SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 4 October 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 6 September 2016.	1 - 8
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the report of the Director of Finance, Single Commissioning.	9 - 22
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the report of the Director of Public Health, Single Commissioning.	23 - 54
b)	**PRIMARY CARE QUALITY STANDARDS REVIEW** To consider the attached report of the Director of Commissioning, Single Commissioning.	55 - 64
6.	**COMMISSIONING FOR REFORM**	
a)	**CONTRACT FOR THE PROVISION OF DIRECT PAYMENT SUPPORT SERVICES - INCLUSION ON LIST OF APPROVED SERVICES** To consider the attached report of the Director of Commissioning, Single Commissioning.	65 - 68
b)	**CONTRACT FOR THE PROVISION OF SPECIALIST DAY SERVICES FOR PEOPLE WITH DEMENTIA** To consider the attached report of the Director of Commissioning, Single Commission.	69 - 74
c)	**PROVISION OF RESPITE CARE FOR ADULTS WITH LEARNING DISABILITY AND ADDITIONAL NEEDS** To consider the attached report of the Director of Commissioning, Single Commissioning.	75 - 82

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.

Item No.	AGENDA	Page No

d) COMMISSIONING DATA MANAGEMENT SERVICES 83 - 88

To consider the attached report of the Director of Public Health, Single Commissioning.

7. PUBLIC HEALTH ANNUAL REPORT 89 - 138

To consider the attached report of the/ Director of Public Health.

8. 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).

9. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on the 1 November 2016 from 3.00 pm to 5.00 pm at 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

6 September 2016

Commenced: 2.30 pm **Terminated: 3.50 pm**

PRESENT: Alan Dow (Chair) – Tameside and Glossop CCG
Steven Pleasant – Chief Executive, Tameside MBC, and Interim Accountable Officer, Tameside and Glossop CCG
Richard Bircher – Tameside and Glossop CCG
Christina Greenhough – Tameside and Glossop CCG
Graham Curtis – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC

IN ATTENDANCE: Sandra Stewart – Director of Governance
Kathy Roe – Director of Finance
Angela Hardman – Director of Public Health and Performance
Clare Watson – Director of Commissioning
Ali Rehman - Public Health

APOLOGIES: Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC

61. WELCOME AND CHAIR'S OPENING REMARKS

In opening the meeting, the Chair made particular reference to the financial context and the financial position of the care together economy, especially the Clinical Commissioning Group position. The CCG Governing Body has convened a special single item meeting regarding this and its QUIPP/ Recovery plan on 7 September 2016 which was required by NHS England on 9 September 2016. He also noted that the decision of the Transformational Fund requested was awaited.

62. DECLARATIONS OF INTEREST

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

63. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 2 August 2016 were approved as a correct record.

64. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance, Single Commissioning Team, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 4 financial position at 31 July 2016 and the projected outturn at 31 March 2017.

It was explained that the report included 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 was £447.5m in value, detailed in **Appendix C** to the report, but this value was subject to change throughout the year as new Inter Authority Transfers were actioned and allocations amended.

The 2016/17 financial year was 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 the year. A financial recovery plan was required by NHS England by 9 September 2016 and an extraordinary meeting of the Governing Body would consider the plan on 7 September 2016. The report also considered the financial risk of the ICF in 2016/17 and further details had been included in section 6.

Members of the Board noted that section 2 of the report included details of the financial position of the Tameside Hospital NHS Foundation Trust which provided an members of the Board with an awareness of the overall financial position of the whole Care Together economy and highlighted 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.

In terms of a financial summary, reference was made to Table 1 detailing the 2016/17 budgets, expenditure and forecast outturn of the ICF and Tameside Hospital NHS Foundation Trust. However, there were a number of key risks that had to be managed within the economy during the financial year:

- Achievement of the original £21.5m projected commissioner financial gap (£13.5m Tameside and Glossop CCG and £8.0m Tameside MBC);
- Delivery of the £17.3m projected financial deficit of Tameside Hospital NHS Foundation Trust;
- Management of any potential overspend within Acute services as any overspend 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;
- Financial pressures as a result of national changes to the health contribution of funded nursing care payments (40% increase) generating an estimated increased liability to the CCG of approximately £0.6m but this would be confirmed and reported at month 5;
- Management of Care Home placements due to volatility in this area;
- Unexpected and complex dependency placements within Children's Services;
- Emergency in-year reductions to Central Government resource allocations;
- Proactive management of Continuing Healthcare and Prescribing, both of which were subject to volatility;
- Remaining within the running cost allocation for 2016/17.

It was further reported that the Greater Manchester Strategic Partnership Board would be meeting to consider the Tameside and Glossop proposals for Transformational Funds. A revised sum of £23.2m had been requested over the period to 2019/20, £5.2m of which had been requested in 2016/17. A decision on the proposals was expected mid-September.

RESOLVED

(i) That the 2016/17 financial year update on the month 4 financial position at 31 July 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.

(iii) That the significant amount of financial risk in relation to achieving an economy balanced budget across this period which had become more pertinent given the request from NHS England for a CCG financial recovery plan by 9 September 2016.

65. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on CCG assurance and performance based on the latest published data. The June position was shown for elective care and an August snap shot in time for urgent care. Also attached was a CCG NHS Constitution scorecard showing CCG performance across indicators. It also included referral data and a section on care homes.

The assurance framework for 2016/17 had been published nationally. However, the framework from GM Devolution was still awaited.

Particular reference was made to the following matters:

- Performance issues remaining around waiting times in diagnostics and the A & E performance;
- The number of patients still waiting for treatment 18 and over continued to decrease and the risk to the delivery of incomplete standard and zero 52 week waits was being reduced;
- Cancer standards were achieved in June apart from 62 day screening and Quarter 1 performance achieved;
- Endoscopy was till the key challenge in diagnostics particularly at Central Manchester;
- A & E standards were failed at Tameside Hospital Foundation Trust;
- Attendances and NEL admissions at Tameside Hospital Foundation Trust (including admissions via A & E) had increased;
- The number of Delayed Transfers of Care recorded remained higher than planned;
- Ambulance response times were not met at a local or at North West level.

RESOLVED

(i) That the 2016/17 CCG Assurance position be noted.

(ii) That the current levels of performance be noted.

66. INTEGRATED NEIGHBOURHOOD BUSINESS PROPOSITION

The Director of Commissioning presented a report which stated that the Neighbourhood Development work stream was leading the design and delivery of an innovative, ambitious, high quality and financially sustainable locally based integrated health and social care system. The system would 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.

There would be five Integrated Neighbourhoods across the Tameside and Glossop CCG footprint. Four of the neighbourhoods were co-terminous with the Tameside MBC Neighbourhoods and Glossopdale would be supported by Derbyshire County Council from a social care perspective.

The development of Integrated Neighbourhoods would build upon the recent development of the place based hubs in Tameside, the public sector prevention agenda which went live in May 2016 and bringing together front line providers from across a range of agencies to focus resource where it was needed most and responding to issues in a holistic rather than single agency way. Agencies currently included social services, police, housing, mental health, fire and the voluntary and community sector. The system would be developed over the next 3 to 5 years and in full partnership with patients, staff, voluntary sector, residents and regulators to ensure the model achieved its aims, was well understood and would meet the needs of the population

The Integrated Neighbourhood vision was to support neighbourhoods to deliver asset rich, high quality and connected services, looking after the whole neighbourhood population to support all to have improved outcomes, prosperity and wellbeing. The key objectives were outlined as follows:

- 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 improvement 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.

The fundamental principle of the Integrated Neighbourhood approach to care was that individuals were assessed for the level of care they required and took a proactive approach to the management of individuals across the whole risk spectrum and not just those at the higher end of need.

The Neighbourhood Development workstream would support and lead the establishment of 5 Neighbourhood Management Teams to lead the implementation of the model. The Model of Care workstream would 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.

Funding to implement this model had been requested as part of the economy's £23.2m bid from GM Health and Social Care Partnership and a decision was awaited on the outcome of the bid.

RESOLVED
That in principal approval be given to the business proposition for the Integrated Neighbourhood model proceeding to the implementation stage as part of the Care Together Programme pending the outcome of the GM funding decision.

67. INDEPENDENT SERVICES TO TAMESIDE BIRTH PARENTS AND RELEVANT GRANDPARENTS

The Director of Commissioning presented a report outlining the statutory requirement for the provision of independent services for Tameside birth parents and relevant grandparents and seeking authorisation to extend the contract for a period of up to twelve months (effective from 1 September 2015) where there was provision to do so in the contract.

It was explained that during the period 1 April 2015 to 31 March 2016 the supplier, Adoption Matters, had processed 31 Tameside enquiries to the action line and 19 new cases were allocated to an adoption support worker. In addition, the supplier had 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 supporting during this financial year, 13 had received long term / intensive involvement. The contract appeared approximately the correct size for the level of demand in terms of total number of referrals and provided some capacity for flexibility. The current service provided had shown a commitment to continually improving systems and service delivery to meet the needs of its service users.

RESOLVED
That approval be given to extend the contract for the provision of independent services for Tameside birth parents and relevant grandparents with Adoption Matters for a period of up to twelve months from 1 September 2016.

68. SEND – INSPECTIONS TO LOCAL REPORT

Consideration was given to a report of the Director of Commissioning outlining 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) had been implemented. It was important to note that this was a local area inspection, not a local authority inspection and included the CCGs, Public Health and the Local Authority. The report detailed the process and exposed the risks that the joint inspection framework could hold.

The Care Quality Commission (CQC) and Ofsted would jointly carry out the inspections of local areas evaluating how effectively the local area identified children and young people with special educational needs and / or disabilities, how it was meeting their needs and improving their outcomes. How well a local area engaged with, and involved children and young people and their parents and carers, both in commissioning services at the strategic level and in assessing individual need would be a key area of inspection focus.

In preparation for the inspection, a Tameside and Glossop CCG Audit was completed in July 2016 providing a framework for considering progress to date and divided into 6 key areas of the role of a CCG in supporting children with SEND. A brief summary result included in the report indicated that the CCG was able to evidence its current baseline compliance within the reforms. However, further actions were needed to ensure clear evidence of the CCG / Single Commission function commitment to implementing the reforms.

RESOLVED

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

(ii) That the CCG / Single Commission officers and the Clinical Lead be authorised to continue to take relevant steps, make decisions, and to progress arrangements to further the implementation of the SEND reforms.

(iii) That an action plan be developed based on the findings of the CCG SEND diagnostic audit tool and approved through emerging governance structure, ensuring oversight and inspection readiness.

(iv) That all relevant providers be briefed in relation to the new inspection framework and its requirements.

(v) That a re-audit applying CCG SEND diagnostic audit tool be undertaken in July 2017.

69. NEURO REHABILITATION

Consideration was given to a report of the Director of Commissioning advising that the Greater Manchester Heads of Commissioning, with the Stroke and Neurology Operational Delivery Networks (ODNs) had produced a report providing an update on the work undertaken to date.

It included 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. Tameside and Glossop already commissioned in this way when the specifications for the previous SPRINT (neuro-rehab) and Community Stroke Team merged in 2013-14 to form the Community Neuro-Rehabilitation Team.

The report also outlined the opportunities for GM working to achieve consistency and to identify areas where efficiencies could be made and the following steps were highlighted 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 were quantifiable and assessable.

Tameside and Glossop were represented at Head of Commissioning and also in the discussions with ODNs on the details of the proposed model and had provided information on the local service provision to inform the content of the report.

The Commissioning Team would ensure that there were no additional cost implications of this work for the Tameside and Glossop Single Commission and would work with the ICO on any redesign implications.

The request from the GM Heads of Commissioning was that each CCG take this proposal through local governance for approval.

RESOLVED

(i) That the update report be noted.

(ii) That the intention for a combined service mode at GM level be confirmed.

(iii) That the proposal for the completion of an Impact Assessment including a cost benefit analysis be approved.

(iv) That Tameside and Glossop's involvement in this commissioning project be confirmed.

(v) That NHS Tameside and Glossop CCG would continue to commission a combined stroke and neuro-rehab service from Tameside NHS Foundation Trust.

70. INTEGRATED NEIGHBOURHOOD PHARMACY PROPOSAL

Consideration was given to a report of the Director of Commissioning outlining a model for pharmacy and medicines management support to the integrated neighbourhood model. As part of the consultation process for the emergent Integrated Neighbourhood Offer the single commission and care together programme had held workshops in all 5 of our neighbourhoods to agree the Integrated Neighbourhood priorities and core offer. One issue that had arisen as a priority from discussions in all 5 neighbourhoods was the need for pharmacy and medicines management support. This scheme complemented the Integrated Neighbourhood offer and the Care Homes policy.

The key outcome of this new service would be improved care and health outcomes for patients as well as improved access to care in general practice. Pharmacists would 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 would include those in care homes. They would support patients to self-manage their wellbeing and long term conditions through optimising medicines and enabling improved medicine related communication between general practice, hospital and community pharmacy. It was also expected that this service would release savings in primary care budgets through a reduction in medicine related non-elective admissions. The CCG spent £14,230 on unplanned admissions last year. As noted, literature suggested that between 5 to 8% of all unplanned hospital admissions were due to issues related to medicines.

Reference was also made to the current practice pharmacist situation, potential barriers to the effectiveness of service offerings, interventions, inter-pharmacy liaison and the overarching benefits.

It was reported that the provision of approximately 2 WTE per neighbourhood at a total cost of £640,500 was roughly in line with the figure quoted in the GP forward view of a pharmacist per 30,000 population and supported the Integrated Neighbourhood offer.

There was much evidence nationally and locally to promote the benefit of using the skills of clinical pharmacists in general practice and community teams. The proposed approach would 'top slice' any GM transformation funding awarded to the Integrated Neighbourhood model to enable a Neighbourhood Pharmacy Support Team to be commissioned working across all 5 Neighbourhoods. The benefits of this approach would include:

- Ability to deliver key pharmacy interventions providing financial and clinical efficiency in prescribing;
- Delivery of an identified priority for Integrated Neighbourhoods;
- Improve the recruitment and retention of pharmacists;
- Cover 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 with potential to work across primary and secondary care.

RESOLVED
That the proposal to develop a Neighbourhood Pharmacy model to support the model for Integrated Neighbourhood working be approved.

71. ENHANCED APPROACH TO 'DO NOT PRESCRIBE', GREY LIST AND RED MEDICINES

The Director of Commissioning presented a report setting out a proposed approach for the application of prescribing guidance in the local health economy. Whilst Tameside and Glossop CCG sought to ensure that all patients had access to the most appropriate medicines and treatments to maintain their health and wellbeing, some medicines had been identified as not providing adequate value for the local health economy and the prescribing of any such medicines or appliances might be restricted. This could be as a general Do Not Prescribed (DNP) message, prescribed under limited circumstances (Grey list) or not be prescribed in primary care (Red status).

Reference was made to the NHS Act and the NHS Constitution in line with the NHS Standard Contract set a number of broad principles in place when considering the use of treatment within the NHS which were detailed in the report.

The aim of the approach was to promote recognition of DNP, Grey and Red list criteria at time of requesting so they could be highlighted and challenged before any GP prescribing occurred. Often it was practice staff who were the first point of contact for these requests and having 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. Such lists were available on the Greater Manchester Medicines Management Group website but the information was not always easy to find and it was intended that the localised version of these lists would be accessible for the public / GPs / practice staff on the CCG website.

The proposed policy for consideration for inclusion in the DNP, Grey list was attached at **Appendix 1**. Any prescriber would be able to input ideas into the development of the DNP and Grey list which would be received on a regular basis. It was proposed that those medicines or appliances which were agreed as going forward for inclusion would then be signed off for such by the Quality Committee and thereafter updated on the CCG website.

RESOLVED
(i) That the approach for the application of prescribing guidance in the local health economy be approved.
(ii) That the Single Commission Management Team (via medicines management teams) work with prescribers in the local economy to implement the model.

72. URGENT ITEMS

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

73. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 4 October 2016 commencing at 3.00 pm at New Century House, Denton.

CHAIR

This page is intentionally left blank

Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
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 AUGUST 2016 AND PROJECTED OUTTURN TO 31 MARCH 2017**
Report Summary:	This is a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial position of the Economy. The report provides through a presentation a 2016/2017 financial year update on the month 5 financial position (at 31 August 2016) and the projected outturn (at 31 March 2017). The Tameside and 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 summary of the Tameside Hospital NHS Foundation Trust financial position is also included within the presentation. 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 : 1. To note the 2016/2017 financial year update on the month 5 financial position (at 31 August 2016) and the projected outturn (at 31 March 2017). 2. Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. 3. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report provides the financial position statement of the 2016/17 Care Together Economy for the period ending 31 August 2016 (Month 5 – 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. It should also 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 set out in Public and Patient Implications.
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 on slide 8 of the presentation
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

This page is intentionally left blank

TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position: M5 2016/17

2016/17 Revenue Monitoring Statement at 31 August 2016 and projected outturn to 31 March 2017

Single Commissioning Board – 4 October 2016

Stephen Wilde
Tracey Simpson
Ann Bracegirdle

NHS Tameside and Glossop Clinical Commissioning Group

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

Tameside Metropolitan Borough

Combined Financial Position for the ICF

£000's	Year to Date (M5)			Year End			Movement	
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	82,174	82,477	(304)	198,339	198,256	83	(274)	357
Mental Health	12,123	12,217	(94)	29,096	29,168	(72)	(203)	132
Primary Care	33,481	33,882	(401)	80,423	81,167	(744)	(590)	(155)
Continuing Care	4,053	4,139	(86)	12,254	12,445	(191)	(206)	15
Community	11,409	11,396	13	27,539	27,572	(33)	(5)	(28)
Other	10,833	9,869	964	25,237	24,838	399	783	(383)
QIPP				0	4,790	(4,790)	(12,893)	8,103
CCG Running Costs	1,815	1,907	(92)	5,162	4,604	558	425	132
CCG Sub Total	**155,888**	**155,888**	**(0)**	**378,050**	**382,840**	**(4,790)**	**(12,963)**	**8,173**
Adult Social Care & Early Intervention	17,585	18,111	(526)	41,995	43,258	(1,263)	(1,263)	0
Childrens Services, Strategy & Early Intervention	10,507	10,719	(213)	25,877	26,387	(510)	(308)	(202)
Public Health	(2,653)	(2,533)	(120)	1,400	1,687	(287)	(237)	(50)
TMBC Sub Total	**25,439**	**26,297**	**(858)**	**69,272**	**71,332**	**(2,060)**	**(1,808)**	**(252)**
GRAND TOTAL	**181,327**	**182,185**	**(858)**	**447,322**	**454,172**	**(6,850)**	**(14,771)**	**7,921**

A: Section 75 Services	**93,866**	**93,263**	**603**	**232,236**	**235,396**	**(3,160)**
CCG	78,435	78,074	361	190,216	191,739	(1,523)
TMBC	15,431	15,189	242	42,020	43,657	(1,637)
B: Aligned Services	**74,409**	**75,808**	**(1,399)**	**183,435**	**186,570**	**(3,135)**
CCG	64,402	64,700	(298)	156,183	158,895	(2,712)
TMBC	10,008	11,108	(1,100)	27,252	27,675	(423)
C: In Collaboration Services	**13,051**	**13,114**	**(63)**	**31,650**	**32,206**	**(556)**
CCG	13,051	13,114	(63)	31,650	32,206	(556)
TMBC	0	0	0	0		0

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 and timing of the recovery plan. 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 QIPP/recovery plans)

- Opening commissioner financial gap of £21.5m. Total economy gap (inc FT of £17.3m) is £38.8m.
- Still need to close £6.85m of the commissioner gap.
- Significant improvement in the CCG QIPP position following submission of recovery plan.
- Still work to do to ensure delivery of full savings target. Significant risk attached to this.
- Currently forecasting:
  - CCG to deliver 1% surplus in 2016/17
  - Keep 1% of CCG allocation uncommitted
  - Maintain Mental Health parity of esteem
  - Remain within CCG running cost allocation
  - TMBC deliver a balanced budget

Recommendations

- Note the updated M5 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position
- Acknowledge significant savings required to close the long term financial gap

Key Movements & Narrative: CCG

CCG

- Submission of recovery plan has led to significant increase in value of green rated QIPP schemes (£0.6m to £8.7m)
- Significant changes in outturn position by directorate:

  - **Acute**: Movement of £350k budget from reserves to fund pressures in Independent sector.

