in July 2016. The diagnostic audit provides a framework for considering progress to date; and is divided into the 6 key areas of the role of a CCG in supporting children with SEND.

1. Leadership
2. Joint Arrangements
3. Commissioning
4. EHC plan
5. Engagement; and
6. Monitoring and Redness

8.5 RAG rating scores are applied to accordingly and trend description options can be selected in re-auditing recommended in 1 years' time.

9. NHS TAMESIDE AND GLOSSOP CCG SEND DIAGNOSTIC AUDIT FINDINGS

9.1 The overall summary indicates the areas of potential weakness and risk the CCG holds in meeting its obligations under the reforms. In brief, the CCG when applied against the diagnostic tool is compliant or has started implementing the reforms. Through the application of the tool the CCG can be seen as holding 'Full Compliance/Fully Achieved/Implemented'

with half (50%) of the required expected elements of the reforms. However large areas (50%) are seen as only 'Partially Achieved: Some Progress/Implemented'.

9.2 On closer inspection of the results indicates that the CCG potentially holds noticeable weakness in the following domains: Engagement, Joint Arrangements and Monitoring and Redness. Full audit findings embedded under Appendix.

Figure 1: Brief Summary result on the 6 key areas of the role of a CCG in supporting children with SEND.

	1st Audit		
1. LEADERSHIP	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**70.00%**	**30.00%**	**0.00%**

	1st Audit		
2. JOINT ARRANGEMENTS	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**35.71%**	**64.29%**	**0.00%**

	1st Audit		
3. COMMISSIONING	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**91%**	**9%**	**0%**

	1st Audit		
4. EHC PLAN	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**50%**	**50%**	**0%**

	1st Audit		
5. ENGAGEMENT	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**0.00%**	**100.00%**	**0.00%**

	1st Audit		
6. MONITORING & REDRESS	**GREEN**	**AMBER**	**RED**
OVERALL PERCENTAGE SCORE	**19%**	**63%**	**0%**

10. CONCLUSION

10.1 The CCG is able to evidence through CCG SEND Diagnostic audit tool its current base line compliance within the reforms. However further actions are need to be implemented to ensure clear evidence of the CCG/single commission function commitment to implementing the reforms.

11. RECOMMENDATIONS

11.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**COMMUNITY REHABILITATION SERVICES FOR STROKE AND NEURO-REHABILITATION**

Report Summary:

The Greater Manchester Heads of Commissioning, with the Stroke and Neurology Operational Delivery Networks (ODNs) have produced the attached report to provide an update on the work undertaken to date.

The report includes a proposal for the alignment of stroke and neuro-rehab services by developing a service specification for a combined model, providing a consistent approach to these areas of rehabilitation across Greater Manchester. We already commission in this way in T&G – the specifications for the previous SPRINT (neuro-rehab) and Community Stroke Team were merged in 2013-14 to form the Community Neuro Rehab Team (CNRT).

This report outlines the opportunities for GM working to achieve consistency and to identify areas where efficiencies can be made. It also outlines the following steps as essential in preparation for the implementation of a combined model:

- Consultation on a combined service specification
- Development of eligibility criteria
- Development of commissioning options with risks and benefits per CCG area
- Completion of a cost benefit analysis in order that the benefits of change required are quantifiable and assessable

Tameside & Glossop CCG are represented at Heads of Commissioning and also in the discussions with the ODNs on the details of this proposed model, and have provided information on the local service provision to inform the content of the report.

Recommendations:

The request from GM Heads of Commissioning is that each CCG takes this proposal through local governance for approval. SCB are therefore asked to APPROVE the following recommendations:

- Confirm the intention for a combined service model at a GM level
- Approve the proposal for the completion of an Impact Assessment including a cost benefit analysis
- Confirm Tameside & Glossop's involvement in this commissioning project

NHS Tameside and Glossop CCG will continue to commission a combined stroke and neuro rehab service from Tameside NHS Foundation Trust – currently the Community Neuro-Rehabilitation Team (CNRT).

The commissioning team will ensure that there are no additional

	cost implications of this piece of work for T&G Single Commission, and will work with the ICO on any redesign implications.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	Proposals have been made at a GM level for a single combined service for stroke and neuro rehab. A single integrated service is already in operation across Tameside and Glossop, which is funded on a recurrent basis. We believe our service is already compliant with the aims and objectives of the current proposal, therefore we do not envisage that implementation of the combined GM service will materially impact on our financial position. However detailed KPI's and service specifications are not yet available for the GM service. As such there is some risk that once consultation has been completed, GM specifications may develop or change resulting in future pressures (though this risk is not quantifiable at this stage).
Legal Implications: ***(Authorised by the Borough Solicitor)***	The model being proposed for community neuro-rehabilitation services is a needs-led model, with a focus on sustainable change and promoting self-management. Community teams will in-reach into inpatient services to draw people out of hospital and support a seamless transition from inpatient to community services. This should result in more expedient and effective recovery. It may result ij a need to invest more heavily in these services to avoid longer hospital and nursing home stays. Any changes to the services required may require consultation and engagement.
How do proposals align with Health & Wellbeing Strategy?	NHS Tameside and Glossop CCG already provide a combined neuro rehab service which meets the Health and wellbeing priorities of: - Providing a joined up service to meet the local need, - Providing targeted support - Improve health and wellbeing.
How do proposals align with Locality Plan?	In line with the locality plan, the combined neuro rehab service provides a high quality, safe, clinically effective and local service which will deliver long term change.
How do proposals align with the Commissioning Strategy?	The combined neuro rehab service provides appropriate and cost effective services for people living with long term conditions
Recommendations / views of the Professional Reference Group:	PRG in August 2016 agreed with the recommendations
Public and Patient Implications:	One combined service allows patients and carers easier access to support and rehab. By splitting up the service there would be several access points with referrals made between services. We already operate a single service model therefore there will be no changes for our population in terms of access points. A Greater Manchester service specification would require consultation and this will include feedback from patients as well

	as therapists and commissioners. We will ensure we participate in this process.
Quality Implications:	An action plan would be put in place ensure the service offer is in line with the new service model and specification. The changes would provide extra support for patients and their carers, and also support discharges out of hospital. The specification will include robust quality outcome measures.
How do the proposals help to reduce health inequalities?	Delivering a model of care around people's neuro-rehabilitation needs will enable us to target the delivery of interventions in a way that will reduce health inequalities and broaden the range of support available to people with these needs.
What are the Equality and Diversity implications?	Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.
What are the safeguarding implications?	All providers included in the delivery of this rehabilitation model are bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	All partners involved in the delivery of this work will be bound by the necessary information governance guidelines.
Risk Management:	Risks related to the development and implementation of this model will be identified and managed through the ODN
Access to Information :	The background papers relating to this report can be inspected by contacting Samantha Hogg, Commissioning Development Manager: Telephone: 0161 3045300 e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 The purpose of this report is provide an update to the GM Heads of Commissioning regarding the work that has been undertaken, an outline of current commissioning arrangements by CCG and a draft service specification for a combined ESD and Community Neuro model.

1.2 This report further asks for the GM Heads of Commissioning to:

- Note the work to date
- Confirm the intention for a combined service model at a GM level (subject to individual CCG approval)
- Approve the proposal for the completion of an Impact assessment including a cost benefit analysis
- Define the overall timescales for the work detailed above

2. CONTEXT

2.1 Commissioning of community rehabilitation services for both stroke and also neuro rehabilitation patients is currently being taken forward by the respective Operational Delivery Networks (ODNs). It was agreed at the Greater Manchester Heads of Commissioning Group in January 2016 for both ODNs to work together with local commissioners on this issue with Bolton CCG leading on the initiative on behalf of commissioners.

2.2 It was determined that a group would be established and tasked with exploring the options to support the development of a single model and service specification for a combined ESD and community neuro service which embraces the potential differences in the two patient groups and how they are managed. Furthermore to develop shared principles for commissioning of services.

3. PROGRESS TO DATE

3.1 A group has been established with representation from both ODNs (including clinical leads) and with one or more representative from each of the CCGs across GM.

3.2 The section below details the work to date from each of the ODNs in regards to their respective areas.

4. STROKE

4.1 The acute care pathway for stroke was centralised in 2015, with standardised service specifications put in place for all stroke units. Community rehabilitation services for stroke patients are currently not standardised in Greater Manchester leading to significant variation in the model of delivery, services provided and capacity. Patients receive different post-acute care depending on where they live, with long waiting lists for more complex patients in some areas and wide variation in the type and intensity of rehabilitation support offered. Two CCGs currently have no stroke specific community rehabilitation services (Eastern Cheshire and Stockport) and others such as Salford and Trafford have separate Early Supported Discharge (ESD) and Community Neuro Rehabilitation Teams (CNRT) managing stroke patients, which evidence has shown to have less benefit in terms of patient care and efficiency than other models.

4.2 ESD provides intense rehabilitation that ensures stroke survivors have an earlier discharge from hospital. ESD teams provide rehabilitation for up to 6-8 weeks and patients who have more complex needs and dependency may be referred to either a community stroke team, a CNRT or a combined team who provide support for a longer time period. This two-tier system can result in patients waiting different lengths of time to receive rehabilitation, often with hidden waiting lists.

4.3 The recovery of patients after stroke relies on timely access to a mix of services and support, many of which are delivered by voluntary sector organisations and not the NHS. However, these services are often viewed as "add-ons" to NHS care, and are not consistently commissioned across Greater Manchester, and in many areas they are being decommissioned.

4.4 In June 2015, the Greater Manchester, Lancashire & South Cumbria Strategic Clinical Network developed an integrated rehabilitation model and service specification for stroke that if implemented across the region should reduce inequalities and be more cost effective. The model is currently in operation, wholly or partly, in half of Greater Manchester CCGs, although not via a single service specification. It includes a number of pathways for patients with different rehabilitation needs and outlines the benefits of a more integrated approach to post- acute care if implemented across the conurbation:

- Standardisation of community stroke provision and equality of access for patients across Greater Manchester. Bench marking of GM community services will be made possible.
- Timely access to rehabilitation services for all stroke survivors (not just the 40% eligible for ESD), no hidden waits and longer provision of services for those who need them
- More co-ordinated, efficient and integrated health and social services that meet the needs of patients – i.e. a blend of NHS and voluntary sector services
- Reduction in lengths of stays at stroke units
- Recently updated NICE Standards for stroke highlight the need for commissioning of a number of areas where we know there are gaps and that will need special consideration, potentially on a Greater Manchester wide basis:
- Adults who have had a stroke have access to a clinical psychologist with expertise in stroke rehabilitation who is part of the core multidisciplinary stroke rehabilitation team
- Adults who have had a stroke are offered active management to return to work if they wish to do so
- Adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually
- A report has already been developed on addressing the gaps in clinical psychology, although further scoping is needed and a GM wide solution may be advantageous. Engagement with the voluntary sector will be key to improving access to vocational support and the two ODNs will work together to develop best practice and solutions in this area, although additional commissioning may be required. 6 month reviews are currently not conducted in all areas and consideration is needed as to the most appropriate organisation/team to deliver an annual review.

5. NEURO REHABILITATION

5.1 Greater Manchester neuro-rehabilitation services provide rehabilitation for people with a neurological condition. The current NHS service in GM is comprised of one hyper-acute/acute service at Salford Royal NHS Foundation Trust, four post-acute neuro-rehabilitation units (Rochdale, Stockport, Leigh and Trafford) and nine community neuro-rehabilitation services (the areas without a specialist community service are Bury, North Manchester and South Manchester). A scoping exercise of community neuro-rehabilitation services in 2015 demonstrated the extent of the variation of the services across GM. Staffing levels, entry criteria, intensity of treatment, waiting times for assessment/treatment,

assessing performance and number of referrals all differ greatly between each of the nine areas. The time people spend waiting to access community services was found to be between 5 days and 58 weeks dependent upon geographical area and/or which profession was required. The impact of the waiting times is significant to the people waiting and also has a knock-on effect on services referring into the community:

- People can deteriorate whilst waiting to access services, resulting in longer lengths of stay within the service and unnecessary difficulties for individuals
- Outcomes are unlikely to be optimised, as early intervention has been shown to result in better outcomes[1].
- People are not returning home as early as they could and not receiving care in the most appropriate setting
- People are staying longer in neuro-rehabilitation beds when there is no community service or long waits to access community services
- The knock-on effect is that people are stuck in other NHS beds (neuro-surgery, neurology, ICU, HDU etc..) whilst they wait for a neuro-rehabilitation bed
- NHS money is wasted whilst people wait in expensive inpatient services
- In December 2015 CCG Heads of Commissioning, and in January 2016 Chief Finance Officers, gave the neuro-rehabilitation ODN the 'go-ahead' to develop an outline business case to address the issues with the neuro-rehabilitation pathway, including community services. In addition, neuro-rehabilitation has been included within the top priorities for Devolution Manchester to address within 2016/17, with Salford Royal NHS Foundation Trust being appointed as the Transformational Lead for neuro-rehabilitation.

5.2 The model being proposed for community neuro-rehabilitation services is a needs-led model, with a focus on sustainable change and promoting self-management. Community teams will in-reach into inpatient services to draw people out of hospital and support a seamless transition from inpatient to community services. Access to the service will be timely and again based upon need and risk. There will be one service specification across GM to ensure equitable access, provision and quality of service. Standardised key performance indicators, outcome measures and reporting will provide assurance to commissioners and service users about the quality of services; benchmarking each area with the comparable services in other parts of region.

5.3 For the whole of the neuro-rehabilitation service (inpatient and community), vocational rehabilitation services are a vital part of the pathway. Supporting people to return to previous employment or seek new employment opportunities will have long term benefits for individuals, families and the local economy. Working with the GM Major Trauma Network and Stroke ODN, the extent of the vocational rehabilitation need will be identified, along with services that can meet that need or indeed gaps in service provision.

6. PRINCIPLES FOR COMMISSIONING COMMUNITY REHABILITATION SERVICES FOR STROKE AND NEURO REHABILITATION PATIENTS IN GREATER MANCHESTER

6.1 There are similarities and shared principles that have been established to support the commissioning and delivering care to the respective patient groups. Services need to be delivered and procured by each CCG with the idea position being the establishment of integrated teams delivering care to both patient groups using the respective model/service specification.

[1] Royal College of Physicians, 2003. *Rehabilitation following Acquired Brain Injury, National Clinical Guidelines*.

6.2 NHS England recently published guidance on commissioning rehabilitation services advocating a model that includes specialist and non-specialist services as well as peer support and community assets. It also outlines key expectations of patients, as well as principles of good rehabilitation services.

6.3 Building on this at a local level, the following principles, developed by the group, are shared across both patient groups and their respective models of care:

- Evidence based care pathways with access for patients being discharged from hospital or living in the community, using clinical consensus when no evidence exists
- Equality of patient experience across the conurbation through access to appropriate, timely care including shared decision making with patients and carers
- A consistent, flexible and needs-led approach with integration between inpatient and community rehabilitation teams, as well as other NHS providers (e.g. primary care)
- Involvement of other providers such as the voluntary sector to develop a more blended, asset based approach to rehabilitation care that addresses the wider needs of the patients and carers
- Timely discharge from the service using community assets effectively to continue longer term goals and ensuring there is capacity to provide responsive assessment and treatment times following referral to the service
- Standardised geographical inclusion criteria for all CCGs to promote efficient referrals
- As similar as possible outcome measures and KPIs that are a mixture of process indicators and measures that include patient reported experience and outcomes
- Timely discharge from hospital via in-reach to support people returning home more quickly and prevention of unnecessary readmission to hospital or attendance at GP
- Promotion of self-management where appropriate
- Ability to re-refer patients back into services they may need

7. CURRENT LANDSCAPE OF COMMUNITY REHABILITATION COMMISSIONING

7.1 Work has been undertaken via the ODNs on behalf of the group to determine the current local arrangements for the commissioning and delivery of ESD and Community Neuro across each of the CCG areas and is detailed below;

CCG	Stroke	Neuro rehabilitation
Bolton	ESD (RBH) and CNRT	CNRT within long term conditions service (RBH)
Bury	Integrated community stroke team (Pennine care)	No CNRT
Central Manchester	ESD (CMFT) and CNRT	CNRT (CMFT)
Eastern Cheshire	No stroke specific services	?
HMR	Developing community stroke team – recently awarded to	Neuro rehabilitation team – recent tender awarded to PAT
North Manchester	Integrated community stroke team (PAT)	Developing CNRT (PAT)
Oldham	Integrated model - ESD (Pennine care) and CNRT	CNRT (Pennine care)
Salford	Separate ESD (SRFT) and CNRT	CNRT (SRFT)
South Manchester	Integrated model - ESD and integrated rehabilitation team	No CNRT
Stockport	No stroke specific rehab services	STAR team (SHH)
Tameside & Glossop	Integrated model - ESD and CNRT	CNRT (TGH)
Trafford	2 providers of ESD (Pennine care & UHSM) and 1 for	CNRT (Pennine care)

CCG	Stroke	Neuro rehabilitation
Wigan Borough	Integrated model - ESD (WWL) and CNRT	CNRT (Bridgewater/WWL)

7.2 A more detailed summary of each CCG areas current community rehab services, including provider, workforce, known gaps in service and commissioned budget has been developed and shared with commissioners.