    Release of £500k savings in CATs to fund QIPP target. Also release cross year benefit on NCA to QIPP.

    Detailed breakdown of movements in acute providers detailed seperately

  - **Mental Health**: £61k benefit in the position due to reduced activity in Hurst Beckett unit.

    Still on track to meet parity of esteem commitments.

  - **Primary Care**: £145k movement in position relates to pressures in relation to provision of 7 day access.

    Detailed work on value of prescribing spend ongoing.

  - **Continuing Care**: Reduction in value of both budget and forecast in relation to 15/16 estimates.

    Detailed work on value of 16/17 forecast and monitoring arrangements ongoing.

  - **Community**: £181k for community IT moved from reserves into budgets.

  - **Running Costs**: Value of underspend is increased to £558k as part of review of cost to feed into recovery plan.

Acute Provider Drilldown

- **Tameside FT**: Overspent by (£631k) YTD. Showing as breakeven by year end due to the expectation that transformational schemes will be realised and activity will reduce. Pressures driven by:
  - Elective & DC Admissions: Particularly T&O (£320k)
  - Ambulatory: Pulmonary embolism (£105k) / DVT (£79k)
  - Maternity (£65k) / Gynaecology (£90k)
  - Dispute over cross year excess bed days not included in actuals below (£290k)
- **Central Manchester**: Pressures driven by macular activity (£234k) and waiting list initiatives for gastroenterology (£34k) / cardiology (£28k)
- **South Manchester**: High cost Critical Care patient (£94k) & vascular day cases (£59k)
- **Salford**: Outpatient follow ups (£30k) / Ad Hoc Drugs (£32k)
- **Stockport / Pennine Acute:** Underspend of £66k in T&O elective / £12k in T&O Daycase for the respective providers which offsets the increase in independent sector and other providers.

£000's	Year to Date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
Tameside	52,511	53,142	(631)	127,075	127,075	0
Central Manchester	9,352	9,428	(76)	22,280	22,601	(321)
Stockport	4,950	4,640	310	11,969	11,685	284
South Manchester	2,676	2,750	(74)	6,568	6,751	(183)
Pennine Acute	1,681	1,538	143	4,029	3,796	233
Salford	1,339	1,462	(122)	3,226	3,421	(195)
WWL	579	585	(5)	1,409	1,278	131
Bolton	33	32	0	80	76	4
Total	**73,122**	**73,577**	**(455)**	**176,635**	**176,683**	**(48)**

Key Movements & Narrative: TMBC

Adult Social Care

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

Children's Social Care

- 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. Current estimates are that spend will be in excess of budget by £0.442m 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

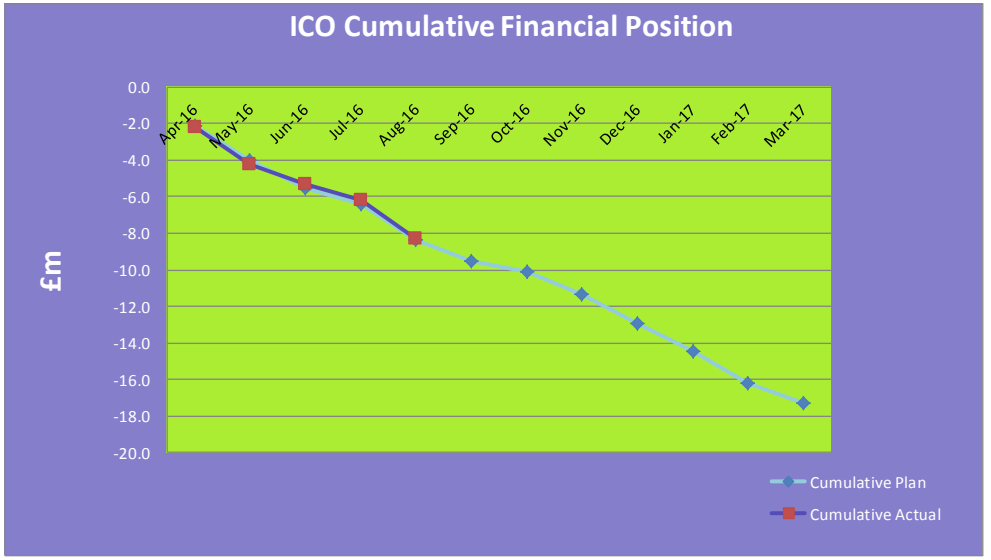
- Temporary resourcing of the Active Tameside capital investment prudential borrowing repayments is currently under consideration. The temporary resourcing arrangements will be replaced in future years via the recurrent savings achieved from a significant reduction to the annual management fee payable.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

Key Movements & Narrative: Tameside & Glossop Integrated Care FT

- For the 5 months to August 2016, the ICO is delivering a deficit of £8.3m, broadly on line with plan.
- The year end forecast is for the planned £17.3m deficit, and assumes the following;
  - Delivery of the £7.8m savings target
  - Payment from commissioners will be reflective of activity incurred inclusive of any forecast over performance from T&G CCG
  - Small over performance on all PbR contracts
  - Financial and performance criteria for receipt of £6.9m Sustainability and Transformation funding (STF) is achieved in full.
  - £17.3m working capital/loan is received to fund the deficit position.
  - Agency expenditure does not increase significantly

<u>Key Risks to the Financial Position</u>

- Under-performance of savings target
- Over performance not funded by the CCG
- STF metrics and therefore funding not achieved in full
- Additional unplanned expenditure due to winter pressures incurred
- Savings relating to transformation schemes delayed



Closing the Financial Gap

Establishing the Financial Gap

- Current financial gap across the health and social care economy in Tameside & Glossop will be £70.2m by 20/21
- In 16/17 the gap is £45.7m. This is made of £13.5m CCG, £8m Council and £24.2m ICO. The provider gap 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

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**

Closing the Financial Gap

- CCG recovery plan recently submitted to NHS England which demonstrates initiatives which would allow the CCG to close 16/17 gap and deliver required 16/17 surplus. Some risk associated with this.
- More work required to identify recurrent, activity backed, transformational schemes which will contribute towards to residual gap of £14.7m in 17/18.

Summary of QIPP £'000s	2016/17 R	A	G	Total	2017/18 R	A	G	Total
Priority 1 - Prescribing	0	1,449	0	**1,449**	0	1,393		**1,393**
Priority 2 - Effective Use of Resources/Prior approval	0	500	0	**500**	0	2,400	0	**2,400**
Priority 3 - Demand Management	96	265	0	**361**	0	1,886	0	**1,886**
Priority 4 - Single Commissioning Function responsibilities	0	463	391	**854**	0	1,060	219	**1,279**
Priority 5 - Back office functions and enabling schemes - IM&T and Estates	0	250	0	**250**	1,000	1,000	0	**2,000**
Priority 6 - Governance	0	30	0	**30**	0	100	0	**100**
Other Schemes in progress/achieved:	R	A	G	Total	R	A	G	Total
Neighbourhoods	0	0	460	**460**	0	451	230	**681**
Primary Care	0	0	360	**360**	100	2,000	0	**2,100**
Mental Health	0	0	232	**232**	0	1,000	232	**1,232**
Acute Services - Elective	0	310	500	**810**	0	1,210	0	**1,210**
Enabling schemes to facilitate QIPP achievement	0	0	0	**0**	0	1,000	240	**1,240**
Other efficiencies	0	1,007	6,767	**7,774**	0	0	28	**28**
Grand Total:	96	4,274	8,710	**13,080**	**1,100**	**13,500**	**949**	**15,549**
Including adjustment for Optimum Bias:	10	2,137	8,710	**10,857**	110	6,750	949	**7,809**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								
QIPP Target				**13,500**				**22,485**
Savings still to find assuming application of optimism bias:				2,643				14,676
Other Actions to close the gap in 2016-17 **(to be confirmed)**				2,643				
Outstanding QIPP at close of 2016-17:				**0**				

Closing the Financial Gap (cont)

Closing the Financial Gap – Tameside MBC

- Range of options currently being explored and proposals being considered by the Council to deliver the remaining gap in 2016-17.

Scheme Detail	R	A	G	Total
Public Health - Planned reduction to the annual management fee payable to Active Tameside and additional incidental savings delivered within the service			217	217
Public Health - Reduction in the Community Services contract value has been agreed with Tameside FT			169	169
Public Health - Reduction in the Pennine Care Community Health contract value			160	160
Public Health - Additional resource (projected cost pressures)			49	49
Public Health - Reduction in estimated capital financing repayments (Active Tameside) - The capital financing figure in 16-17 has reduced due to a rephasing of works to reconfigure the Active Tameside estate			514	514
Public Health - 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		272		272
Adult Social Care - Additional resource (projected cost pressures)			3,908	3,908
Adult Social Care - 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	997			997
Childrens Social Care - Reduction to inflationary increases that were projected to materialise during 2016/17			120	120
Childrens Social Care - Additional resource (projected cost pressures)			1,215	1,215
Childrens Social Care - 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	379			379
TOTAL	**1,376**	**272**	**6,352**	**8,000**

Financial Risk Within the ICF

- Main financial risks within the ICF are listed to the right.
- Detailed registers which include further information about the risk and mitigating actions are reviewed by Audit Committee. Copies are available on request.
- Overall level of risk is comparable to that reported at M4.
- Removed risk about receipt of transformation money from GM Health and social care partnership.
- Added new risks about national changes to rates of FNC contribution and ensuring that transformation money
- Significant risks include:
  - CCGs ability to maintain spend within allocation and deliver a surplus in 16/17: A financial recovery plan was recently submitted to NHS England to demonstrate how we meet business rules. We now need to focus on successful delivery of this plan.
  - Meeting the financial gap recurrently: Many of the actions within the 16/17 recovery plan are non recurrent and transactional in nature. To ensure economy wide gap is met in the long term we need to replace these short term measures with recurrent, activity backed transformational schemes.

Extracts From the Corporate Risk Registers	Probability	Impact	Risk	RAG
The achievement of meeting the Financial Gap recurrently.	4	4	16	R
Over Performance of Acute Contract	3	4	12	A
Not spending transformation money in a way which delivers required change	2	4	8	A
Over spend against GP prescribing budgets	3	4	12	A
Over spend against Continuing Health Care budgets	2	3	6	A
Operational risk between joint working.	1	5	5	A
CCG Fail to maintain expenditure within the revenue resource limit and achieve a 1% surplus.	4	4	16	R
In year cuts to Council Grant Funding	2	3	6	A
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
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Provider Market Failure	2	5	10	A
Funded Nursing Care – impact of national changes to contribution rates	4	2	8	A

Other Significant Issues

Better Care Fund

- Tameside Better Care Fund plan for 16/17 was approved by NHS England on 1 September 2016.
- Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.
- All spend is monitored through the Integrated Care Fund and is being spent in the following areas:

Scheme Name	2016-17 Budget (£000's)		
	CCG	TMBC	Total
Urgent Integrated Care Service	**578**	**2,374**	**2,952**
IRIS	578	1,338	1,916
Early Supported Discharge Team		286	286
Community Occupational Therapists		750	750
Localities	**412**	**3,265**	**3,677**
Telecare / Telehealth	174	667	841
ICES (Joint Loan Store)	238	450	688
Reablement Services		2,148	2,148
Carers Support (In line with national conditions of Care Act related funding)	**412**	**0**	**412**
Carers Breaks (Adults)	412	0	412
Primary Care (£5 per head for over 75s)	**1,070**	**0**	**1,070**
Existing Grant - Disabled Facilities Grant		**1,978**	**1,978**
Impact Of New Care Act Duties		**529**	**529**
Integration Pump Priming	**982**		**982**
Maintaining Services	**0**	**4,801**	**4,801**
Mental Health Services		2,450	2,450
Adult Social Care - Community based services (incl Care homes)		2,351	2,351
Contingency	**900**		**900**
Total BCF Fund	**4,354**	**12,947**	**17,301**

Funded Nursing Care

- 40% increase in health contribution toward FNC cases has been agreed nationally. Total CCG impact of up to £593k.
- This was an interim change until December 2016 pending outcome of national review into FNC charges. Element of the rate for agency nursing staff (which could lead to reduction of the rate in the future regional variation
- Local authority stand to be significant beneficiary of this. Therefore across the health and social care economy the net impact will be lower than the pure health impact above and we are managing within ICF.

Transformation Funding

- £23.2m bid for transformation funding has been made to Greater Manchester Health & Social Care Partnership. A decision about whether this funding has been approved is due to be formally ratified by end September.
- Currently in the process of determining milestones and KPIs against which the investment will be assessed.

This page is intentionally left blank

Report to: **SINGLE COMMISSIONING BOARD**

Date: 4 October 2016

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

Subject: **DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE**

Report Summary:

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

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

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	**92.3%**	**1**	**1.70%**	**89.03%**

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 July apart from 62 day upgrade. 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 11 Sept 2016	April 2016/ 17	May 2016/ 17	June 2016/ 17	July 2016/ 17	Aug 2016/ 17	Sept to 11 2016/ 17
89.03%	**92.46%**	**92.16%**	**86.61%**	**84.98%**	**90.48%**	**85.57%**

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 apart from CAT A 8 mins at CCG 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. This doesn't currently achieve this but is work in progress. This report will be received by the CCG for its assurance purposes to avoid duplication of resources.
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

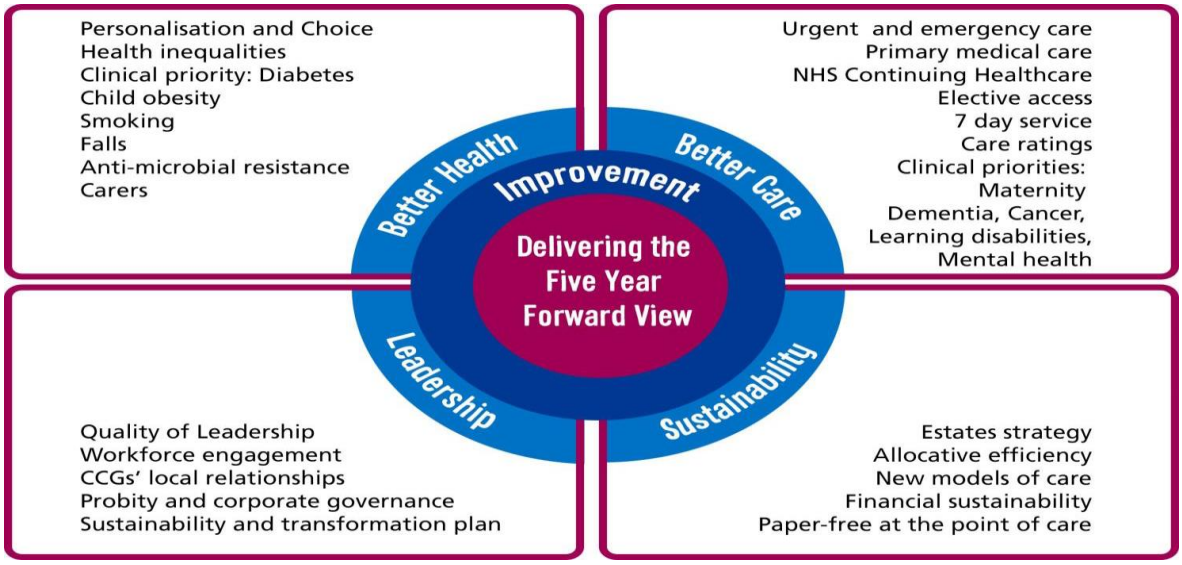
1. INTRODUCTION

1.1 This report provides an update on CCG assurance and performance, based on the latest published data (at the time of preparing the report). The July position is shown for elective care and a September "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

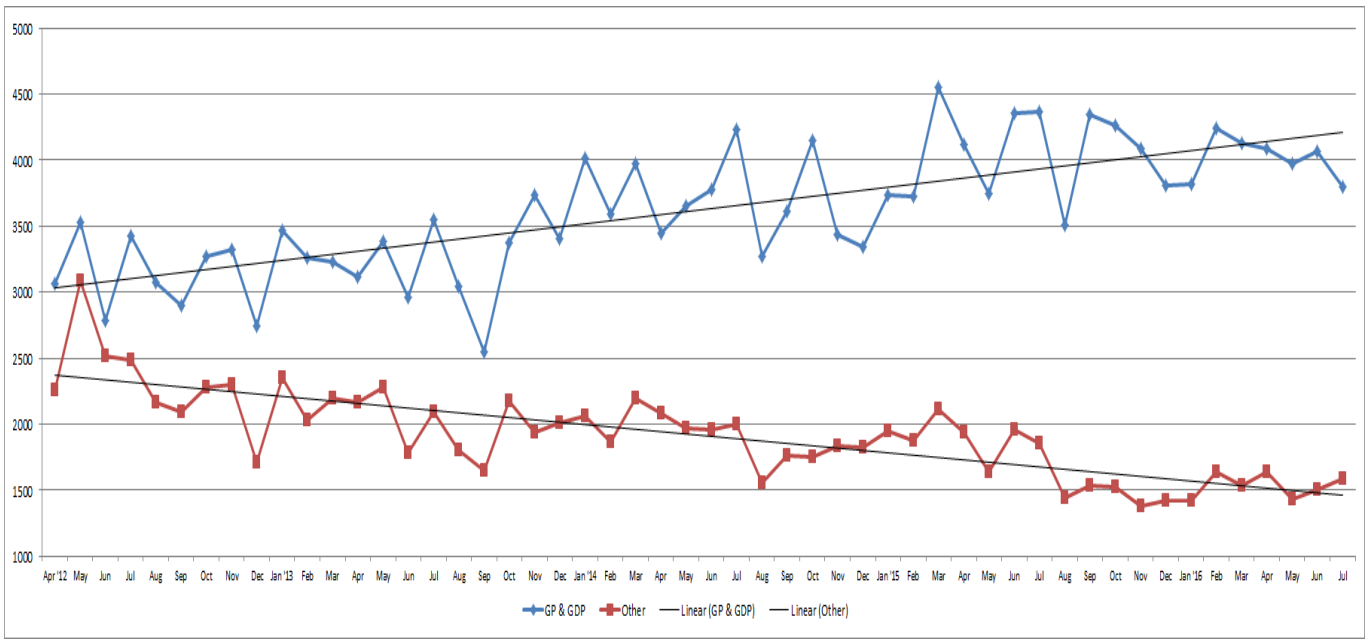
2.1 The assurance framework for 2016/17 has been published nationally however, we are awaiting the framework from GM Devolution. A recent WebEx led by NHS England provided further info on the new assessment framework for 16/17. CCGs will be assessed in relation to four key areas of their functions and 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.