8. PROPOSED MODEL

8.1 Following the agreement of the core principles and building in the work already completed by the ODNs on their respective service areas, a draft service specification for a combined ESD and Neuro service has been developed. This service specification is in the early stages and is yet to be consulted on and developed further by members of the group.

8.2 One of the key difficulties with the development of a combined model is that the preparatory work undertaken by the respective ODNs are at different stages and working to different timescales. The work relating to the development of services for stroke are more developed with local areas already underway with implementation of the recommendations and pathways. The ODN for neuro rehab is only just coming to the end of the initial scoping work and as this forms part of a much wider programme of work looking at the whole pathway from diagnosis through to community the lead in time is much longer. The ODN for neuro are currently developing their system model and will be submitting a bid for investment from the GM Transformation Fund in September 2016.

8.3 Discussion between the commissioners and ODN leads has determined the need for further analysis of the current and future requirement for investment into both ESD and Neuro. Furthermore that consideration needs to be given to the geographical criteria for access to services which will need to be agreed on a GM basis. This will ensure that patients have a positive experience particularly pertinent to those patients living on boundaries.

8.4 Commissioners have also suggested and recommended that each CCG puts this combined model work in their commissioning intentions for providers. It may result in decommission of services which may be tough but necessary to achieve what is needed. Furthermore as each locality currently has differing service models, range of providers and range of investment, the work required for total service transformation if it is agreed for all localities to move towards commissioning and implementing a new combined model, this will inevitably present different challenges to certain areas across the conurbation.

8.5 Further work has been identified for the completion of a cost benefit analysis in order to support the development of a workforce model. Potential implications on social care will also need to be considered and quantified as part of this work.

9. NEXT STEPS

9.1 Opportunities for GM wide working to achieve a consistent approach and identify areas where efficiencies can be made (e.g. psychology) need to be explored. Local decisions on how a combined model can be achieved must be agreed across GM taking into account the nervousness of providers in implementing this change. There are a number of steps that need to be taken in preparation for the implementation of a combined model across GM;

- Consultation on the combined service specification to be completed
- Eligibility criteria to be developed and agreed on a GM basis
- Development of Commissioning options with risks and benefits per CCG area

- Completion of a cost benefits analysis in order that the benefits of change required are quantified and assessable.

9.2 Timescales need to be considered and a decision agreed as to whether implementation of a combined model can move forward now or wait for the outcome of the neuro bid in September.

10. RECOMMENDATIONS

10.1 As set out on the front of the report.

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INTEGRATED NEIGHBOURHOOD PHARMACY PROPOSAL**
Report Summary:	This report outlines a model for pharmacy and medicines management support to our integrated neighbourhood model. As a part of the consultation process for the emergent Integrated Neighbourhood offer the single commission and care together programme have held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue which has arisen as a priority from discussions in all 5 neighbourhoods is the need for pharmacy and medicines management support.
Recommendations:	SCB are asked to APPROVE the proposal to develop a Neighbourhood Pharmacy model to support our model for integrated neighbourhood working.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The CCG has a £1m QIPP target for medicines management/GP prescribing in 2016/17. This saving is risk rated red and we are currently reporting circa £500k overspend in this area. Due to the financial pressures in prescribing and other areas the CCG has no money available for schemes which cannot guarantee quick wins and savings in excess of investment. As part of the integrated neighbourhood funding request from GM, there is an element of money, which is not currently allocated. Assuming our business case is approved, the intention is that funding will be delegated to each neighbourhood to invest in new ways of working that address the unique needs of each community and which aligns to the neighbourhood development and wider Care Together strategies. Consideration must be given to determining the most appropriate employer for these appointments. It may be beneficial for these to be employed in the ICO as part of the neighbourhood offer, which could potentially improve recruitment and retention and allow rotation from hospital to community and vice versa. It could also broaden skill sets. If SCB support the principle of community pharmacists, the only source of funding available is the GM transformation money. A decision would need to be made about whether we top-slice money from devolved neighbourhood budgets to fund a consistent neighbourhood pharmacy offer, or if we share the business case with neighbourhoods to allow them to determine for themselves whether the pharmacists represent value for money within the unique circumstances of their community. This is a decision which would need to be made in conjunction with Programme Board.
Legal Implications: (Authorised by the Borough Solicitor)	If the principle is agreed a further report will be required setting out the implementation plan, how it will be funded and options and/or recommendations as to the way forward in respect of

	issues for consideration set out in the report such as whether employed or not. It may be the case that these are irrelevant to the delivery of the outcomes.
How do proposals align with Health & Wellbeing Strategy?	Reduce health outcomes variation, help elderly population, deliver lifestyle interventions, reduce premature deaths.
How do proposals align with Locality Plan?	Healthy lives, self-care, neighbourhood based services, planned care services.
How do proposals align with the Commissioning Strategy?	Improved management of long term conditions, lifestyle, mental health, planned care, urgent care, end of life.
Recommendations / views of the Professional Reference Group:	The model is accepted by PRG.
Public and Patient Implications:	Improving patient outcomes, supporting patient care and independence. Developing patient centred care models
Quality Implications:	Ensure correct levels of support are given to patients around their medicines with a particular emphasis on safety and quality. Ensure prescribing is in line with national and local guidance as well as NICE and GMMMG.
How do the proposals help to reduce health inequalities?	Ensuring prescribing is in line with guidance as per NICE and GMMMG. Ensuring reduction of any geographic variation.
What are the Equality and Diversity implications?	Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.
What are the safeguarding implications?	All providers included in the Integrated Neighbourhood model are bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is included as an element of the core offer for Integrated Neighbourhoods, and will be addressed via the Care Together IG and data sharing agreement work. All partners in the neighbourhood work will be bound by the necessary guidelines, including the pharmacy support function.
Risk Management:	Risks related to the Integrated Neighbourhood pharmacy support will be managed and reported through the Care Together and single commission governance as appropriate.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Transformation.  Telephone: 0161 304 5300  e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 As a part of the consultation process for the emergent Integrated Neighbourhood (Integrated Neighbourhood) Offer the CCG has held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue which has arisen as a priority from discussions in all 4 neighbourhoods is the need for pharmacy and medicines management support. The request for GM Transformation funding for our neighbourhood model is £400k per neighbourhood for the implementation of service developments and redesign initiatives to deliver prevention of growth in elective and non-elective activity across the system. Our proposed approach, which if supported we will take through the appropriate Single Commission and Care Together governance, is that we 'top slice' any GM transformation funding awarded to enable us to commission any initiatives developed to support this workstream, to include a 'Neighbourhood Pharmacy Support Team'.

1.2 Both nationally and locally there is a recruitment/ retention issue with both GPs and practice nurses. According to the GP Taskforce, the number of GPs per 100,000 population in the UK fell from 62 in 2009 to 59.5 in 2012. Incorporation of a practice pharmacist element in the workforce Has generated national interest.[1,2,3].

1.3 In tandem with this crisis in General Practice most areas of the Health care system are under increasing financial pressure. Even the most optimistic predictions on efficiency savings mean £8 billion a year above inflation would have to be found to close the gap. That would require efficiency savings of about 2-3% per year Locally T&G has a £70 million financial gap over the next 5 years.