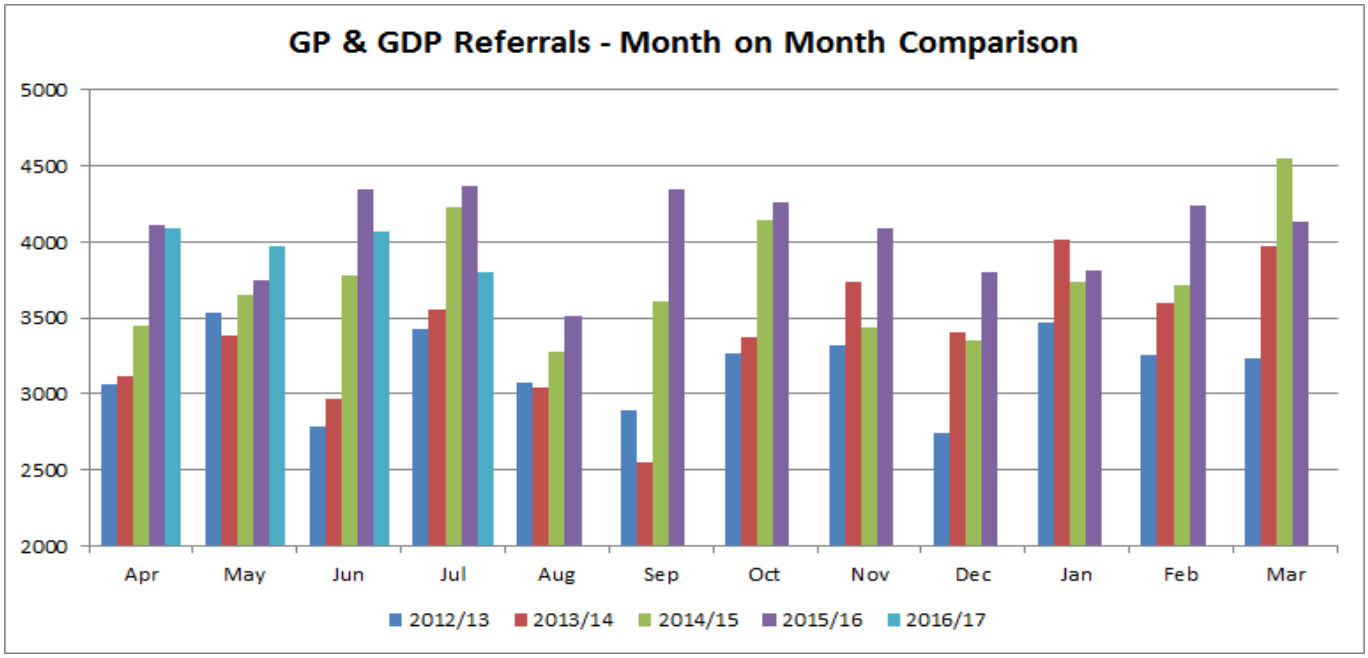


3. CURRENT CCG PERFORMANCE

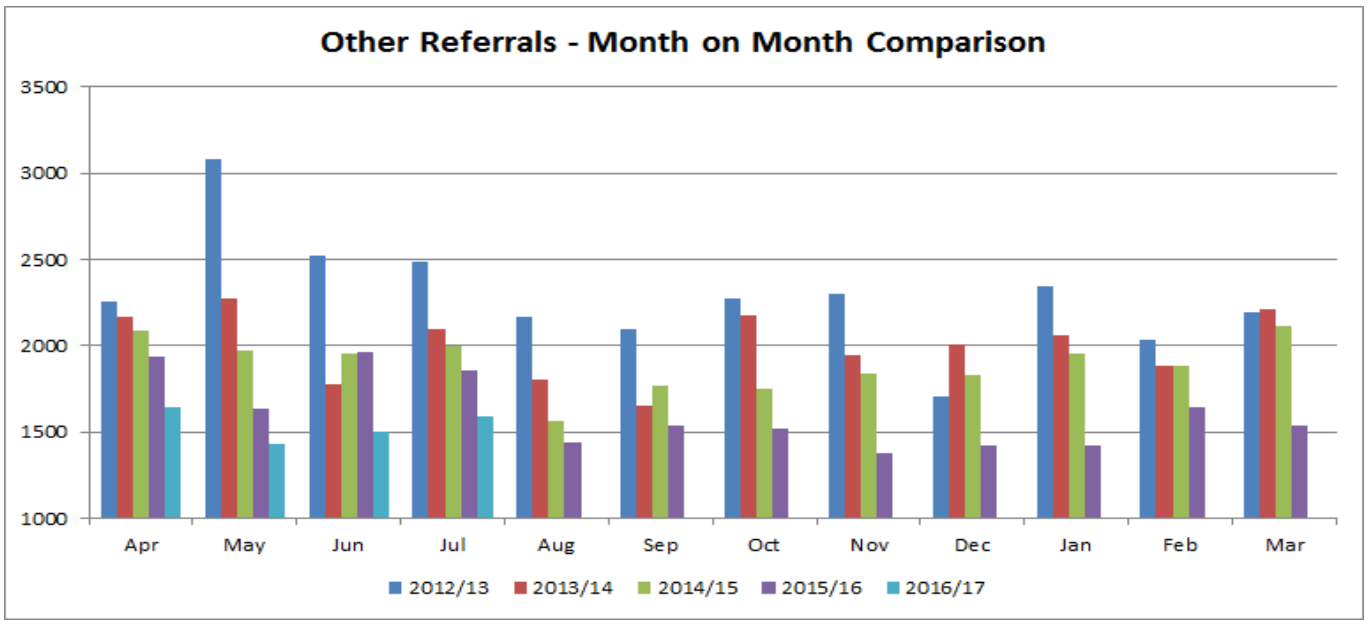
Referrals.

3.1 GP/GDP referrals to TFT only have decreased during the month of July 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.



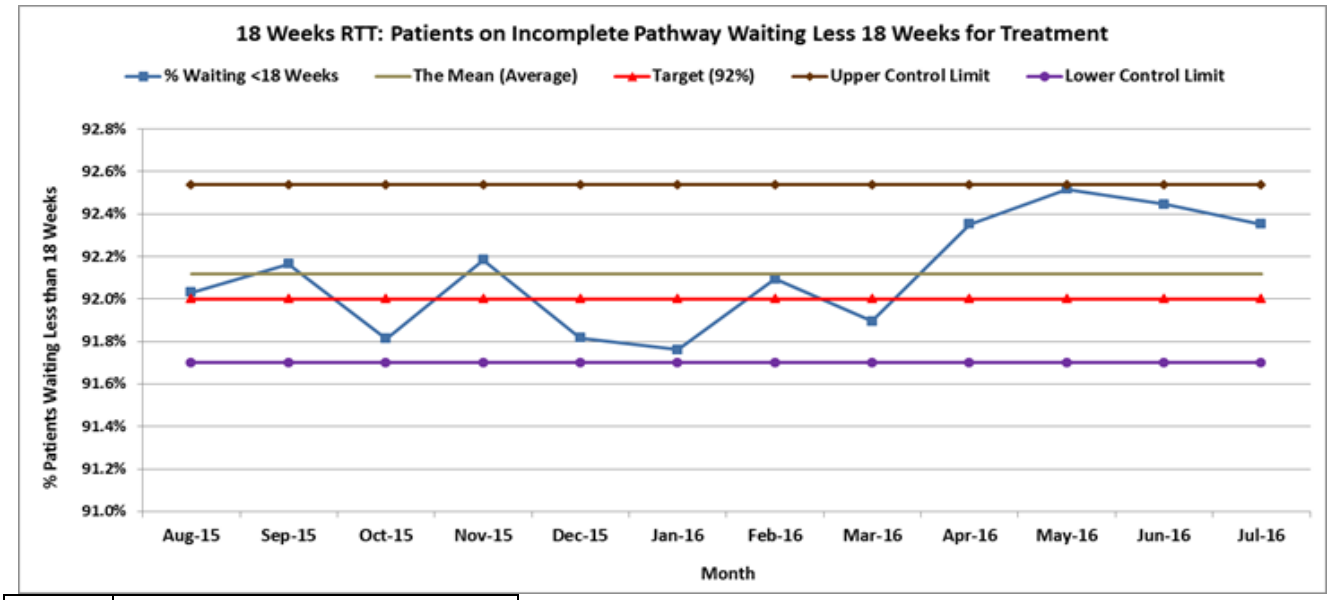


3.2 Other referrals (TFT only) have decreased during the month of July compared to the same period last year. This is a continuing trend.



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

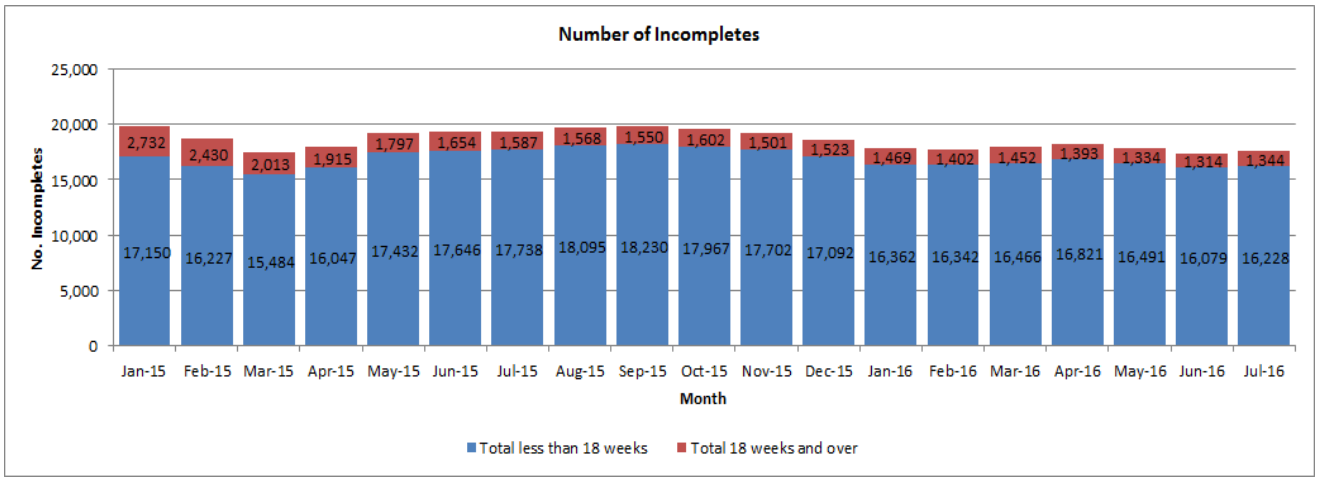
3.3 In July the CCG achieved the incompletes standard at 92.35% and THFT continued to achieve at 93.06%. The National RTT stress test demonstrates the trust are continuing to reduce the risk of failing RTT, this will have a positive impact on CCG performance.



	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%
July	92.3%	93.0%

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



	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	Jul-16
52+ Weeks	29	18	6	6	5	1	1	0	1	2	0	1	0	2	0	1	0	0	1
40+ Weeks (inc. 52+	149	118	90	126	101	92	61	45	39	30	28	42	47	51	49	34	31	24	28
28-40 Weeks	680	642	512	525	486	422	307	300	307	272	295	341	339	255	245	265	274	251	243
18-27 Weeks	1903	1670	1411	1264	1210	1140	1219	1223	1204	1300	1178	1140	1083	1096	1158	1094	1029	1039	1073
14-17 Weeks	2395	1959	1884	1254	1828	1987	1890	2039	2242	2288	2038	2051	2191	1930	1836	1424	1670	1591	1415
0-13 Weeks	14755	14268	13600	14793	15604	15659	15848	16056	15988	15679	15664	15041	14171	14412	14630	15397	14821	14488	14813
Total	19882	18657	17497	17962	19229	19300	19325	19663	19780	19569	19203	18615	17831	17744	17918	18214	17825	17393	17572

3.5 There was one patient waiting more than 52 weeks for treatment at UHSM, this was incorrectly reported by the trust.

3.6 Tameside expects to report zero 52-week waits for August. However the risk of 52 week waiters remains with eleven 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 13 September 2016, six patients had been waiting longer than 52 weeks when treated. 1 patient was still waiting to be 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	990	66	23	12	7	0	1	0	0	1.8%
Cardiothoracic Surgery	35	2	2	1	1	0	0	0	0	4.9%
Dermatology	959	19	2	3	2	2	0	0	0	0.7%
Ear, Nose & Throat (ENT)	1445	45	24	3	4	1	1	0	0	0.6%
Gastroenterology	688	30	11	3	1	0	1	0	0	0.7%
General Medicine	923	29	14	4	2	1	0	0	0	0.7%
General Surgery	1885	96	46	12	14	3	1	1	0	1.5%
Geriatric Medicine	7	1	0	0	0	0	0	0	0	0.0%
Gynaecology	1178	70	44	9	8	1	1	0	0	1.4%
Neurology	3	0	0	0	0	0	0	0	0	0.0%
Neurosurgery	34	1	0	0	0	0	0	0	0	0.0%
Ophthalmology	1189	8	6	1	2	1	0	0	0	0.3%
Oral Surgery	1	0	0	0	0	0	0	0	0	0.0%
Other	2742	106	38	25	17	8	0	0	0	1.7%
Plastic Surgery	149	6	9	4	0	2	1	0	0	4.1%
Rheumatology	290	5	4	2	5	0	0	0	0	2.3%
Thoracic Medicine	165	14	6	2	2	0	0	0	1	2.6%
Trauma & Orthopaedics	2441	142	79	41	22	3	4	0	0	2.6%
Urology	1104	78	47	16	8	3	1	0	0	2.2%
Total	**16,228**	**718**	**355**	**138**	**95**	**25**	**11**	**1**	**1**	**1.5%**

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.

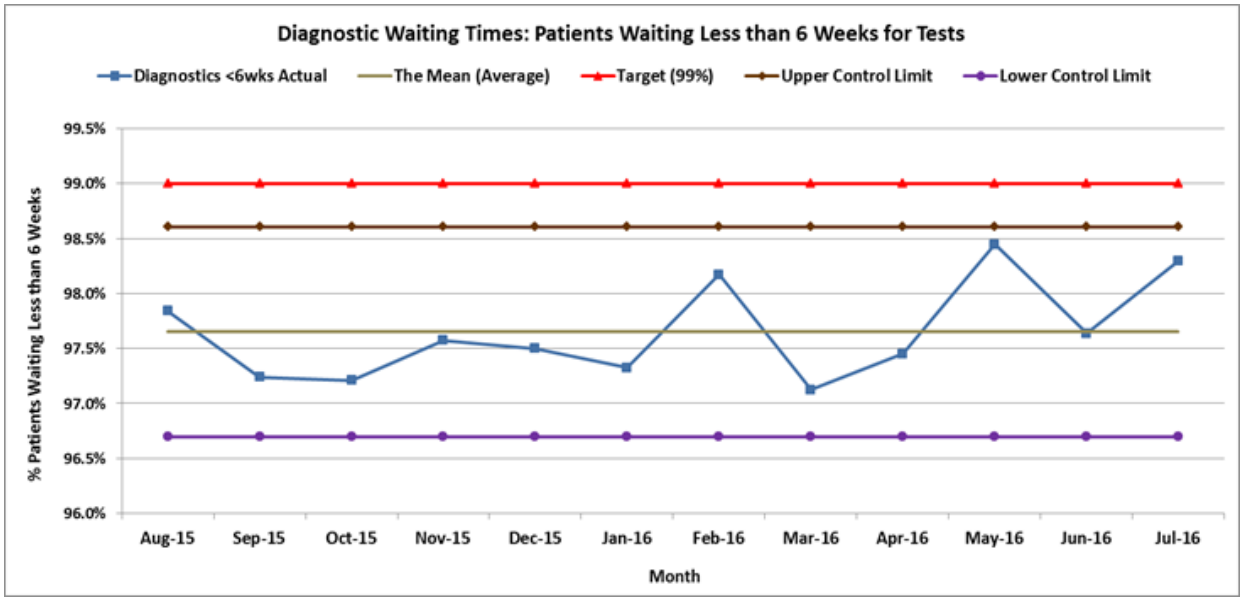
% of Patients waiting less than 18 weeks, by speciality, from All	Incomplete	Clearance Rates	
	Threshold 92%	Threshold 10-12 weeks	Change from last month
Cardiology	90.08%	15.21	↓
Cardiothoracic Surgery	85.37%	5.47	↓
Dermatology	97.16%	17.17	↑
Ear, Nose & Throat (ENT)	94.88%	10.22	↑
Gastroenterology	93.73%	7.73	↑
General Medicine	94.86%	16.22	↑
General Surgery	91.59%	6.91	↓
Geriatric Medicine	87.50%	4.00	→
Gynaecology	89.86%	9.30	↑
Neurology	100.00%	12.00	↓
Neurosurgery	97.14%	17.50	↑
Ophthalmology	98.51%	12.16	↑
Oral Surgery	100.00%		
Plastic Surgery	87.13%	8.14	↓
Rheumatology	94.77%	12.62	↑
Thoracic Medicine	86.84%	15.83	↑
Trauma & Orthopaedics	89.35%	10.21	↑
Urology	87.83%	16.17	↑
Other	93.39%	12.43	↑
Total	**92.35%**	10.83	↑

3.8 Three of these are the specialities where THFT also failed the standard and still have a backlog. Whilst reducing the backlog for Gynaecology and Urology there appears to be a small backlog in Oral Surgery Orthopaedics has stayed static. Overall the backlog at THFT has decreased by 13.

Specialty	Incomplete Performance	> 18 Weeks	< 18 Weeks	Total	July Backlog	June Backlog	May Backlog	Apr Backlog	Mar Backlog	Feb Backlog	Jan Backlog	Dec Backlog	Nov Backlog	Oct Backlog	Sept Backlog	August Backlog	July Backlog	Ju Ba
General Surgery	92.87%	146	1901	2047										10	40	70	90	13
Urology	92.05%	62	718	780		9	7	7	30	30	40	20	5	25	10			
Orthopaedics	86.37%	242	1534	1776	100	100	100	89	120	130	140	160	150	180	210	210	190	24
ENT	95.08%	49	947	996														
Ophthalmology	99.83%	1	574	575														
Oral Surgery	91.62%	45	492	537	2													
Neurosurgery	95.83%	1	23	24			2	1										
Plastic Surgery	93.10%	4	54	58		2	1						7	30	15			
CT Surgery	100.00%	0	4	4						5			1					
Adult Medicine	94.99%	45	854	899														
Gastroenterology	94.36%	39	652	691								6	30				10	35
Cardiology	93.26%	65	900	965								6		10	40	40	100	11
Dermatology	97.21%	29	1012	1041				9										
Rheumatology	96.22%	9	229	238														
Gynaecology	88.25%	126	946	1072	40	44	50	70	60	25								
Other	96.15%	63	1573	1636														
Trust	**93.06%**	**926**	**12413**	**13339**	142	155	160	176	210	190	180	192	193	255	315	320	390	51

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

3.9 In July we failed the diagnostic standard at 1.70% against 1.0% Standard for waiting 6 or more weeks. This was primarily due to Central Manchester Trust. This month we have seen a decrease 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	July	Choose Trust	All

Diagnostic Waiting - All Providers

	All Providers	May 2016				June 2016				July 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	452	0	0	0.0%	579	0	0	0.0%	507	0	0	0.0%
	CMMC	44	4	16	31.3%	28	3	3	17.6%	44	1	3	8.3%
	Pennine Acute	7	3	0	30.0%	9	3	0	25.0%	10	4	0	28.6%
	Salford	6	0	0	0.0%	3	0	0	0.0%	2	1	0	33.3%
	South Mc.	7	0	0	0.0%	5	0	0	0.0%	5	0	0	0.0%
	Stockport	15	0	0	0.0%	18	0	0	0.0%	23	1	0	4.2%
	Ashton Primary Care Centre	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Care UK	7	0	0	0.0%	7	0	0	0.0%	11	0	0	0.0%
	Other	4	1	0	20.0%	2	0	0	0.0%	4	1	0	20.0%
	Total	**542**	**8**	**16**	**4.2%**	**651**	**6**	**3**	**1.4%**	**606**	**8**	**3**	**1.8%**
Non-Endoscopy	THFT	2622	29	0	1.1%	2654	28	0	1.0%	2677	31	0	1.1%
	CMMC	332	7	6	3.8%	340	16	5	5.8%	313	4	4	2.5%
	Pennine Acute	86	0	0	0.0%	69	0	0	0.0%	73	0	0	0.0%
	Salford	146	0	0	0.0%	131	0	0	0.0%	149	0	0	0.0%
	South Mc.	84	2	0	2.3%	100	0	0	0.0%	58	1	0	1.7%
	Stockport	174	0	0	0.0%	204	1	0	0.5%	171	0	0	0.0%
	Ashton Primary Care Centre	54	0	0	0.0%	54	0	0	0.0%	32	0	0	0.0%
	Care UK	636	6	0	0.9%	709	50	0	6.6%	524	24	0	4.4%
	Other	81	1	0	1.2%	91	12	0	11.7%	68	6	0	8.1%
	Total	**4215**	**45**	**6**	**1.2%**	**4352**	**107**	**5**	**2.5%**	**4065**	**66**	**4**	**1.7%**
	Overall Position	**4757**	**53**	**22**	**1.55%**	**5003**	**113**	**8**	**2.36%**	**4671**	**74**	**7**	**1.70%**

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. July's performance has increased.

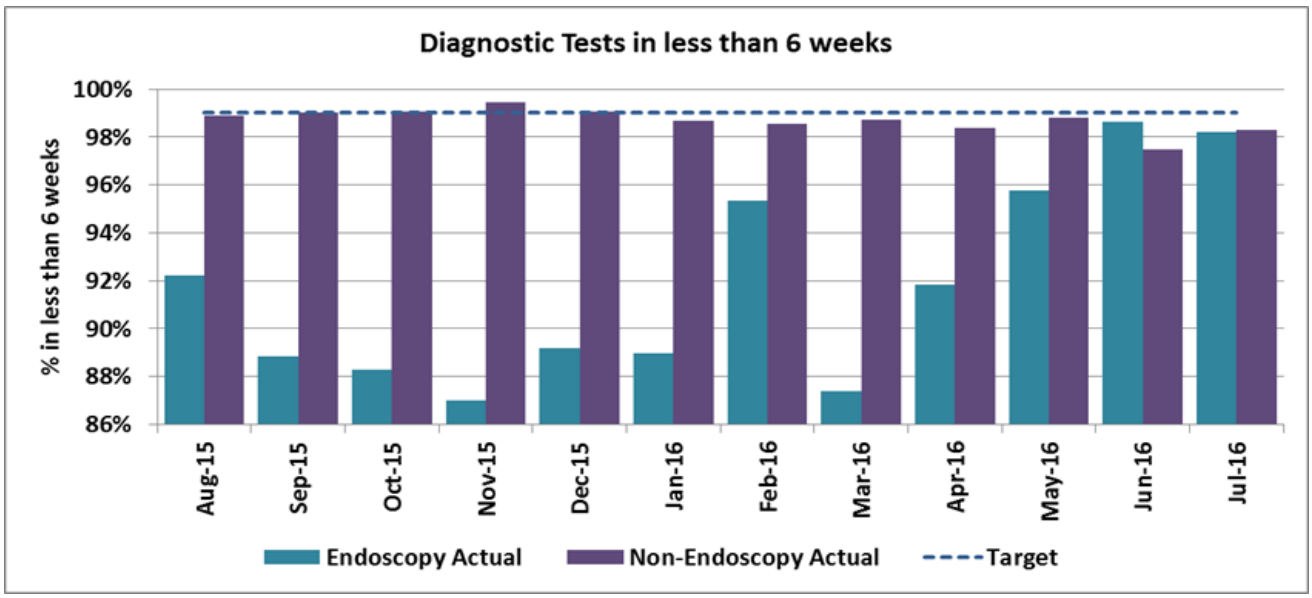
3.11 At the end of July 81 patients were waiting 6 weeks and over for a diagnostic test, seven of which were over 13 weeks. 12 were at Central Manchester Trust. Requests are continued to be made to obtain a copy of the action plan and trajectory from Central Manchester Trust including discussions with NHS England as their role as assurers of Lead CCGs.

Provider	Test	Total 6-13 weeks	13+ Weeks
CMMC	Cardiology - echocardiography	1	3
	Colonoscopy	0	3
	Gastroscopy	1	0
	Magnetic Resonance Imaging	3	0
	Urodynamics - pressures & flows	0	1
	Total	**5**	**7**
Pennine Acute	Colonoscopy	2	0
	Gastroscopy	2	0
	Total	**4**	**0**
Salford	Colonoscopy	1	0
	Total	**1**	**0**
South Mc.	Non-obstetric ultrasound	1	0
	Total	**1**	**0**
Stockport	Colonoscopy	1	0
	Total	**1**	**0**
THFT	Audiology - Audiology Assessments	29	0
	Neurophysiology - peripheral neurophysiology	1	0
	Non-obstetric ultrasound	1	0
	Total	**31**	**0**
Care UK	Magnetic Resonance Imaging	24	0
	Total	**24**	**0**
Other	Colonoscopy **(RJN East Cheshire NHS Trust)**	1	0
	Neurophysiology - peripheral neurophysiology **(NEY Pioneer Healthcare Limited)**	6	0
	Total	**7**	**0**
	Total	**74**	**7**

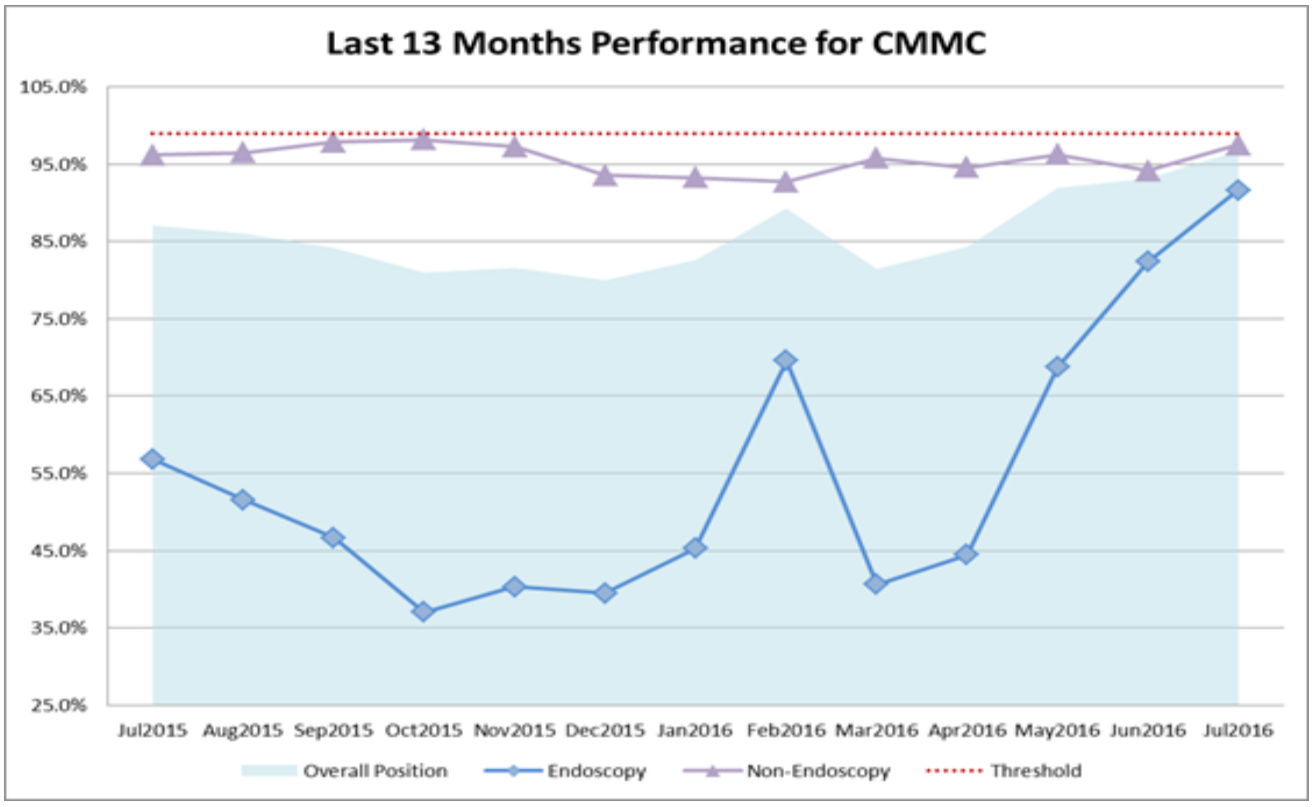
3.12 The backlog in endoscopy appears to have decreased and now accounts for 14% of breaches. Central Manchester Trust has agreed with a private provider to undertake additional activity to help with the backlog clearance. They expect to clear the backlog by the end of July 2016.

Diagnostic Waiting - All Tests for All

All Providers		May 2016				June 2016				July 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	228	3	10	5.4%	281	4	3	2.4%	256	5	3	3.0%
	Cystoscopy	46	0	0	0.0%	52	0	0	0.0%	45	0	0	0.0%
	Flexi sigmoidoscopy	8	3	3	42.9%	61	0	0	0.0%	79	0	0	0.0%
	Gastroscopy	260	2	3	1.9%	257	2	0	0.8%	226	3	0	1.3%
	Total	**542**	**8**	**16**	**4.2%**	**651**	**6**	**3**	**1.4%**	**606**	**8**	**3**	**1.8%**
Non-Endoscopy	Audiology - Audiology Assessments	306	20	0	6.1%	329	21	0	6.0%	433	29	0	6.3%
	Barium Enema	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Cardiology - echocardiography	579	2	3	0.9%	515	8	4	2.3%	407	1	3	1.0%
	Cardiology - electrophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Computed Tomography	797	1	0	0.1%	831	2	0	0.2%	781	0	0	0.0%
	DEXA Scan	105	0	0	0.0%	108	0	0	0.0%	78	0	0	0.0%
	Magnetic Resonance Imaging	1289	8	1	0.7%	1320	59	0	4.3%	1146	27	0	2.3%
	Neurophysiology - peripheral neurophysiology	128	12	0	8.6%	158	15	0	8.7%	160	7	0	4.2%
	Non-obstetric ultrasound	972	0	0	0.0%	1059	1	0	0.1%	1031	2	0	0.2%
	Respiratory physiology - sleep studies	34	1	0	2.9%	30	0	0	0.0%	23	0	0	0.0%
	Urodynamics - pressures & flows	5	1	2	37.5%	2	1	1	50.0%	6	0	1	14.3%
	Total	**4215**	**45**	**6**	**1.2%**	**4352**	**107**	**5**	**2.5%**	**4065**	**66**	**4**	**1.7%**
	Overall Position	**4757**	**53**	**22**	**1.55%**	**5003**	**113**	**8**	**2.36%**	**4671**	**74**	**7**	**1.70%**



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



3.14 The latest update received from CMFT as at 21st 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:

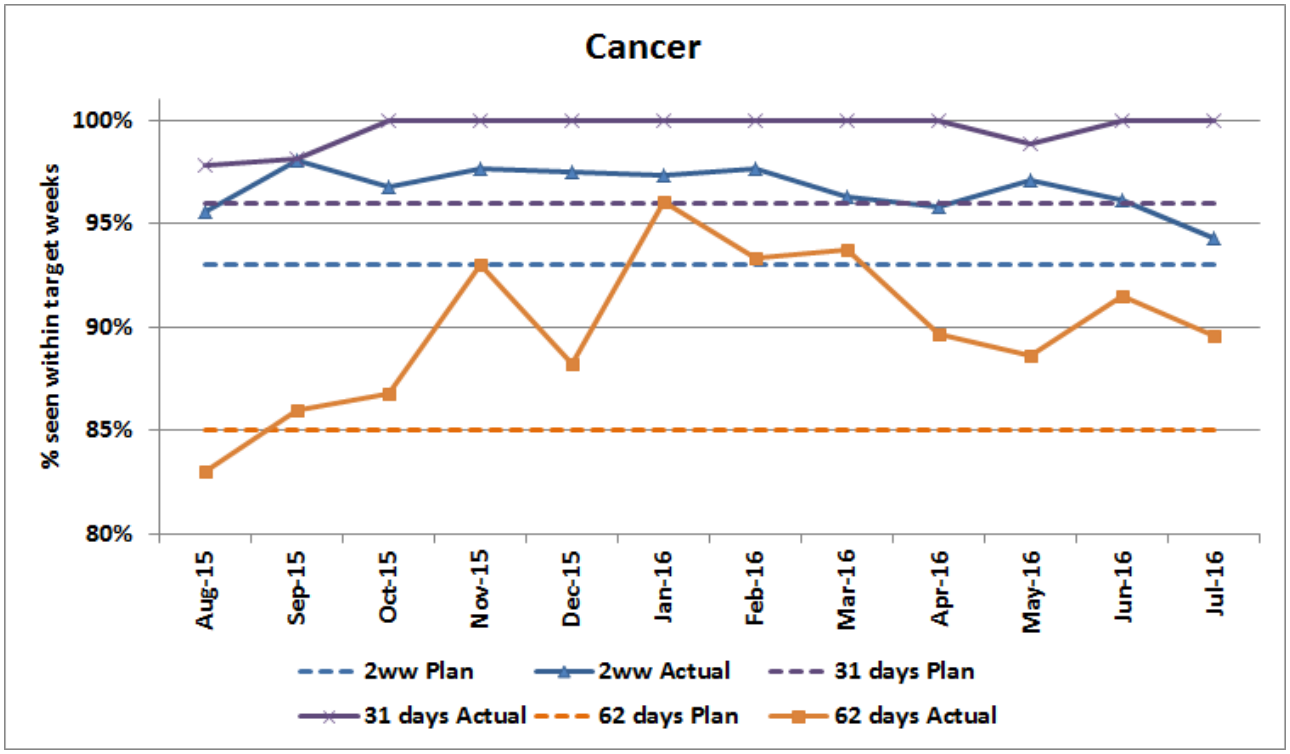
- The trust is transferring patients from the planned list to the active list and will report them in the next submission.
- An extension to the arrangement with the independent sector for extra capacity.
- The balancing of waiting lists across the MRI and Trafford Endoscopy units continues.
- The director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

- Administrative and reporting routines have been improved/adapted.

The trust expects 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 July position is reported in this update

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



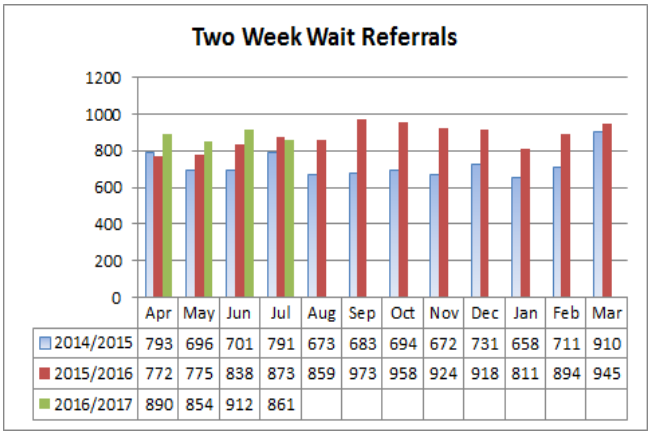
3.16 Our full performance is shown below with all standards achieved apart from 62 day upgrade. Quarter 1 standards achieved.