1.4 Commonly identified issues for patients regards their medicines are: (5)

- Up to 50% of medicines are not taken as intended by the prescriber
- Between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s).
- Multi-morbidity and inappropriate poly pharmacy in frail elderly people can be problematic. These patients need regular review of their medicines to ensure that all medicines prescribed, or bought over the counter, are safe and appropriate.
- There is often a communication breakdown at the point of discharge from hospital resulting in prescribing errors. These errors can lead to damage to health, much time wasted for administrative and clinical teams in primary care and potential re-admission to hospital.
- From the patient perspective, with increased focus on patient-centred care, there is much more to be done to allay concerns about polypharmacy and address the lack of support with medicines taking.
- Transfer of care issue on medicines has also been highlighted by the CQC when they surveyed 280 GP practises and found that in 17% of GP practices patient notes are updated by managerial or clerical staff, rather than someone with a clinical background. They concluded that there is not always timely, complete sharing of patient information on medication changes.
- T&G has the potential to be innovative in investing in this clinical workforce and linking it to the integration work and to share learning across the GM devolution platform. Such a service may also provide a unique selling point for practices recruiting GPs to come to T&G.

1.5 The key outcome of this new service will be improved care and health outcomes for patients as well as improved access to care in general practice. Pharmacists will work as part of the Integrated Neighbourhood team to help identify patients at risk and intervene to reduce this risk as well as make interventions to help those in frequent contact with health services, this will include those in care homes. They will support patients to self-manage their well-being and long term conditions, through optimising medicines, and enabling improved medicine related communication between general practice, hospital and community pharmacy. It is also expected that this service will release savings in primary care budgets through a

reduction in medicine related non-elective admissions. **The CCG spent £14,230,672 on unplanned admissions last year**. As noted literature suggests that between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s). The scheme complements the Integrated Neighbourhood offer and the Care Homes policy.

2. CURRENT PRACTICE PHARMACIST POSITION

2.1 The current practice pharmacist situation is confusing as it has evolved over the last 12- 18 months in an ad-hoc manner. Thirty five practices currently have or soon will have some practice pharmacist provision, some of this being practice level some being neighbourhood level. This support is being provided by 7 WTE pharmacists who are working a variety of hours as arranged by the practices or the neighbourhoods. The latest current funding will extend to is 31 March 17.

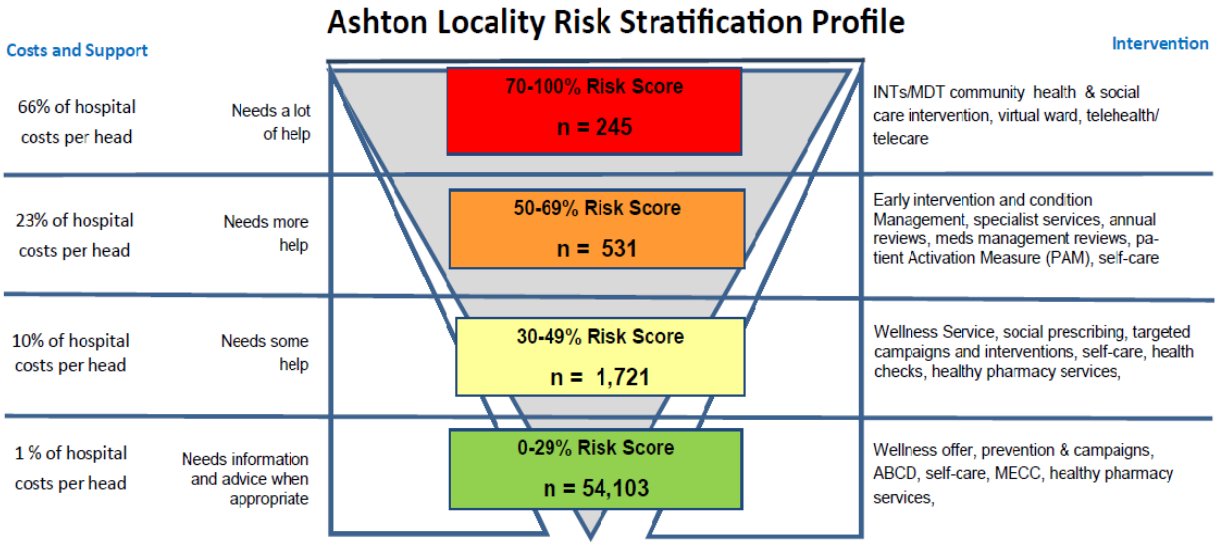
2.2 The model this report is proposing is provision of pharmacist support from the ICO across a neighbourhood as part of the Integrated Neighbourhood Offer. Any existing pharmacists will be able to apply to switch to the proposed Integrated Neighbourhood team should they wish.

3. POTENTIAL BARRIERS

3.1 There are a number of potential barriers to effectiveness of service offerings.

- *Pharmacist availability* - other CCGs and NHSE via its national scheme are recruiting practice based pharmacists. Medium risk/medium impact. A phased implementation would probably be needed.
- The practices would need to provide a GP to liaise with the pharmacists to ensure those areas where they were only able to make recommendations were fully actioned. Low risk/ High Impact.
- *Lack of suitably skilled staff* - If recruits come from community setting they may lack the clinical skills necessary particularly for the Over 75s work. Medium risk/high impact.
- *Lack of familiarity with GP i.t. systems* - It is possible that many will not be conversant with GP i.t. systems and so the CCG MMT and the practices would need to arrange arranged for a quick, on the job, training program to up-skill the pharmacists in operation of EMIS & Vision Medium risk/low impact.
- *Lack of non-medical Rx*. - Wherever the source it is unlikely that many non-medical prescribers would be amongst those recruited. High risk/ Medium impact. Whilst this is a risk and a limiting factor regards initial level of support it is also an opportunity longer term for primary care work force enhancement.
- *Increase in meds queries to CCG MMT* - Depending on level of expertise there may be more queries, Medium risk/ Medium impact.
- *Practices don't engage with service* - Low risk/ Medium impact. T&G practices have always engaged with CCG MMT. Discussions with GPs at neighbourhoods indicates practices would welcome the types of support described in this report.

3.2 Key pharmacist led



4 INTERVENTIONS

4.1 The Ashton neighbourhood risk profile is given as an example. Though the numbers in above schematic change slightly by neighbourhood from the Ashton example they are very similar across all neighbourhoods and the level of resource drawn by the upper two strata is also very similar across the whole economy. The top two categories account for approximately 90% of hospital costs even though they only contain 245 and 531 of individual patients respectively.

4.2 The Integrated Neighbourhood design is intended to better synchronise support to these groups in a more co-ordinated manner. This proposal in this report is in line with that requested via the neighbourhood consultation and would see practice pharmacist support as part of the Integrated Neighbourhood Offer delivered across a neighbourhood.

Pharmacist interventions

4.3 **Discharge facilitation** In-reach to liaise with ward based pharmacist teams to plan ahead of discharge and also with community pharmacy to help streamline transition post discharge. There will be reconciliation of medicines post discharge and any changes managed including performing a clinical medication review where indicated. Production of a post-discharge medicines care plan including dose titration and booking of follow-up tests.

- Undertake clinical medication reviews with patients with LTC and polypharmacy issues in particular those medicines associated with unplanned hospital admissions and including care home and domiciliary bound patients, in the case of an NMP implement own prescribing changes. In the case of care homes work with care home staff, LA commissioners and MMT technicians to improve safety of medicines ordering and administration. Attend and refer patients to multidisciplinary case conferences. Input into case management plans to ensure optimal benefit and reduced harm from medicines.
- Carry a case load of patients including those in the care home setting from the upper two strata of the Risk Profile, intervening pro-actively to reduce likelihood of crisis, in effect conducting a community based ward round.
- Deliver training programmes to other members of the Integrated Neighbourhood team designed to allow them to assess patients need and level of intervention required.

Support Integrated Neighbourhood team in application of assessment. Work with members of the MMT to deliver medicines training to nurses and carers

4.4 **Pharmacist support to GP practices** Working across a neighbourhood the practice pharmacist team would help relieve some of the pressure on General Practice as indicated in the five year forward view and 'The future of primary care ; creating teams for tomorrow'.

4.5 **Repeat Systems** Produce and implement a practice repeat prescribing policy. Manage the repeat prescribing reauthorisation process by reviewing patient requests for repeat prescriptions and reviewing medicines reaching review dates; make necessary changes as an independent prescriber.

4.6 **Acute management** Provide a telephone help line for patients with questions, queries and concerns about their medicines. Hold clinics for patients requiring face-to-face reviews.

4.7 **CQC** Work with the practice manager and GPs to ensure the practice is compliant with CQC standards where medicines are involved.

4.8 **Cost Savings Programmes** Undertake changes to medicines (switches) designed to save on medicine costs where a medicine or product with lower acquisition cost is now available.

4.9 **Medicines Information** Answers all medicine--related enquiries from GPs, other practice staff and patients suggesting and recommending solutions and providing follow up for patients to monitor the effect of any changes.

4.10 **Medicines Quality improvement**
Undertake audits of prescribing in areas directed by the GPs, feedback the results and implement changes in conjunction with the practice team. Implement changes to medicines that result from MHRA alerts, product withdrawal and other local and national guidance.

4.11 **GMMMG** Monitor practice prescribing against the GMMMG formulary/ NT decisions/ DNP and RAG list and ensure shared care is in place before amber prescribing and that red prescribing is repatriated to the relevant Trust.

4.12 **Training** Provide education and training to primary healthcare team on therapeutics and medicines optimisation. Provide training to visiting medical students.

4.13 **Non-Medical Prescribing** It is unlikely that there will be many NMP pharmacists available to hire but although the majority of the practice based pharmacists are not NMPs they do form a pool of potential non- medical prescribers. With the likelihood of no short term reversal of GP shortages development of non-medical prescribers would be an approach to help strategically the local health economy. We already have two of the practice pharmacists working in area who have just completed an NMP course and three more are to sign up to commence a course in September. The practices in which they work have been keen to support this development. It does need to be recognised that 285 hours per pharmacist would be lost over a 6 month period covering time at university and experience/ mentor time.

5. INTER PHARMACY LIAISON

5.1 The Integrated Neighbourhood pharmacist would work with community pharmacy to ensure patient centred care. This could include where there was any necessary adaptation of service to meet patient specific needs under DDA. The patient could also be offered access to appropriate additional and enhanced services as provided by the community pharmacy and currently commissioned by NHSE. Within the constraints of patient choice the practice pharmacist would help arrange the patient to 'register' with the community pharmacy they

used regularly. This would allow the community pharmacy to help in the longer term management of the patient through proactive assessment of issues as they presented.

5.2 The Integrated Neighbourhood pharmacist would work with members of the CCG MMT around case management of specific patients, training of carers, care home audit and high cost medicines reviews. The practice pharmacist would work with ward pharmacist in cases of in-reach and supported discharge. This function would help ensure a seamless transition as patients are prepared for discharge and help ensure effective discharge with reduced possibility of re-admission. The practice pharmacist could facilitate clarity of information post discharge so that an ambiguity was addressed and provide a link to the community pharmacy notifying them of the patient's imminent discharge. If common problems were found to be present the pharmacist could ensure these fed into a system wide review.

5.3 The practice pharmacists may in part be drawn from the hospital team as part of the re-deployment necessitated by the shift of emphasis as more care is provided in the community

6. OVERARCHING BENEFITS

6.1 Quality

- Improved communication between Practice and community pharmacy, hospital pharmacy on admission, discharge and community/ social services.
- A sector wide, co-ordinated, pharmacy approach to patient care such that all pharmacy activity be it in community, hospital or primary care is centred around the needs of the patient.
- Enhanced medicine reconciliation at transfer of care and mores seamless transition.
- Medications reviewed in more patients who have been discharged from hospital/ are house bound/ in nursing homes/ LTC patients.
- Enhanced patient access and experience
- Reduction in preventable harms and admissions from medicines
- Patients better empowered to manage their long term conditions
- Increase in skill mix within general practice and release of GP time by pharmacist managing repeat prescribing and medication/ acute queries
- Improved management of long term conditions for T&G patients
- Movement towards the GM mean in prescribing area where practice is an outlier based on practice prescribing data obtained from GM IMPACT system.

6.2 Financial

- Reduction in practice costs and WHE costs. Depending on pharmacist areas of expertise and activity:

Activity	**GP**	**Pharmacist**
11 minute appointment	£45	£6.50
7 minute telephone consultation	£27	£4.10
23 minute visit	£114	£13.50

6.3 GP costs. 2013 Units Health and Social Care report from the Personal Social Services Research. Pharmacist costs based on current practice pharmacist rates paid. Allowing that most practice pharmacists will not have the range of skills or experience of a GP so long as they concentrated on medicines and related interventions they could substitute for a GP. Even allowing for possible longer appointment times there is still a significant saving. For example current local practice pharmacist experience shows a care home patient review takes between 30 – 60 minutes this is still only £35 cost versus £114 cost. Outcomes from other areas show that with experience the pharmacist can both broaden their range of skills and trim their consultation times allowing a greater realisation of potential savings.

6.4 The CCG spent £14,230,672 on unplanned admissions last year. Literature suggests that between 5 to 8% of all unplanned hospital admissions are due to issues related to medicines (this figure rises to 17% in the over 65s) if the service saved the lower quoted figure of 5% then **£711,533p**.a. savings would be achieved. If this were 8% it would rise to **£1,138,452p**.a.

6.5 Patients will transition through the levels of the risk pyramid over varying periods of time so that future patients at the highest risk are currently in the next level down. If through activity targeted at this second strata 5% of this population (just over 100 patients) were prevented from moving to the highest need strata then based on unplanned activity costs **£302,400** p.a. would be made.

6.6 KPIs:
To determine effectiveness of pharmacist interventions a number of KPIs should be set.

- To conduct at least 20 patient reviews, per neighbourhood, per week (based on 1WTE pharmacist per neighbourhood).
- To receive good patient/carer feedback
- To receive good practice feedback
- For the pharmacists themselves to provide good feedback about the role.

6.7 It is difficult to predict that a quality/safety intervention would have prevented an ADR but if a couple of such had occurred resulting in a hospital admission then this would have paid for the scheme in itself. The CCG will look internally at whether expected reductions on baseline on the re-admissions and unplanned admissions across the Neighbourhood within the patient cohort reviewed is realised.

6.8 The levels of support would be based on affordability and commitment of any transformational monies available. If NMP development were to be included a decision would need to be taken regards whether part or all of the 285 hours would be paid for by the CCG/practices who would be accessing pre-paid for courses and providing mentors to the pharmacists.

7. CONCLUSIONS

7.1 Provision of approximately 2 WTE per neighbourhoods, adjusted on a per capita basis – total cost £604,500. This is roughly in line with the figure quoted in the GP forward view a pharmacist per 30,000 population and supports the Integrated Neighbourhood offer.

7.2 There is much evidence nationally and locally to promote the benefit of using the skills of clinical pharmacists in general practice and community teams. Our proposed approach, which if supported we will take through the appropriate Single Commission and Care Together governance, is that we 'top slice' any GM transformation funding awarded to the Integrated Neighbourhood model to enable us to commission a 'Neighbourhood Pharmacy Support Team' to work across all 5 Neighbourhoods. The benefits of this approach would include:

- Ability to deliver key pharmacy interventions providing financial and clinical efficiency in our prescribing
- Delivery of an identified priority for Integrated Neighbourhoods
- Improve the recruitment and retention of pharmacists
- Cover for all ages and not just specific age groups
- Release of BCF funding to support other Neighbourhood based initiatives
- Foundation for wider development and further expansion of pharmacy support as a key function / intervention for the ICO – potential to work across primary and secondary care.

1 NHS England, Care Quality Commission, Health Education England, Monitor, Public Health England, Trust Development Authority (2014). NHS five year forward view. London: NHS England. Available at: www.england.nhs.uk/ourwork/futurenhs/
2. Primary Care Workforce Commission. The future of primary care Creating teams for tomorrow. July 2015. Available at http://hee.nhs.uk/wp-content/blogs.dir/321/files/2015/07/The-future-of-primary-care.pdf

3. NHS England, Royal College of general practitioners. BMA, HEE. Building the Workforce – the New Deal for General Practice, January 2015. Available at http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf

4. NHS England. Pharmaceutical waste reduction in the NHS. June 2015. Available at http://www.england.nhs.uk/wp-content/uploads/2015/06/pharmaceutical-waste-reduction.pdf

5. Royal pharmaceutical society England. Pharmacists and GP surgeries. September 2014. Available at http://www.rpharms.com/policy-pdfs/pharmacists-and-gp-surgeries.pdf

6 The scale of repeat prescribing – time for an update; D R Petty, A G Zermansky & DPAlldred. Available at http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-76