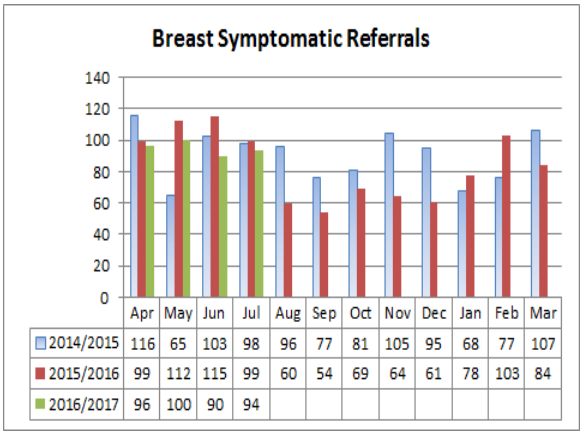
		Performance						No. of patients not receiving care within standard in July
Indicator Name	**Standard**	**March 15/16**	**April 16/17**	**May 16/17**	**June 16/17**	**Q1 16/17**	**July 16/17**	
Cancer 2 week waits	93.00%	96.3%	95.82 %	97.07 %	96.12 %	96.34 %	94.32 %	44
Cancer 2 week waits - Breast symptoms	93.00%	98.88 %	93.88 %	98.00 %	95.79 %	95.92 %	94.00 %	6
Cancer 62 day waits – GP Referral	85.00%	93.75 %	89.66 %	88.64 %	91.49 %	90.00 %	89.58 %	5
Cancer 62 day waits - Consultant upgrade	85.00%	88.24 %	83.33 %	86.67 %	94.44 %	88.24 %	82.35 %	3
Cancer 62 day waits - Screening	90.00%	100%	100%	100%	60.00 %	87.50 %	100%	0
Cancer day 31 waits	96.00%	100%	100%	98.89 %	100%	99.65 %	100%	0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	100%	0

3.17 Tameside achieved all the standards.

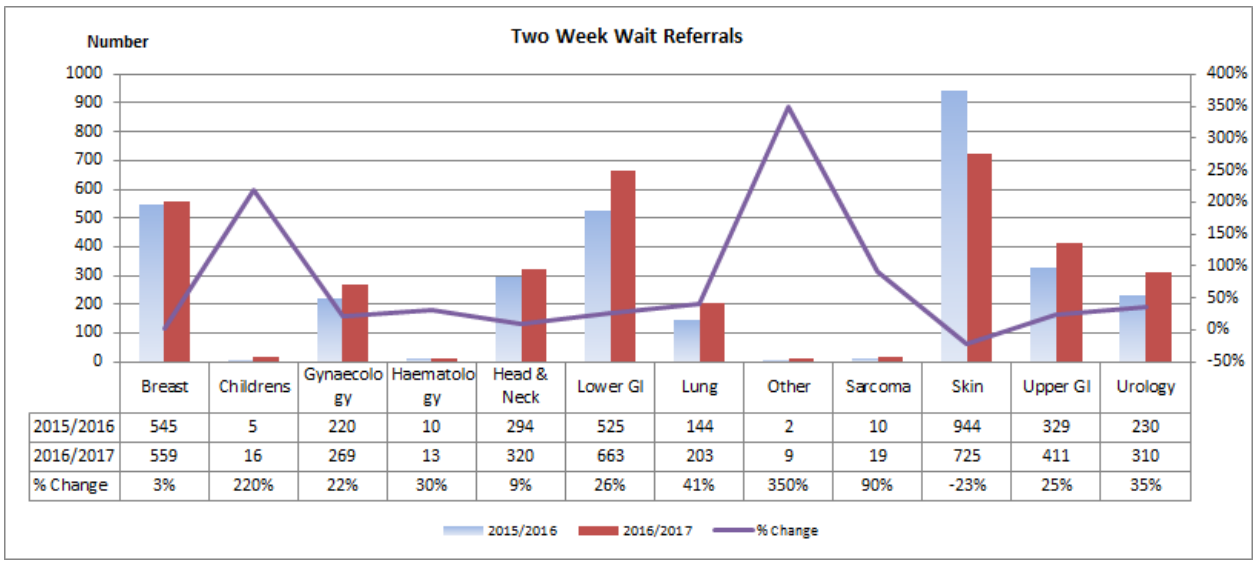
		Performance						No. of patients not receiving care within standard in July
Indicator Name	**Standard**	**March 15/16**	**April 16/17**	**May 16/17**	**June 16/17**	**Q1 16/17**	**July 16/17**	
Cancer 2 week waits	93.00%	95.8%	95.8 %	97.1 %	96.6%	96.5%	94.8%	45
Cancer 2 week waits - Breast symptoms	93.00%	98.8 %	93.8 %	98.0 %	94.4 %	95.5 %	94.7 %	5
Cancer 62 day waits – GP Referral	85.00%	95.9 %	91.3 %	87.7 %	91.0 %	90.2 %	88.2 %	5
Cancer 62 day waits - Consultant upgrade	85.00%	87.1 %	89.5 %	84.6 %	93.5 %	89.5 %	86.1 %	2.5
Cancer 62 day waits - Screening	90.00%	100%	N/A	N/A	100%	100%	N/A	0
Cancer day 31 waits	96.00%	100%	98.6 %	100%	100%	99.5 %	100%	0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	N/A	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	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.



	Breast	Childrens	Gynaecology	Haematology	Head & Neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urology
2015/2016	545	5	220	10	294	525	144	2	10	944	329	230
2016/2017	559	16	269	13	320	663	203	9	19	725	411	310
% Change	3%	220%	22%	30%	9%	26%	41%	350%	90%	-23%	25%	35%

Urgent Care – please note position reported is at 11th September

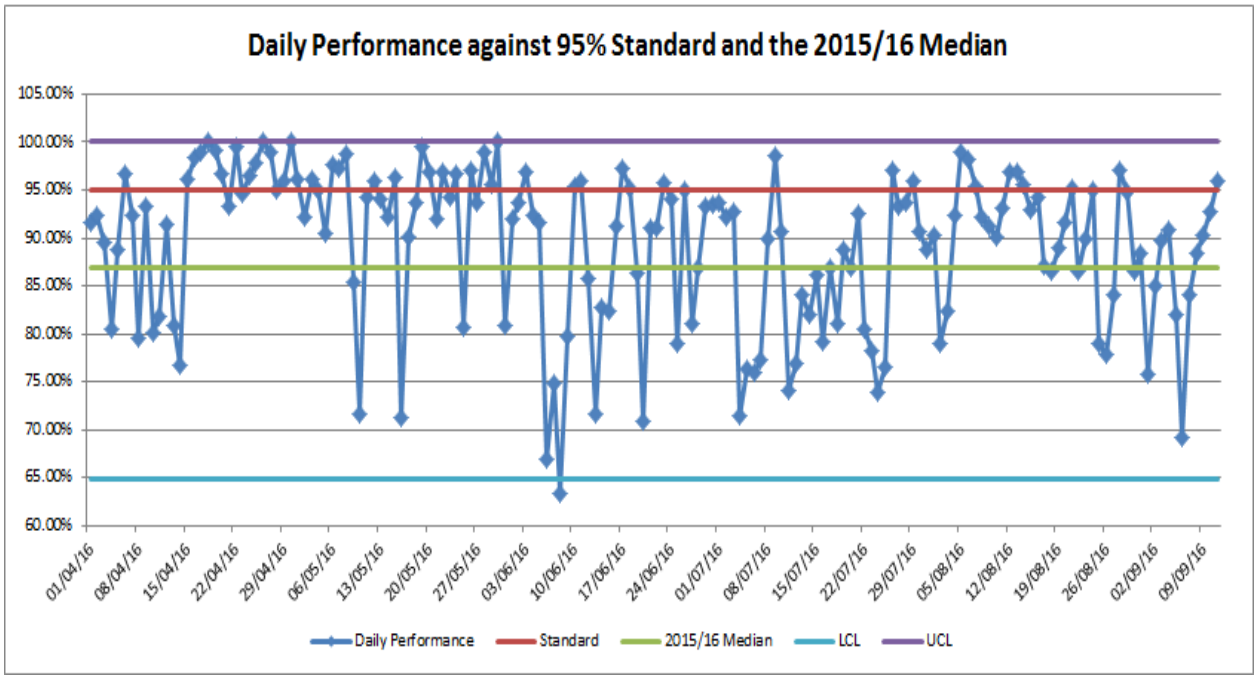
3.20 THFT A&E performance is as below.

Apr-16	May-16	Jun-16	July-16	Aug-16
92.46%	**92.16%**	**86.61%**	**84.98%**	**90.48%**

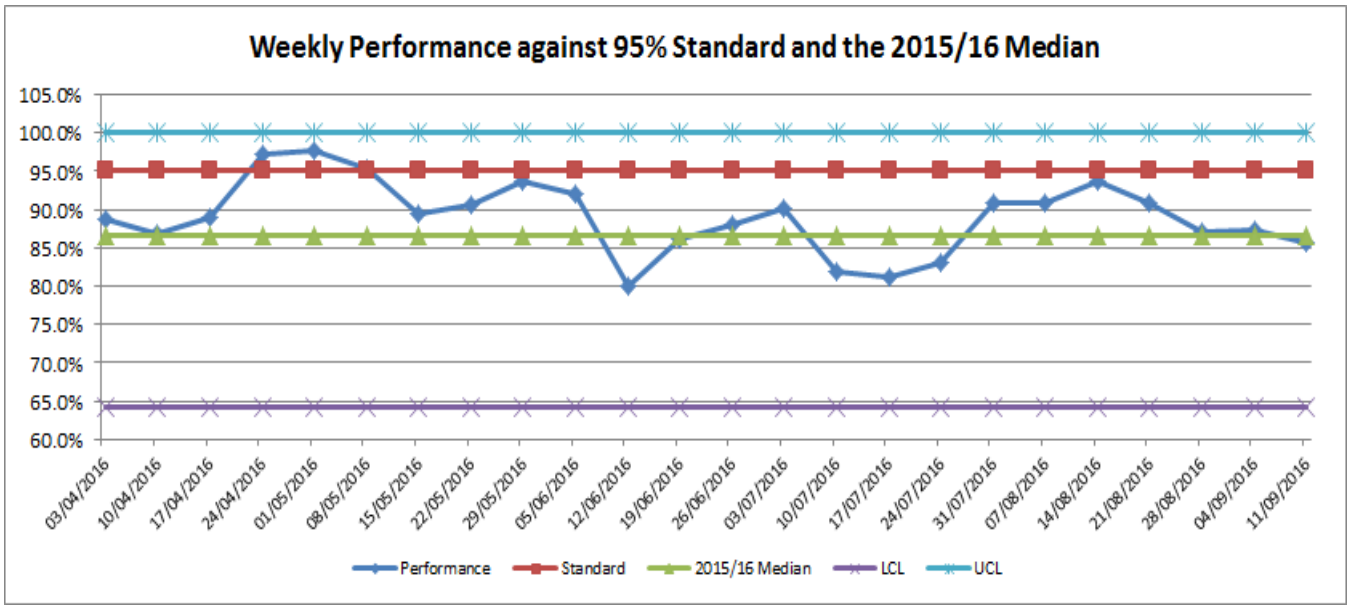
3.21 We are currently the third best performer across the GM trusts YTD, reported through Utilisation Management. Our June and July, August performance and September performance to the 11th has not achieved the standard.

	Financial Year to 11 September 16	April 2016/17	May 2016/17	June 2016/17	July 2016/17	August 2016/17	Sept to 11th 2016/17
Wigan	91.80%	92.93%	90.30%	93.87%	89.67%	92.04%	93.30%
Salford	89.88%	92.52%	90.21%	94.05%	81.69%	89.80%	94.40%
Tameside	89.03%	92.46%	92.16%	86.61%	84.98%	90.48%	85.57%
Oldham	87.22%	86.89%	90.39%	86.58%	83.72%	88.64%	86.93%
Bury	84.26%	82.72%	84.74%	86.35%	82.90%	82.57%	89.99%
Bolton	83.25%	80.25%	81.29%	85.33%	81.94%	86.13%	87.57%
Stockport	80.47%	79.31%	81.59%	85.26%	81.51%	77.11%	72.79%
North Manchester	77.39%	80.20%	77.90%	75.11%	71.24%	83.27%	77.25%

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.

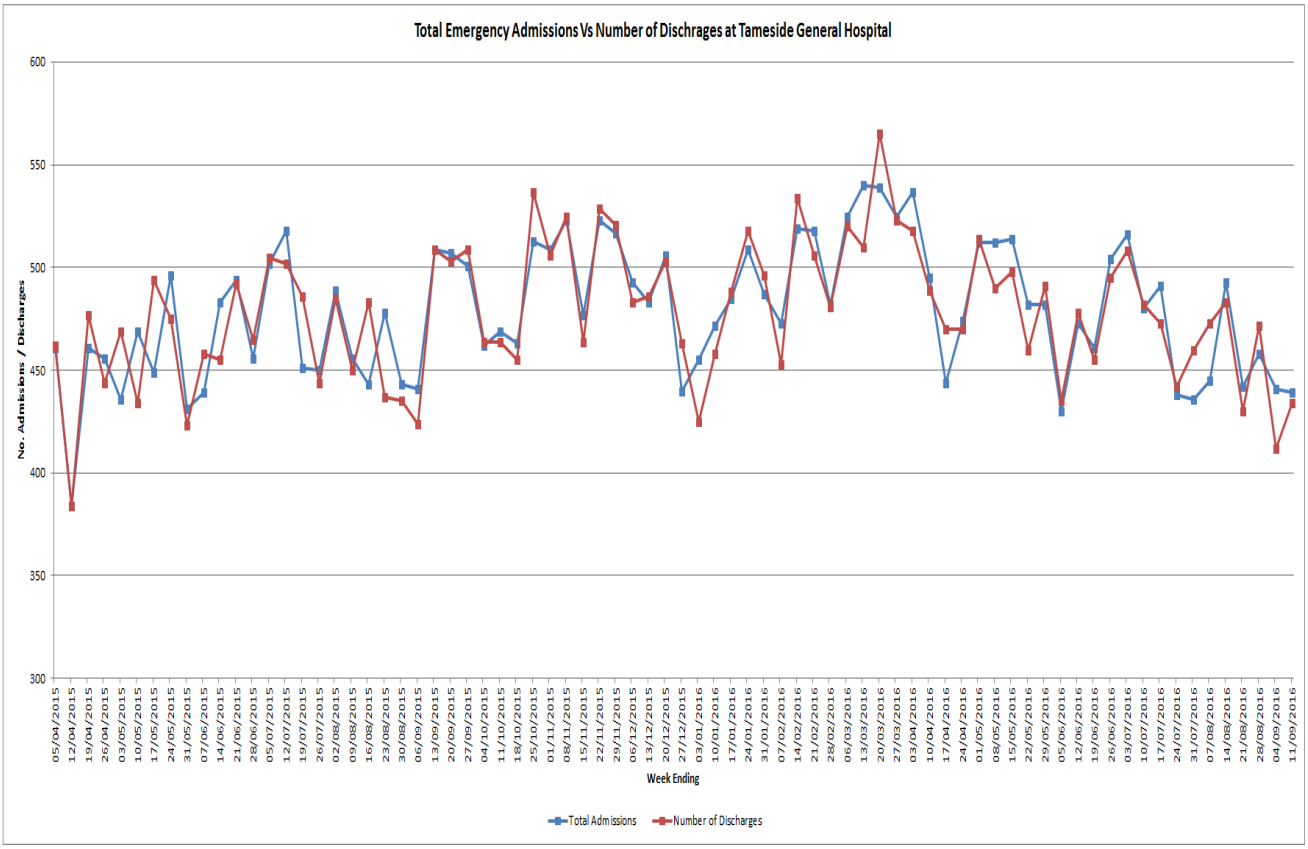


3.24 There has previously been considerable variation on a daily basis with no clear reason, but more recently that has stabilised. During April the standard was achieved but May, June, July and August has seen a drop in performance.

3.25 During June, July and August 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.

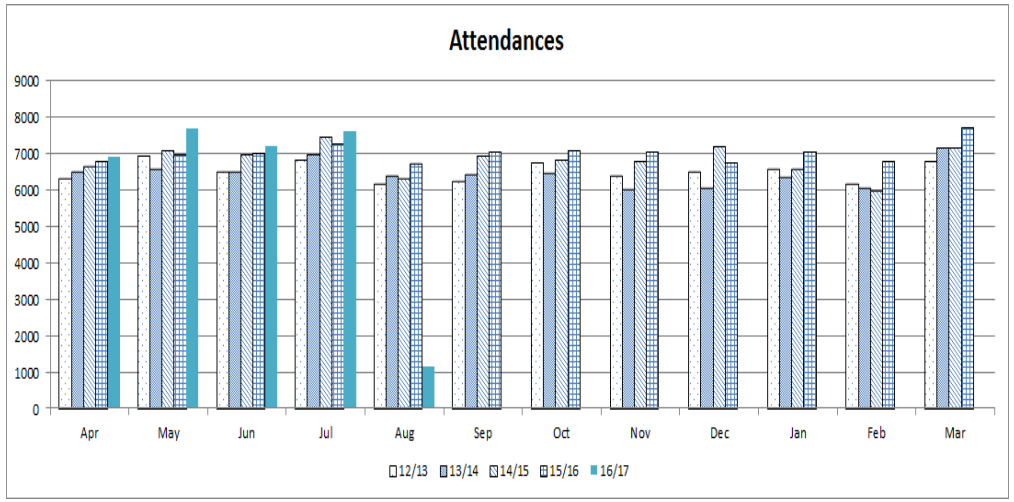
Breach Reason (Actual)	w/e 7 Jul	w/e 10 Jul	w/e 17 Jul	w/e 24 Jul	w/e 31 Jul	w/e 7 Aug	w/e 14 Aug	w/e 21 Aug	w/e 28 Aug	w/e 4 Sep	w/e 11 Sep	Cumulative
Awaiting bed	27	51	66	100	24	34	15	51	54	72	38	3567
Specialty Delay	18	20	26	21	24	20	18	17	19	14	18	1116
Delayed Medical Assessment	0	0	0	0	0	0	0	0	0	0	0	510
Other	2	5	5	7	0	8	2	4	2	5	1	642
Late First Assessment	94	211	215	146	85	61	27	39	85	77	136	5028
Clinical	18	19	15	11	11	9	24	20	20	20	20	961
CT Delay	1	0	0	1	1	1	4	1	1	1	5	190
Late Referral to Specialty	3	3	3	4	3	0	2	8	13	1	8	326
Seen after 4 hours	0	0	0	0	0	0	0	0	0	0	0	23
Awaiting transport	3	0	5	6	5	4	2	1	3	4	3	224
Pathology Delay	0	0	0	0	1	0	1	0	1	0	2	64
XR Delay	0	1	0	0	0	0	0	0	0	0	0	21
Unknown	0	0	0	0	0	0	0	0	0	0	0	84
Total	**166**	**310**	**335**	**296**	**154**	**137**	**95**	**141**	**198**	**194**	**231**	**12756**

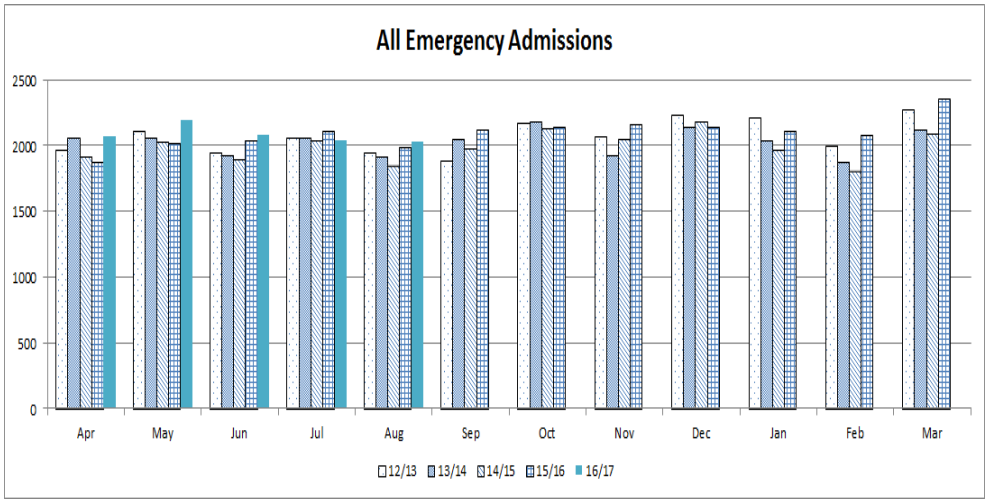
3.26 We frequently have fewer emergency discharges than emergency admissions and so routinely have to escalate discharge to manage the daily demand. The loss of the beds at Darnton House has further impacted on our ability to discharge from acute beds recently.



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. This has decreased in August. The number of 4 hour breaches has decreased significantly during April but increased in May June and July. This also decreased in August.

						Variance					% variance				
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
A&E Attendances	6890	7680	7182	7609	6799	102	715	155	348	62	1.5%	10.3%	2.2%	4.8%	0.9%
4 hour Breaches	523	602	963	1144	647	-402	157	499	548	-83	-43.5%	35.3%	107.5%	91.9%	-11.4%
% Seen within 4 hours	92.41%	92.16%	86.59%	84.97%	90.48%										
Admissions via A&E	1764	1885	1773	1776	1767	174	201	53	-15	86	10.9%	11.9%	3.1%	-0.8%	5.1%
Other Emergency Admissions	309	309	303	267	267	16	-30	-19	-58	-40	5.5%	-8.8%	-5.9%	-17.8%	-13.0%
All Emergency Admissions	2073	2194	2076	2043	2034	190	171	34	-73	46	10.1%	8.5%	1.7%	-3.4%	2.3%
Discharges	2037	2091	2098	2027	2031	117	83	55	-133	85	6.1%	4.1%	2.7%	-6.2%	4.4%



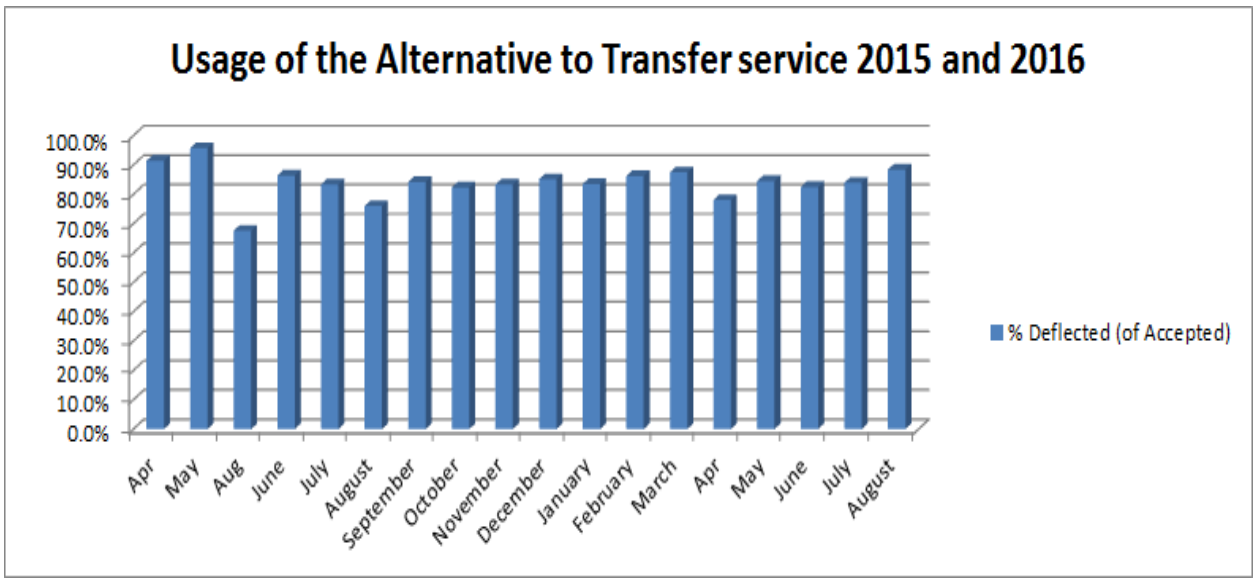


3.28 Since September 2015 there has been considerable variation in the numbers of attendances and admissions and breaches have risen significantly. During April this had stabilised and breaches had reduced, which now look to have increased during May, June, July and August.

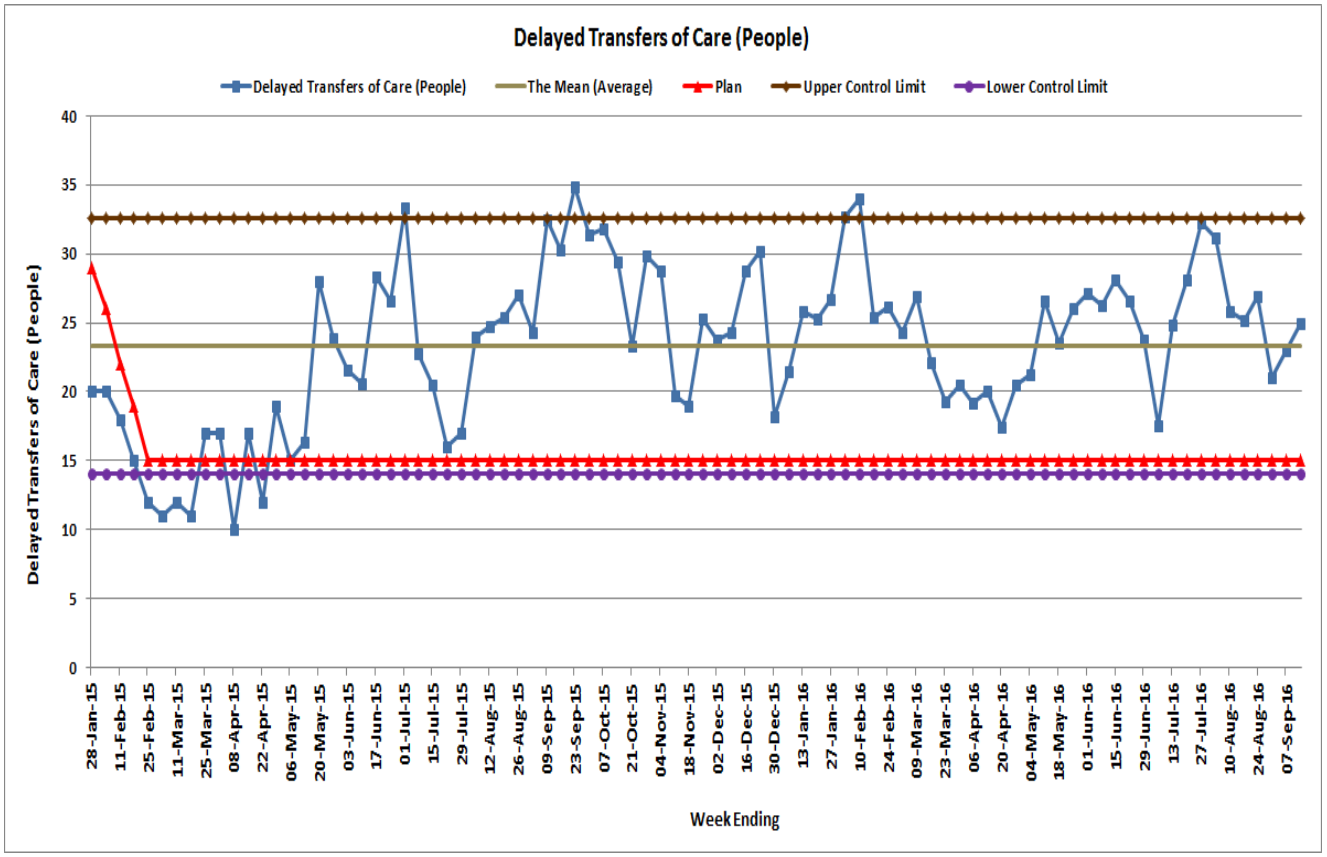
Week Ending	Actual Number of A&E Type 1 Attendances	Actual Number of 4 hour Type 1 breaches	Actual Performance	Number of Emergency Admissions via A&E	Number of Direct Emergency Admissions	Total Emergency Admissions
03 Apr	1787	202	88.7%	453	80	533
10 Apr	1641	217	86.8%	421	85	506
17 Apr	1495	166	88.9%	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
14 Aug	1491	95	93.6%	419	75	494
21 Aug	1535	141	90.8%	383	60	443
28 Aug	1533	199	87.0%	402	55	457
04 Sep	1637	209	87.2%	398	43	441
11 Sep	1636	233	85.8%	367	64	431

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

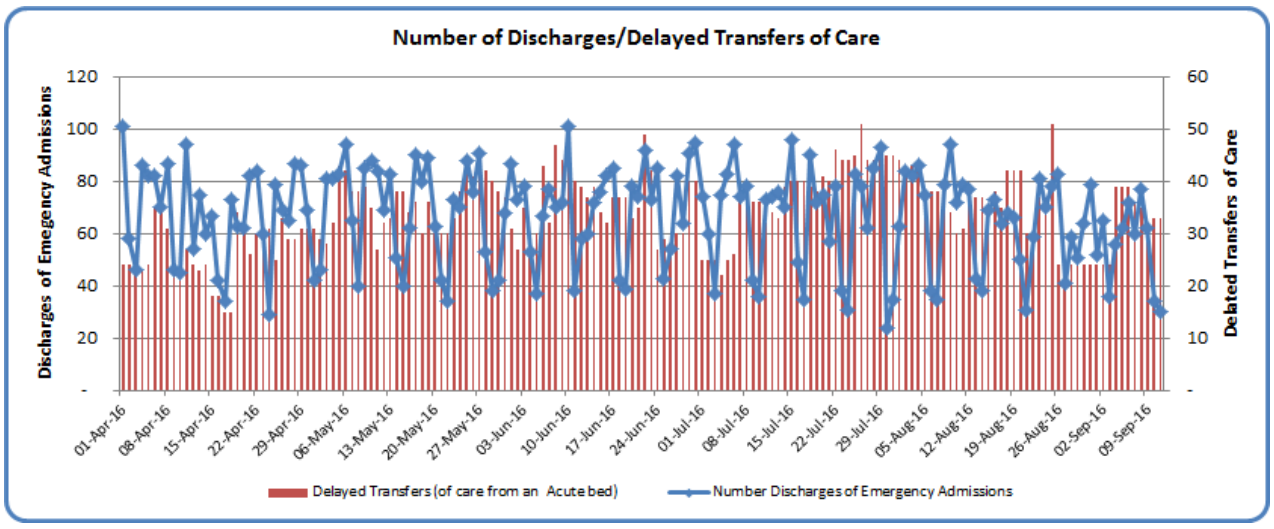
	April	May	June	July	August	September to 11th
Referrals	198	183	178	221	190	77
Accepted	196	183	177	220	190	77
Red Refusals to Hospital also seen	18	15	17	27	34	9
Deflected	139	142	132	162	138	57
Accepted %	99.0	100	99.4	99.5	100	100
% Deflected (of Referrals)	78.1	85	82.5	83.9	88.5	84.0
% Deflected (of Accepted)	**78.1**	**85**	**82.5**	**83.9**	**88.5**	**84.0**

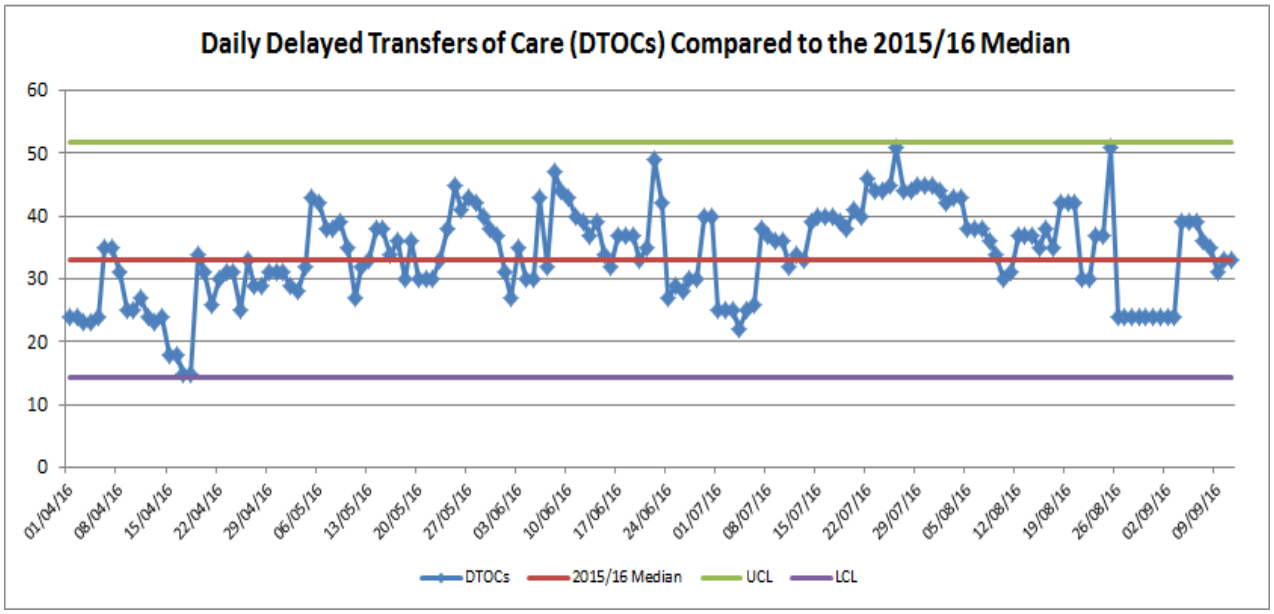


3.30 The number of Delayed Transfers of Care (DTOC) recorded has increased recently.



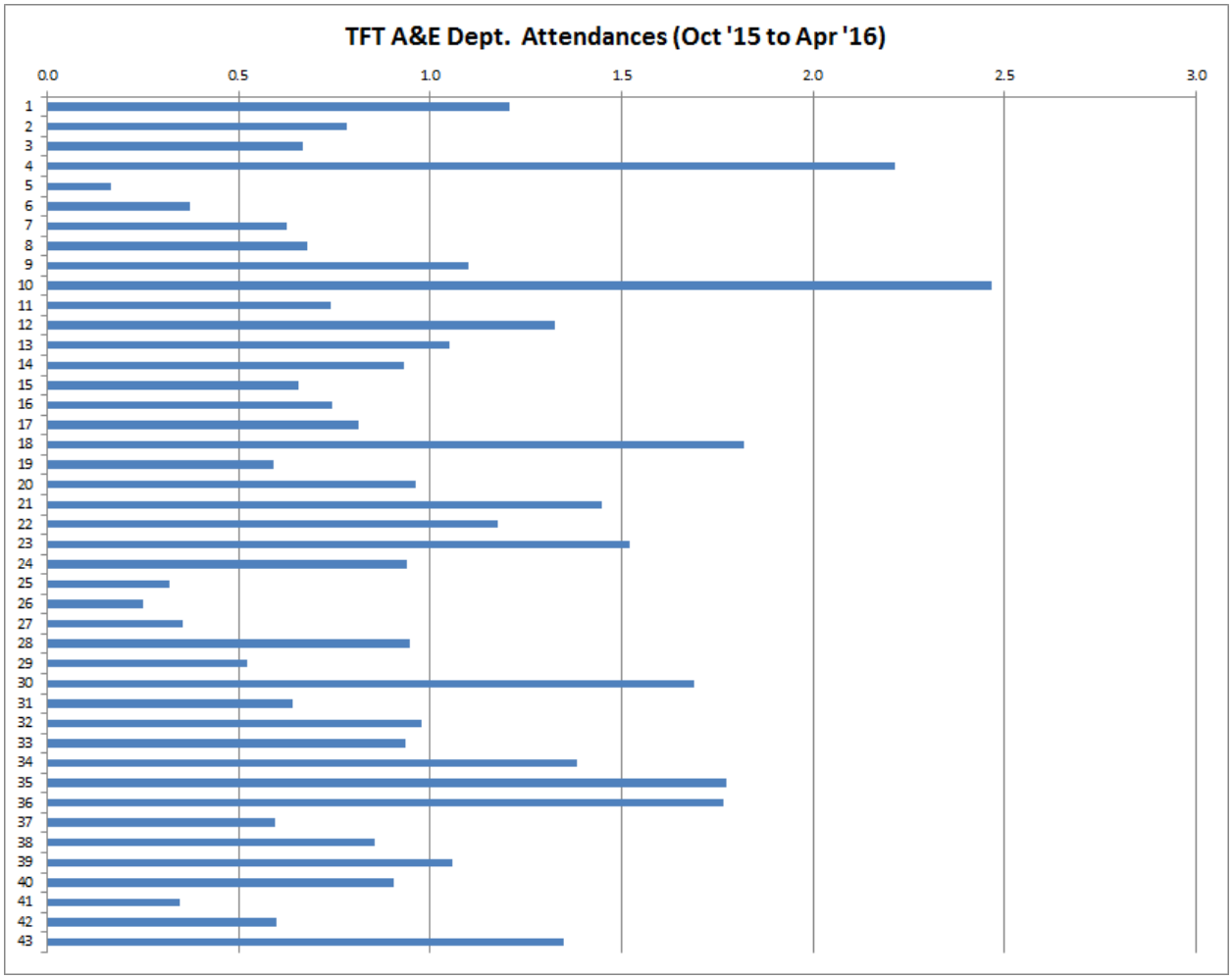
3.31 Reducing DTOC and the level of variation day by day is a key aspect of the improvement plan with Integrated Urgent Care Team designed to significantly impact on bed availability by improving patient flow out of the hospital and avoiding admissions. This should deliver a culture of' Discharge to 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
-
01-Apr-16
08-Apr-16
15-Apr-16
22-Apr-16
29-Apr-16
06-May-16
13-May-16
20-May-16
27-May-16
03-Jun-16
10-Jun-16
17-Jun-16
24-Jun-16
01-Jul-16
08-Jul-16
15-Jul-16
22-Jul-16
29-Jul-16
05-Aug-16
12-Aug-16
19-Aug-16
26-Aug-16
02-Sep-16
09-Sep-16
Delayed Transfers (of care from an Acute bed)
Number Discharges of Emergency Admissions