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**ENHANCED SYSTEM FOR SUPPORT TO PRESCRIBERS AROUND PROMOTION AND ENFORCEMENT OF DNP, GREY AND RED LISTS APPROACHES.**
Report Summary:	Whilst T&G CCG seeks to ensure that all patients have access to the most appropriate medicines and treatments to maintain their health and wellbeing some medicines have been identified as not providing adequate value for the local health economy and the prescribing of any such medicines or appliances may be restricted. This may be as a general 'Do Not Prescribe' (DNP) message, prescribe under limited circumstances (Grey list) or not to be prescribed in primary care (red status). This paper sets out the proposed approach for the application of prescribing guidance in the local health economy.
Recommendations:	SCB are asked to consider and approve the approach included in this paper, and to support the proposal that the single commission management team (via medicines management teams) works with prescribers in the local economy to implement this.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	Finance support the idea of a clear and unambiguous list of drugs we do not prescribe, which will reduce prescribing spend without any requirement for upfront funding. However, assurance would be required regarding the monitoring of compliance with the new policies and how this would link with the support systems above, i.e. can they electronically prevent scripts being written. In addition, regular performance monitoring of progress against this new policy and a quantification of savings must form part of on-going QIPP reporting.
Legal Implications: ***(Authorised by the Borough Solicitor)***	Given this is a voluntary code it will be important that effective communication to achieve the benefits set out in the report. As well as medical professionals it will also need to include the public. It is not clear how much some of these medications cost to prescribe or to purchase where no prescription is necessary and this information may also be helpful for patients in making choices.
How do proposals align with Health & Wellbeing Strategy?	Reduced variation in health, better financial return on CCG investment in current economic climate.
How do proposals align with Locality Plan?	Elements of healthy lives and planned care services.
How do proposals align with the Commissioning Strategy?	Support CCG cost-efficiencies in current economic climate. Implications for prescribing in LTC, mental health, end of life

Recommendations / views of the Professional Reference Group:	PRG supported the finance recommendation. To initiate this system of designation and put the lists and backing documents on the CCG website.
Public and Patient Implications:	Changes to the list of drugs prescribed to our population, to bring in line with national and GM guidance.
Quality Implications:	Improved patient safety at point of prescribing.
How do the proposals help to reduce health inequalities?	Ensuring all patients receive a standard approach to prescribing of DNP, Grey and Red list medicines.
What are the Equality and Diversity implications?	Equality and Diversity implications have been addressed in the development of the guidelines on which this proposal is based, and will continue to be monitored / considered in the implementation and delivery.
What are the safeguarding implications?	All T&G prescribers are bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Existing prescribers, who will be affected by the implementation of this proposal, are already bound by existing information governance through our primary care contracting processes (CCG and NHSE)
Risk Management:	Risks related to this prescribing support proposal will be reported and monitored through existing Medicines Management governance and reported or escalated via Single Commission Board where required.
Access to Information :	Clare Watson, Director of Commissioning  Telephone: 0161 3045300  e-mail: clarewatson2@nhs.net

1. BACKGROUND

1.1 Whilst T&G CCG seeks to ensure that all patients have access to the most appropriate medicines and treatments to maintain their health and wellbeing some medicines have been identified as not providing adequate value for the local health economy and the prescribing of any such medicines or appliances may be restricted. This may be as a general 'Do Not Prescribe' (DNP) message, prescribe under limited circumstances (Grey list) or not to be prescribed in primary care (red status).

1.2 The NHS Act and the NHS Constitution in line with the NHS Standard Contract sets a number of broad principles in place when considering the use of any treatment within the NHS:

a) Clinical Commissioning Groups have legal responsibility for NHS healthcare budgets. Their primary duty is to commission service to meet the healthcare needs of the whole population rather than individuals and to live within the budget allocated to them.
b) The NHS should only invest in treatments which are of proven effectiveness unless it does so in the context of well designed, sufficiently powered and properly conducted clinical trials.
c) All NHS commissioned care should be provided as a result of a specific policy or decision to support the proposed treatment. A third party has no mandate to pre-commit resources from T&G CCG budgets unless directed by the Secretary of State.
d) The priority for an individual patient or group of patients to receive NHS funding for healthcare to meet their needs must always be assessed against other competing demands and within the resources available.
e) The NHS must ensure it demonstrates value for money and appropriate use of NHS funding based on the needs of the population it serves.
f) T&G CCG commissioners have a responsibility to make rational decisions in determining the way in which they allocate resources and to act fairly between patients.
g) T&G CCG should strive to commission the provision of equal treatment in the same clinical circumstance and should not, therefore, offer to one patient a treatment which cannot be afforded for all patients in the same clinical circumstance.
h) Interventions of proven effectiveness should be prioritised above funding research and evaluation.
i) Acknowledgement: East Midlands Specialised Commissioning Group. (EMSCGN003V1): Key Principles for the development of commissioning policies by the EMSCCG. http://www.emscg.nhs.uk/Library/EMSCGN003V1EMSCGKeyPrinciples.pdf

1.3 There are many medicines commonly viewed as of DNP, Grey and Red status both across GM and nationally. T&G CCG is in agreement with such classification however inadvertently some medicines from these categories are prescribed within practices across the CCG often, though not always, at request of secondary care.

1.4 Though patients are reviewed with regard to removing/ changing inappropriate prescribing it is often quite difficult and takes time to effect such change once prescribing has been initiated.

1.5 The aim of this piece of work is to promote recognition of DNP, Grey, Red requests at time of requesting so they can be highlighted and challenged before any GP prescribing occurs. Often it is practice staff who are the first point of contact for these requests and having a reference point which can be checked in the first instance would be of benefit. Similarly having such a reference point available for GPs to back up their decisions not to prescribe would help prevent prescribing contra to the DNP, Grey, Red prescribing lists.

1.6 Though such lists are available on the GMMMG website the information is not always easy to find and the proposal is to have a localised version of these list accessible for the public and GPs/ practice staff on the CCG website. This is part of an approach which has been taken by Stockport CCG and has seen them be one of the lower prescribers within GM of the three categories of medicines.

1.7 Any prescriber would be able to input ideas into the development of the DNP and Grey list which would be reviewed on a regular basis. The form in Appendix 1 would be completed and submitted for consideration to the MMC. It is proposed that those medicines or appliances which are agreed as going forward for inclusion would then be signed off for such by the Quality Committee and then after updated on the CCG website.

1.8 The proposed policy for consideration for inclusion in DNP, Grey list is in **Appendix 1**.

APPENDIX 1

CONSIDERATION OF ITEMS FOR INCLUSION IN T&G CCG DNP OR GREY LISTS

T&G CCG is highlighting on its website those medicines which have a DNP or Grey List criteria. The aim is to heighten practice staff awareness of the status of these medicines and support GPs in applying these statuses so that inappropriate prescribing is reduced.

Medicines may be considered for addition to any of these lists via the form below. There will be a standing item on Medicines Management Agenda each month to discuss submissions.

Any product considered for addition to the Do Not Prescribe or Grey lists produced by the GMMMG Formulary Group should also be considered for inclusion.

Name of product to be considered

Product nominated by

Date of review

Criteria for Inclusion on the T&G CCG DNP or Grey list
(There does not need to be agreement with all statements but they need to be considered)

Criteria Statement	Yes	No	Comment
The drug has an absolute 'not recommended' drug by GMMMG IPNTS from January 2011 as it has limited clinical effectiveness (and data is against placebo) or cost effectiveness data.			
There is no instance where this drug would be appropriate to use from a safety or efficacy point of view, over existing treatments. This may mean there are no further drug options for that patient group*			
There is a only a narrow, defined place for use of the drug. Such drugs will be grey listed to allow use only within this defined situation			
There are more appropriate evidence based alternative(s) available that means this drug should not be prescribed in any situation*			
The evidence base is so poor that it is not an appropriate use of NHS resources to prescribe this drug in any situation. This may include lack of robust, published phase III RCTs, or poor evidence only such as limited benefit in trials against placebo or opinion only*			

There is sufficient concern over safety that it is not appropriate for this drug to be prescribed*			
There is a negative NICE Technology Appraisal not recommending its use at any stage. If NICE has not considered a drug then SMC and AWMSG decisions can be considered.			
The drug is a 'me too' drug that doesn't offer any additional proven benefit over the existing drug or other therapies.			
The drug is considered by the BNF Joint Formulary Committee to be less suitable for prescribing			

* Whilst prescribers should think very carefully before prescribing or recommending any of the DNP products, there may be exceptional instances when the use of one of these products is necessary for a particular patient. A patient may be deemed exceptional if the patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition. Before prescribing clinicians should seek approval to prescribe from the CCG to ensure the CCG agrees the exceptionality and approves prescribing outside of the policy.