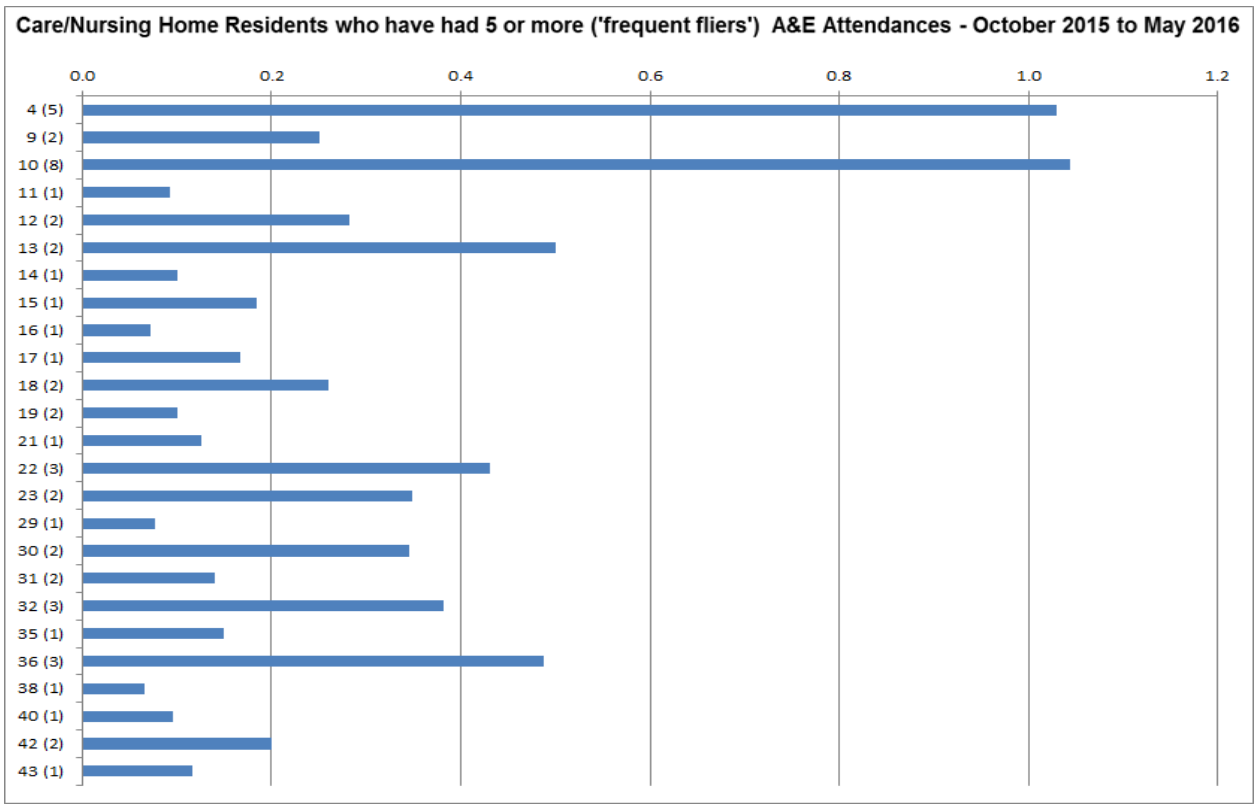

Daily Delayed Transfers of Care (DTOCs) Compared to the 2015/16 Median
60
50
40
30
20
10
0
01/04/16
08/04/16
15/04/16
22/04/16
29/04/16
06/05/16
13/05/16
20/05/16
27/05/16
03/06/16
10/06/16
17/06/16
24/06/16
01/07/16
08/07/16
15/07/16
22/07/16
29/07/16
05/08/16
12/08/16
19/08/16
26/08/16
02/09/16
09/09/16
DTOCs
2015/16 Median
UCL
LCL

Care Homes

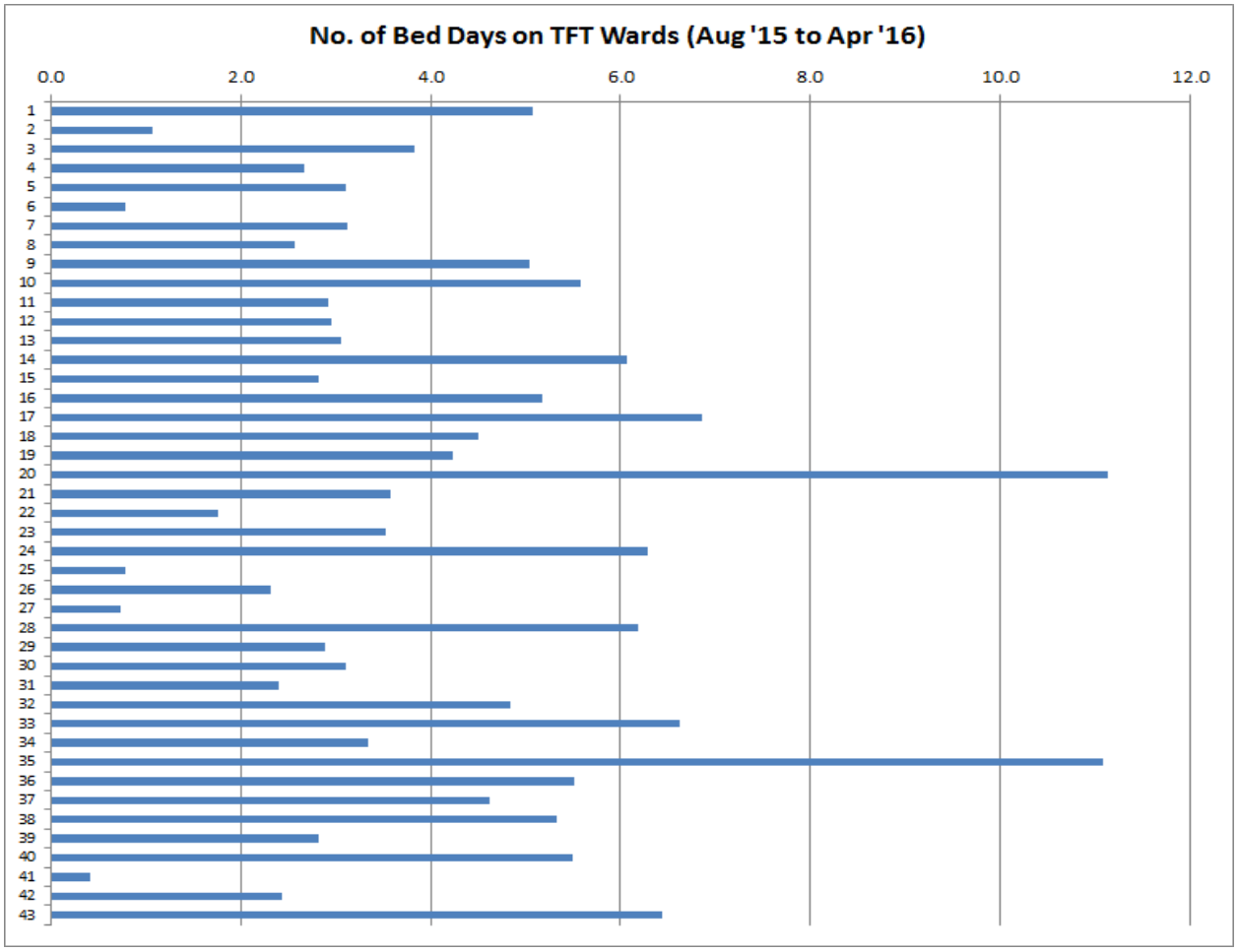
3.32 The decision was made to specifically look at the care homes use of our urgent care systems. This was to allow us to look to see if we can identify themes and trends regarding particular care home providers. In doing this it would allow us to focus support which will be individual to providers. 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 each 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.



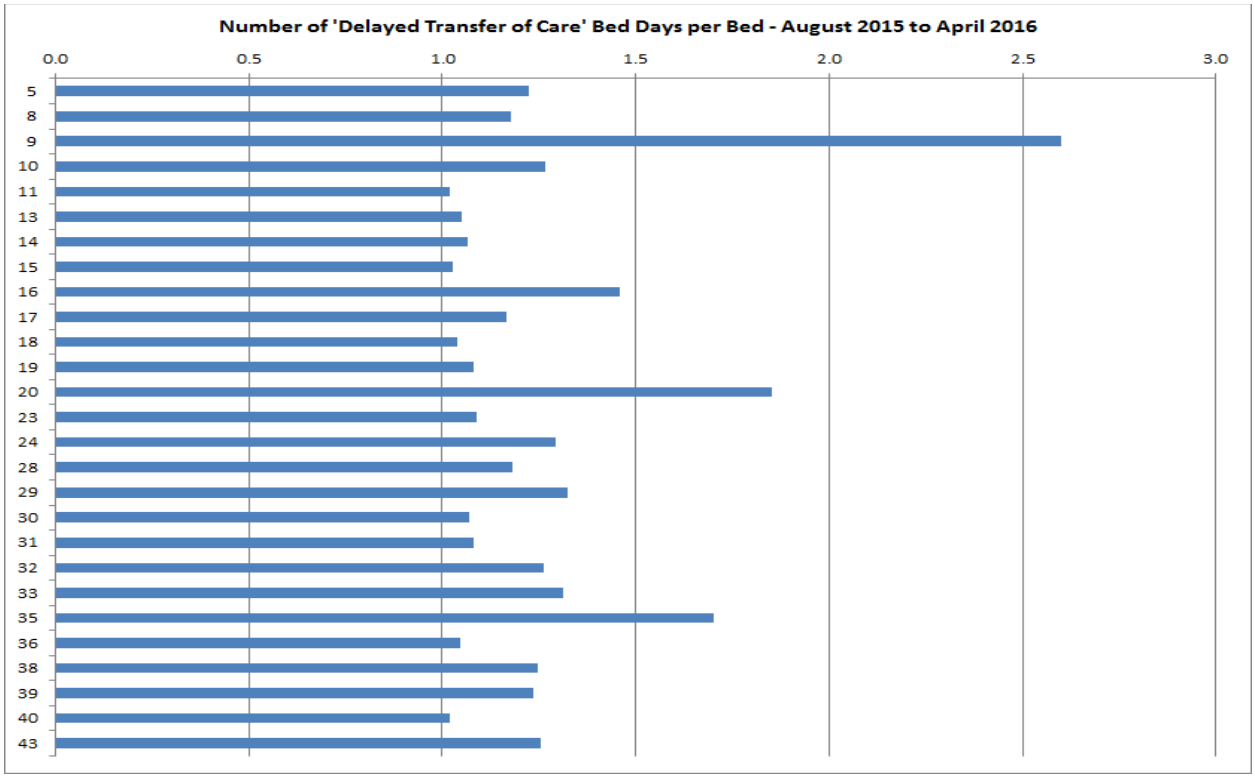
3.33 Work is currently being done to present this graph showing a month on month position. This will allow us to monitor attendances per care home per month giving us the ability to take action in a more timely manner.



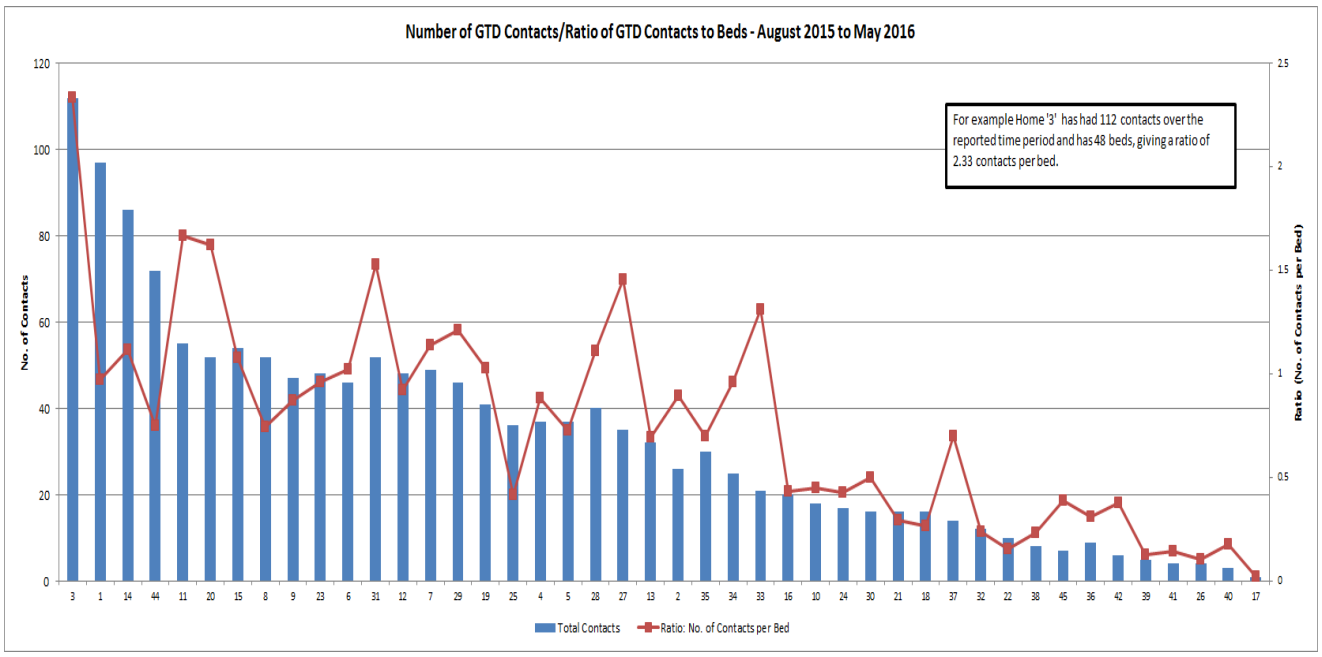
3.34 To enable an MDT to be wrapped around individuals who frequently attend A&E this data also needs to be as live as possible. Early work has already identified that a number of the clients in this category in the above graph had already passed away.



3.35 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.

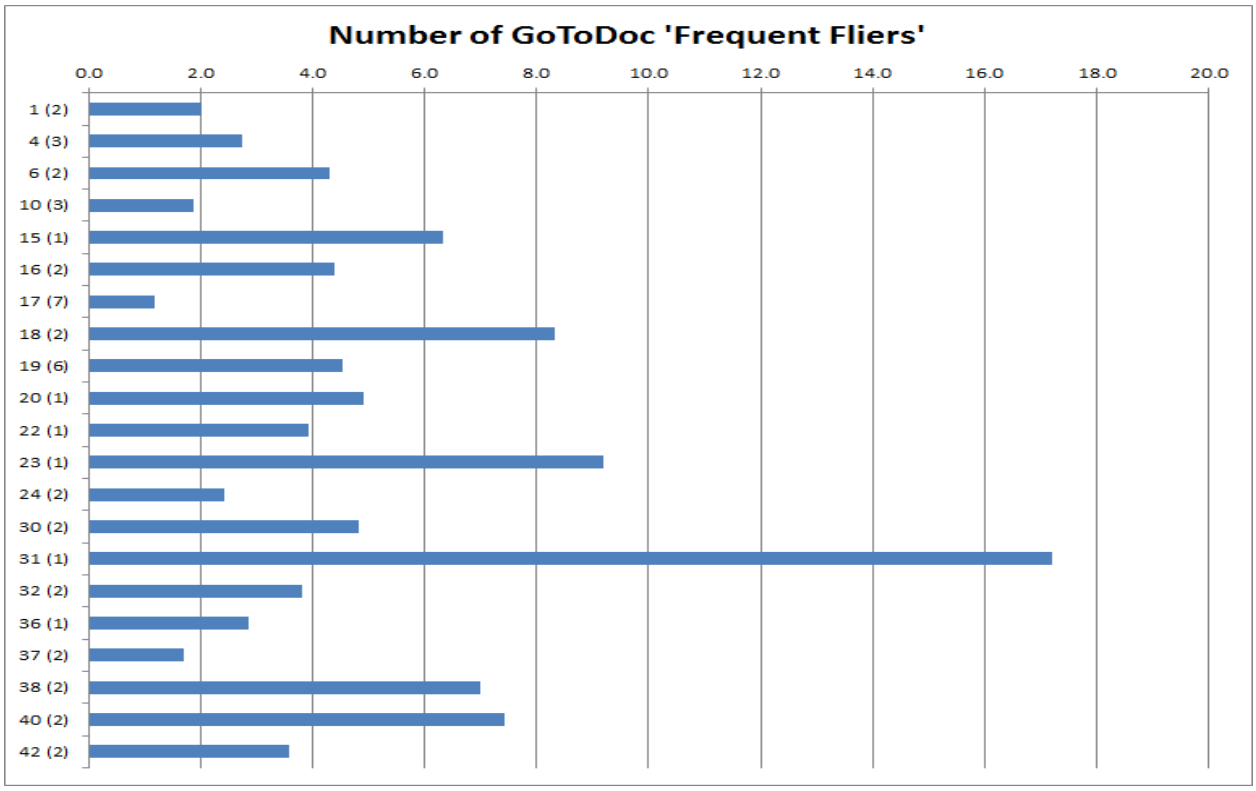


3.36 The above graph shows the number of inpatients bed days by care home once an individual is medically ready to be discharged from hospital. Given these individuals are already in receipt of 24 hour care further work has been requested by the care home steering group to understand why these individuals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



3.37 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

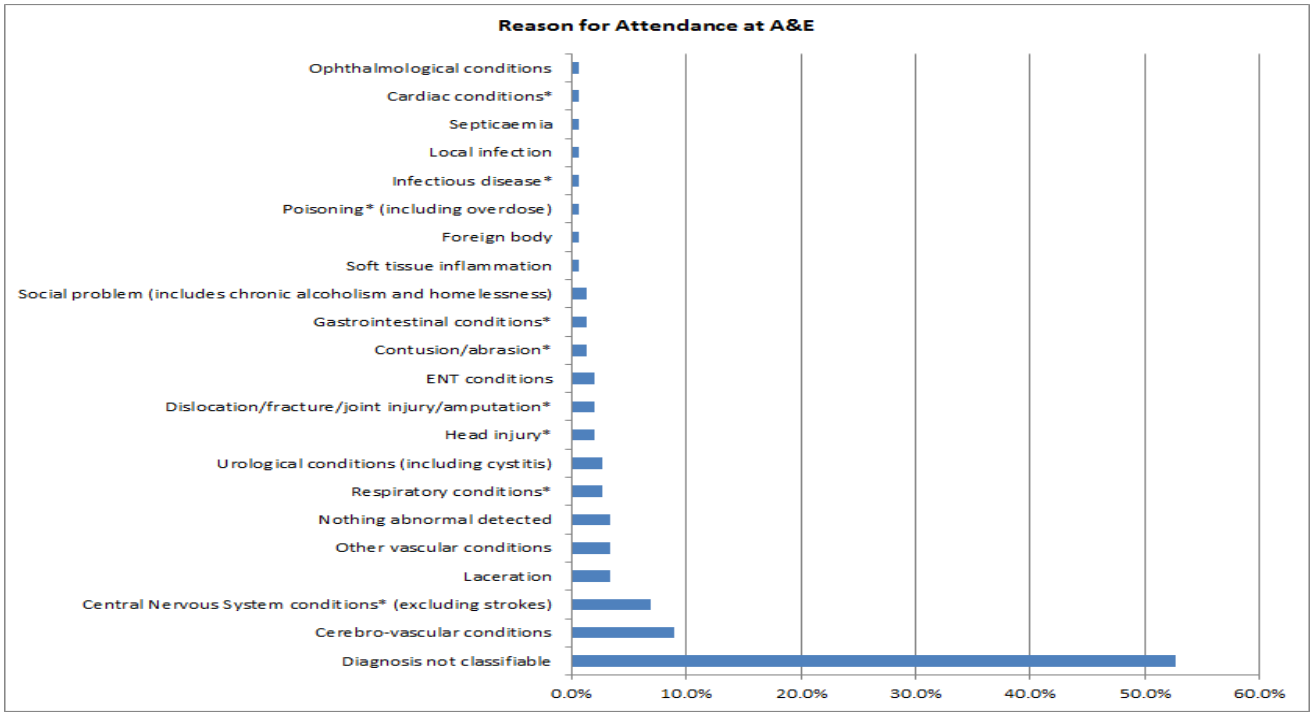
basis with the lead from GTD the details of the calls made to the helpline from care homes allowing us to see if there are any themes or trends.