(acknowledgement to Stockport CCG for sharing this methodology)

Review outcome

Recommendation to MMC for Black Listing Yes/ No

Recommendation to MMC for Grey Listing Yes/ No

Criteria for permissible grey list use

Signed by (Chair of MMC).

MMC decisions will be presented as part of the minutes to PRG, once ratified at PRG they will be incorporated into the DNP, Grey, Red list on the CCG website.

Date at PRG

Outcome

Items not to be prescribed at T&G CCG expense (DNP list) or only in limited circumstances (Grey list)

Please note that in addition to the items listed here there should be no prescribing of any medicine **listed** in Part XVIIIA (Black List) of the Drug Tariff or in the case of appliances any **not listed** in Part IX. of the Drug Tariff.

1.1 There are a number of medications that T&G CCG believes should not be used (**DNP List**) or should only be used in limited circumstances (**Grey List**). Grey listed items will only be funded for patients who meet the specified criteria. The reasons for medicines being included on the lists are as given in the tables below and in line with the GMMMG and national guidance.

In addition there are medicines classed as **Red drugs**. These are medicines which should only be prescribed in a specialist setting (usually a hospital) rather than by a GP. The lists below include some of the more commonly requested Red drugs. **It should be noted this is not the whole list of Red drugs which can be found on the GMMMG website linked here** http://gmmmg.nhs.uk/html/rag.php
T&G CCG recognises that there may be exceptional patients or situations where prescribing of **DNP or Grey** list items may be necessary though such situations should rare. A patient may be deemed exceptional if the patient has a clinical picture that is significantly different to the general population of patients with that condition and, as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition
Red drugs should only be prescribed in the specialist setting

ITEM	RATIONALE	STATUS
Aglomelatine	Monitoring and control remain within secondary care	RED
Albiglutide*	As per Liraglutide	GREY
Alendronate plus vitamin D (Fosavance®) tablets	GMMMG Do Not Prescribe list on basis of poor cost effectiveness	DNP
Anastrozole as branded preparations e.g. Arimidex®*	Branded preparations can be significantly more expensive than the generic. Generic prescribing is required. Seek approval for patients who cannot tolerate the generic.	DNP
Anhydrol Forte*	Product for Cosmetic Purpose. Use prior to referral for botulinum toxin therapy in line with EUR policy is appropriate	GREY
Apixaban (Eliquis®)*	For use as per NICE criteria. Use outside of this requires an approval request to be completed. FOR use in AF a Record of initiation needs to be completed and stored on clinical system for audit purposes. NB For Post operative thromboprophylaxis the full course will be provided by the hospital and it should not need to be prescribed by primary care for this indication.	GREY
Armour Thyroid Preparations	GMMMG Do Not Prescribe list on basis of significant safety concerns and poor evidence base.	DNP
Bio-Oil®	Cosmetic product for the treatment of minor scars, not an appropriate use of NHS resources	DNP

ITEM	RATIONALE	STATUS
BioXtra® toothpaste & mouth rinse (this does not include BioXtra® oral gel)	GMMMG DNP list – efficacy not proven	**DNP**
Branded preparations containing latanoprost as a single active ingredient*	Branded preparations are significantly more expensive and offer no added value over the generic. Generic prescribing is required. Preservative free drops should be considered before requesting approval to prescribe a brand	**DNP**
Calcium 500mg /colecalaferol 200iu e.g.Calcichew D3®. Products that provide 800iu daily with less than 2g Ca^{2+} are appropriate	Daily dose of 800 iu Vitamin D is required for bone protection which cannot be provided by these products without giving a high dose of calcium. Given the possibility of this having a negative impact use of these combinations is not supported	**DNP**
Cannabis extract (Sativex®)	Added to GMMMG DNP list. Local policy already in place not to fund.	**DNP**
Chlorpropamide	Long half life and may contribute to hypoglycaemia, especially in the elderly	**DNP**
Cilostazol	GMMMG assessed this as not suitable for prescribing as the patient group in trials were not representative of the groups seen in clinical practice. NICE does not endorse its use.	**DNP**
Circadin® M/R tablets 2mg*	Only for use within an approved shared care protocol	**GREY**
Clomifene	An infertility drug, part of on going specialist package of care	**RED**
Co-careldopa intestinal gel (Duodopa®)	NTS deemed it low priority due to limited efficacy. Click here to view statement. NHSE may commission	**DNP**
Cod liver oil	Limited evidence of effectiveness. For OTC use patients should be advised that if not effective after a 3 month trial no benefit is likely to be gained.	**DNP**
Co-enzyme Q10 including ubiquinine and ubicdecarenone	GMMMG GREY List only permits use in mitochondrial disorders under the care of a specialist (NICE CG 181)	**GREY**
Compound preparations of aspirin -Co-codaprin, Aspav®	Single dose compound preps don't support effective dose titration Prescribe drug individually	**DNP**
Co-proxamol tablets	Now unlicensed due to concerns over toxicity. Banned in the US. Approval requires proof of exceptionality and failure to respond to all other pain killers to continue prescription beyond December 2010	**DNP**
Cyanocobalamin	Use tablets where a patient is unable to have B12 Injections. Hydroxycobalamin is the preferred therapy for B12 deficiency	**GREY**
Dabigatran (Pradaxa®)*	See Apixaban	**GREY**

ITEM	RATIONALE	STATUS
Dapoxetine	NTS recommendation does not support use. Click here to view statement	DNP
Darbapoetin	Part of on going specialist care	RED
Deferasirox	Part of on going specialist care	RED
Desferrioxamine	Part of on going specialist care	RED
Desloratadine*	Pro drug of loratadine which is cheaper. Desloratadine offers no added benefit	DNP
Diuretics with potassium	Most patients do not require potassium supplements and many of the preparations have low levels of potassium insufficient for those who do require supplementation.	DNP
Dosulepin preparations	NICE states specifically not to use this drug.	DNP
Dulaglutide*	As per Liraglutide	GREY
Duraphat® Toothpaste	Dental preparations are best assessed and monitored by a dental practitioner. Not prescribable by General Practitioners.	DNP
Dymista® (Fluticasone /azelastine nasal spray)	NTS does not recommend use. Reserved for patients in whom other medical treatments have failed before referral to secondary care (listing under review)	GREY
Edoxaban*	As per Apixaban	GREY
Eicosapentaenoic acid preparations e.g. Omacor®/Maxepa® or Prestylon®)	Only prescribable for hyper-triglyceridaemia on specialist advice. Review in line with the Standard Operating Procedure	GREY
Ergotamine all preparations	Poorly absorbed with a high incidence of side effects and complex dose regimen	DNP
Erythropoetin Alpha and Beta	Part of on going specialist care	RED
Esomeprazole tablets - as a branded preparation e.g. Nexium®*	Branded preparations are significantly more expensive and offer no added value over the generic. Generic prescribing is required.	DNP
Exenatide*	As per Liraglutide	GREY
Exenatide MR*	As per Liraglutide	GREY
Fidaxomicin (Dificlir®)*	Use only on advice of microbiologist Use restricted to preserve the effectiveness of this drug against C Diff.	GREY
Fluoride supplements (inc. tablets, mouthwashes and toothpastes)	These products should only be prescribed at CCG expense by a qualified Dental Practitioner who can assess the individuals fluoride status.	GREY
Fulvestrant (Faslodex®)	Only for patients treated with this drug before 30/11/2011 Negative NICE TA 239.	GREY

ITEM	RATIONALE	STATUS
Gabapentin topical*	GMMMG DNP list – efficacy not proven	**DNP**
Gamolenic acid (all preparations)	GMMMG DNP list – efficacy not proven	**DNP**
Gliclazide MR tablets any strength	Similar effect to standard release formulations which are much cheaper at equivalent doses. 30mg MR ~80mg standard release	**DNP**
Glucosamine any salt	Poor Evidence of efficacy in osteoarthritis.	**DNP**
Glucosamine with Chrondroitin	Poor Evidence of efficacy in osteoarthritis.	**DNP**
Grass Pollen extract (Grazax®)	NHS Stockport do not fund and NTS do not recommend. Click Here to view statement.	**DNP**
Icaps® products	See Multivitamin Preps for eye health	**DNP**
Idoxuridine in dimethyl sulfoxide Herpid®	Of little value. Superseded by more effective agents.	**DNP**
Inositol (Hexopal®)	Efficacy in peripheral vascular disease is not established	**DNP**
Iron –all modified release preparations	Offer little added benefit and greatly increased cost.	**DNP**
Ketoconazole oral products	Safety concern and MHRA warning. Click here to view the safety alert	**DNP**
Lactase e.g.Colief®	Lacks supporting evidence base. Can be bought OTC	**DNP**
Lanolin cream (Lansinoh HPA)	Lacks evidence to support use. Can be bought OTC	**DNP**
Latisse® eye drops (bimatoprost 0.03%)*	Cosmetic use, product is licensed to thicken eye lashes. This restriction does not apply to 0.3% drops for treatment of Glaucoma.	**DNP**
Levocetirizine	Pro-drug of cetirizine which is better value for the NHS. Levocetirizine offers no added benefit	**DNP**
Lidocaine (Versatis®) patches/plasters for post herpetic neuralgia	NTS does not recommend this product for this indication as they felt that efficacy and cost effectiveness of the product in comparison to other agents had yet to be proven.	**DNP**
Lidocaine Patches (Versatis®)	The group is aware that lidocaine plaster is also currently used 'off label' for indications other than treatment of post-herpetic neuralgia and the group do not recommend this 'off label' use for the reasons outlined above. All alternatives must have been dried to evidence exceptionality	**DNP**
Linaclotide*	For use with in NICE TA	**GREY**
Liothyronine extracts including Armour thyroid preparations	National Guidance not to prescribe in hypothyroidism	**DNP**
Liraglutide*	Only to be used for people with type 2 diabetes within the NICE guideline see sections 1.6.28 1.6.29 https://www.nice.org.uk/guidance/ng28/resources/type-2-diabetes-in-adults-management-1837338615493	**GREY**
Lixisenatide	As per Liraglutide	**GREY**
Meprobamate all preparations	Less effective than benzodiazepines and greater hazard in overdose	**DNP**
Montelukast- as branded preparations*	Branded preparations can be significantly more expensive and offer no added value over the generic. Generic	**DNP**

ITEM	RATIONALE	STATUS
	prescribing is required.	
Moxisylyte (Opilon®)	Efficacy in peripheral vascular disease is not established	**DNP**
Multivitamin & mineral preps marketed for eye health or for AMD including	There is no instance where these products are appropriate to use from a safety or efficacy point of view, over existing treatments. The list of preparations is not exhaustive due to the large number of supplements marketed.	**DNP**
Nalmefene*	For use within the NICE TA within the agreed local pathway	GREY
Naltrexone / Bupropion (Mysimba®)	NTS Statement not recommended Click here to view the statement	**DNP**
Naproxen + Esomeprazole (Vimovo®)	IPNTS deemed inappropriate. Agents may be prescribed separately.	**DNP**
Omega 3 preparations	See Eicosapentanoic acid	
Omeprazole- as a branded preparation e.g. Losec®*	Branded preparations are significantly more expensive and offer no added value over the generic. Generic prescribing is required by policy.	**DNP**
Ondansetron	Part of limited secondary care package of care	**RED**
Oxycodone with Naloxone* (Targinact®)	NTS – failed to demonstrate sufficient and clinical/cost effectiveness data. Click here to view statement	**DNP**
Paracetamol/ tramadol tablets (Tramacet®)	Single dose compound preps do not allow for effective dose titration and the advantages of using a compound formulation have not been substantiated. This is a fixed dose combination is particularly poor value to the NHS Prescribe drug individually	**DNP**
Pentoxifylline (Trental®)	Efficacy in peripheral vascular disease is not established	**DNP**
Piroxicam (oral preps)	Use on Specialist recommendation only due to safety concerns	GREY
Pollinese Quatro	GMMMG DNP list – efficacy not proven	**DNP**
Prednisolone EC tablets	Now on the GMMMG do not prescribe list	**DNP**
Prednisolone MR tablets (Lodotra®)	NTS determined inappropriate to prescribe. Click here to view statement.	**DNP**
Pregabalin	For neuropathic pain only after If the maximum dose of amitriptyline (or alternatives) is unsuccessful and Gabapentin tried and is effective but not tolerated due to side effects	GREY
RESPeRate®	GMMMG EUR group supported NICE recommendation not to routinely provide relaxation treatments	**DNP**
Rivaroxaban (Xarelto®)*	See Apixaban	GREY
Roflumilast (Daxas®)	Negative NICE TA. Patients prescribed the drug before 31/12/11 can continue provided they are getting benefit.	**DNP**
Sildenafil as a branded preparation e.g. Viagra®*	Branded preparations are significantly more expensive and offer no added value over the generic. Generic prescribing is required but only within CCG policy	**DNP**
Silk Garments e.g. Dermasilk® , Skinnies®	NTS determined as not appropriate to prescribe due to a poor evidence of clinical benefit	**DNP**

ITEM	RATIONALE	STATUS
and Dreamskin®		
Simvastatin with ezetimibe (Inegy®)	Not cost effective. Ingredients can be prescribed separately and dose titrated.	**DNP**
Sodium Oxybate Xyrem®*	NTS deemed low priority for funding due to limited efficacy data. Click here to view statement.	**DNP**
Spatone® 100% natural iron supplement. Spatone® liquid iron supplement with vitamin C*	The supplement contains a limited amount of iron (5mg) that could easily be got from other food sources or by using a small dose of a licensed iron 5mg ferrous iron= 10 drops Nifrex® or1 ml Sytron® or supplement. 0.5ml of Fersamal® or Galfer® syrup	**DNP**
Sunscreens listed under ACBS rules* LA Roche-Posay Anthelios XL SPF 50+ Sunsense Ultra (Ego) SPF 50+ Uvistat Lipscreen SPF 50 Uvistat Suncream SPF 30 Uvistat Suncream SPF 50	Nationally these are only permitted for protection from UV radiation in abnormal cutaneous photosensitivity resulting from genetic disorders or photodermatoses, including those resulting from radiotherapy and chronic or recurrent herpes simplex labialis.	**GREY**
Sunscreens not listed above*	Not permitted under ACBS rules	**DNP**
Synovial fluid injections including Hyaluronan and sodium hyaluronate for osteoarthritis of the knee.	There is limited evidence of effectiveness and NICE CG59 Osteoarthritis R32 recommendation states “Intra-articular hyaluronan injections are not recommended for the treatment of osteoarthritis.	**DNP**
Tadalafil 2.5mg and 5mg tablets*	Stockport CCG policy does not support the use of daily treatment for ED and there is an NTS statement which does not recommend this product for the 2nd licensed indication of benign prostatic hyperplasia	**DNP**
Tadalafil 10mg and 20mg tablets*	Use is only permitted to a maximum of 4 treatments per month in line with NHS Stockport CCG policy on the treatment of erectile dysfunction	**GREY**
Tapentadol M/R tablets	Restricted to those requiring treatment of severe chronic pain which can be adequately managed only with opioid therapies. Other alternatives should be tried first	**GREY**
Testosterone Patches for hypoactive sexual desire (Intrinsa®)*	Marketing licence in the UK was withdrawn. Listed to prevent supply of imported products	**DNP**
Tobramycin – inhaled and nebulised	Primary care can’t monitor therapy sufficiently to oversee treatment or adjust the dose where necessary to ensure safety.	**RED**
Topiramate capsules	Capsules are not good value for the NHS please use tablets instead for new patients and change existing prescriptions to tablets where clinically appropriate	**DNP for new initiations**
Trandolapril/ Verapamil (Tarka®)	No flexibility for dose titration. Use separate agents as not licensed in UK	**DNP**

ITEM	RATIONALE	STATUS
Ulipristal acetate 5mg (Esmya®) * (Please note 30mg tablets for emergency hormonal contraception are not affected.)	Surgeon responsible for arranging the surgery should prescribe the full course only for use in secondary care within a commissioned pathway as per NTS recommendation. Click here to view statement.	**DNP**
Unlicensed vitamins minerals & supplements for any indications	NTS not advise due to lack of a licensed preparation and absence of proven benefit but with potential for harm. Click here to view statement	**DNP**
Vitamin B Compound & Vitamin B Compound Strong Tablets	Should only be used on the advice of a dietician or in secondary care to prevent "re-feeding syndrome	**GREY**
Yohimbine	NTS deemed inappropriate due to lack of robust evidence of efficacy/safety.	**DNP**