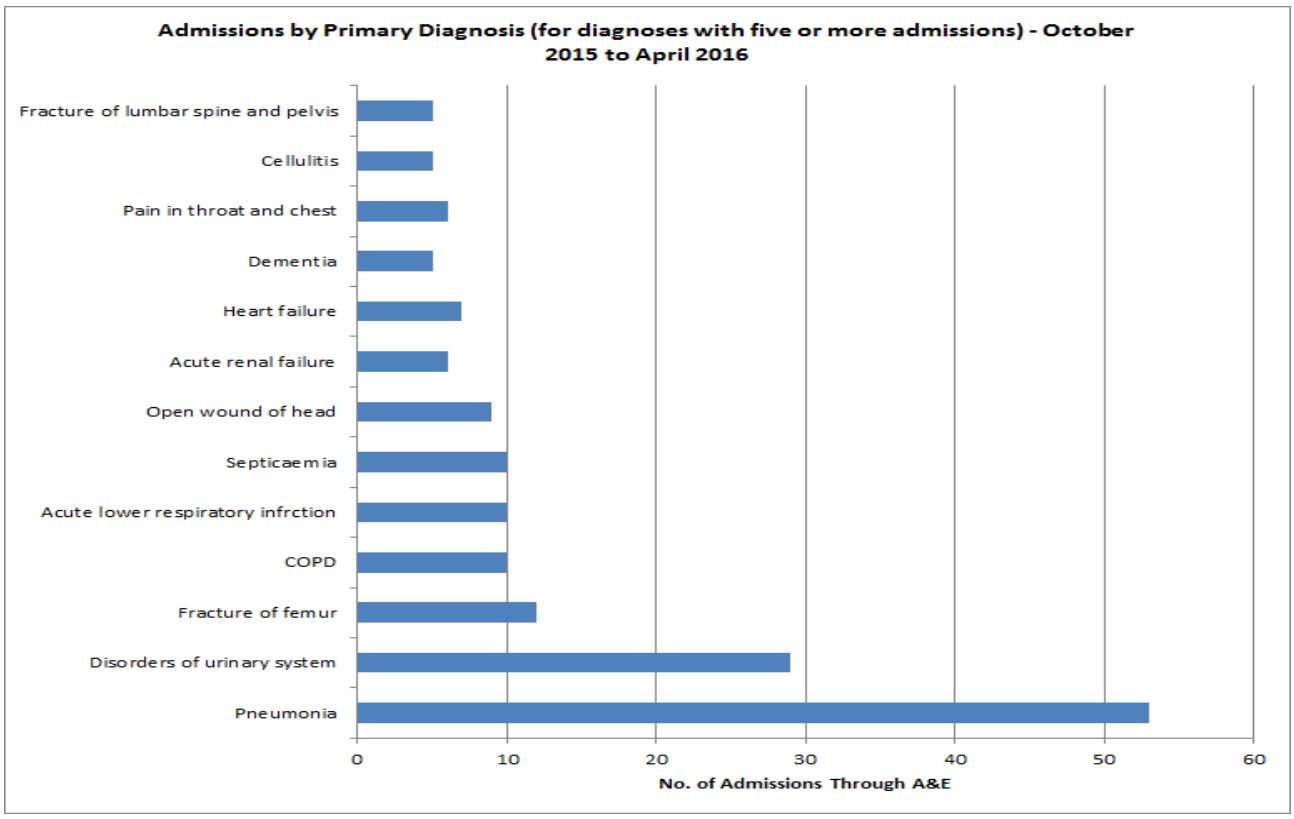


3.38 We need to move to a position where this data is reported monthly to allow us to mobilise an MDT in a more timely manner.

3.39 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.

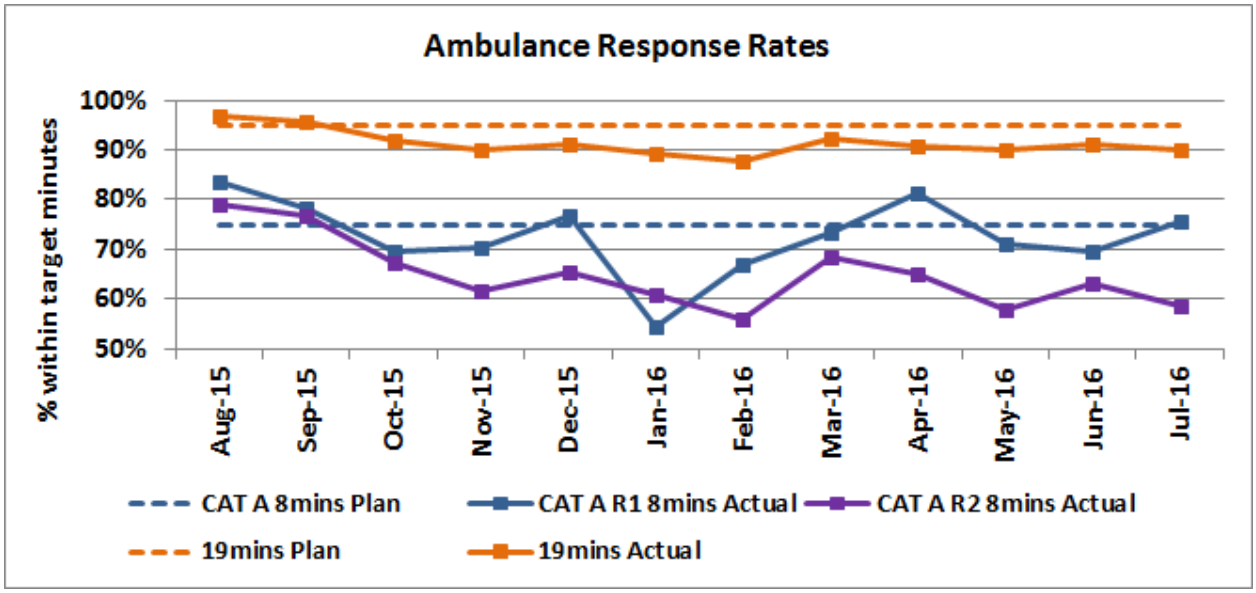
3.40 The following graphs show the reason for attendance at A&E and admissions by primary diagnosis for admissions with five or more admissions.





Ambulance – please note position reported is July

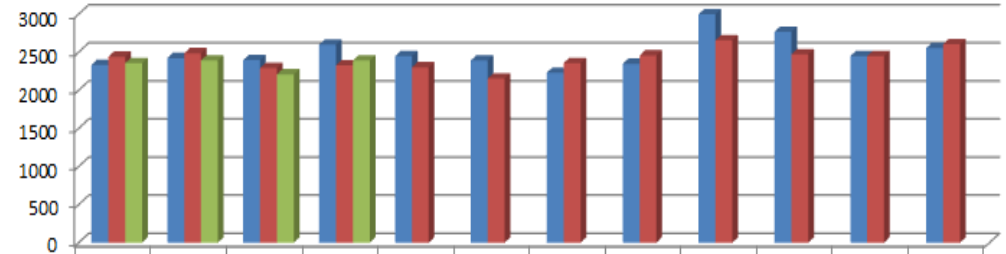
3.41 In July 2016 the CCG achieved the response rates locally with 75.61% for CAT A 8mins Red 1, however, we failed to achieve with 58.62% for CAT A 8mins Red 2 and 89.94% for CAT A 19mins Red 2.



3.42 However, we are measured against the North West position which was 70.45% for CAT A 8mins Red 1; 62.69% for CAT A 8mins Red 2 and 89.81% for CAT A 19mins Red 2 which means none achieved this month.

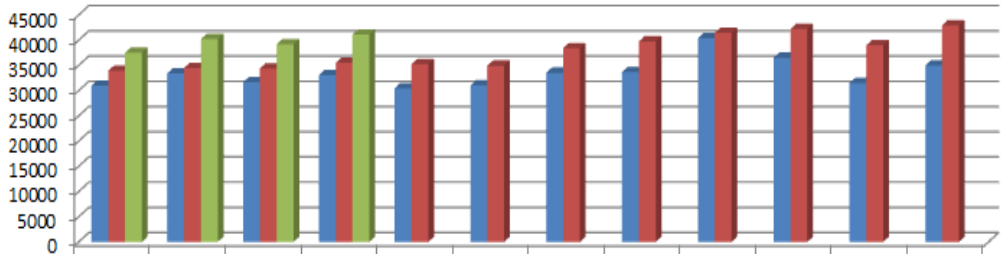
3.43 Increases in activity have placed a lot of pressure on NWAS which has not been planned for. This is impacting on its ability to achieve the standards.

Red 1 <8 Minutes NWAS Activity



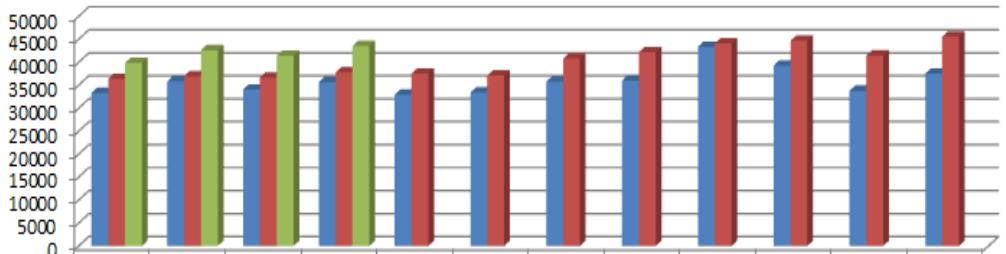
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	2333	2422	2395	2597	2446	2391	2230	2347	2997	2767	2449	2553
2015/16	2439	2485	2292	2327	2300	2155	2357	2456	2655	2469	2449	2604
2016/17	2354	2392	2208	2390								

Red 2 <8 Minutes NWAS Activity



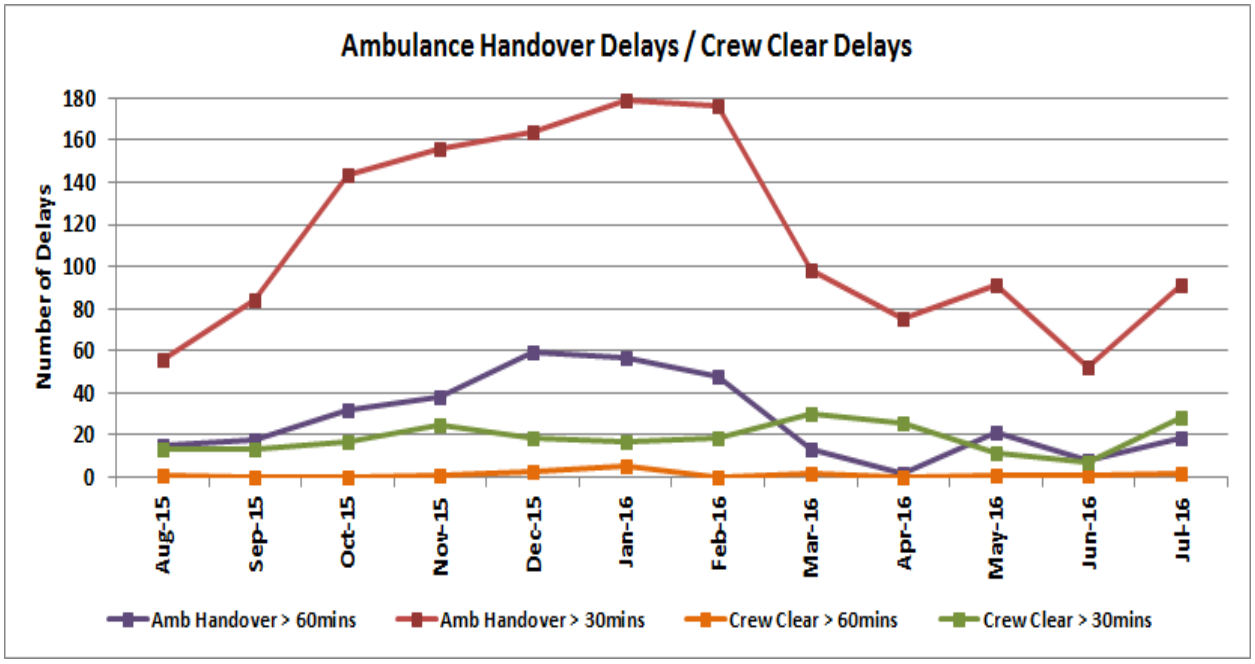
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	30976	33416	31651	33071	30478	31029	33540	33665	40362	36508	31521	34972
2015/16	33939	34473	34374	35485	35216	34942	38414	39743	41435	42203	38992	42951
2016/17	37506	40212	39199	41122								

All Red <19 Minutes NWAS Activity

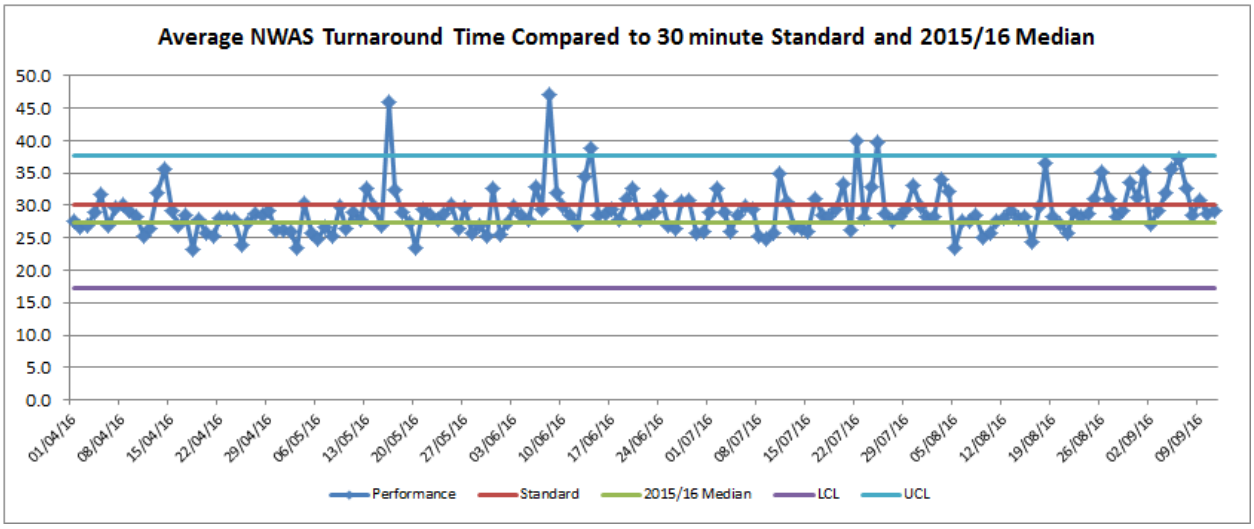


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	33309	35838	34046	35668	32924	33420	35770	36012	43359	39275	33776	37525
2015/16	36378	36958	36666	37812	37516	37097	40771	42199	44090	44672	41441	45555
2016/17	39860	42604	41407	43512								

3.44 The number of ambulances with handover delays increased in July.



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



111– please note position reported is July

3.46 111 went live in GM 10th November so this is the eighth full month reported under the new arrangements.

3.47 Primary KPI performance

- The North West NHS 111 service was offered 167,598 calls in the month, answering 140,160.
- 126,176 (90.02%) of these calls were classified as being triaged

In July the service experienced a number of issues which had a short term detrimental effect on the ability to sustain the much improved performance position in June. These related to subcontractor fulfilment and changing demand profile. These issues were identified early in July and during the month were either mitigated or resolved to ensure return to improved performance in August.

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.

3.48 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)	82.93%
•	Calls abandoned (<5%)	3.76%
•	Warm transfer (75%)	32.85%
•	Call back in 10 minutes (75%)	37.94%

3.49 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 July). 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.

3.50 Our use is in line with NW levels.

	15 and Under	16 to 65	65 and Over	Total
Callers Triaged by Age	917	1,982	736	3,635
% Breakdown	25%	55%	20%	100%
Total for NW Region	30,232	69,646	26,298	126,176
% Breakdown NW Region	24%	55%	21%	100%

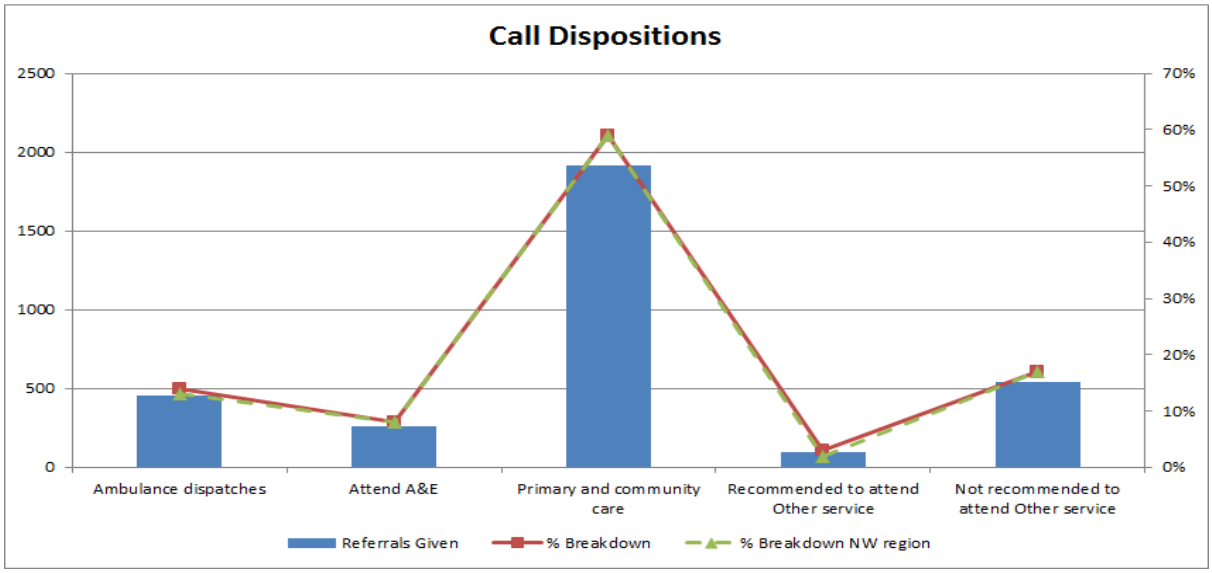
3.51 Our treatment is generally in line with NW levels. Though the number of call backs within 10 minutes was lower than the monthly average across GM by 10%.

	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	3,635	316	183	738	250	488	135
% Breakdown	100%	9%	5%	20%	34%	66%	28%
Total for NW Region	126,176	11,129	3,998	25,407	8,345	17,062	6,473
% Breakdown NW Region	100%	9%	3%	20%	33%	67%	38%

3.52 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	3,635	488	298	2,032	76	741
% Breakdown	100%	13%	8%	56%	2%	20%
Total for NW Region	126,176	17,096	10,839	70,606	2,882	24,753
% Breakdown NW Region	100%	14%	9%	56%	2%	20%

3.53 Our dispositions are in line with this.



4. RECOMMENDATION

4.1 The Single Commissioning Board are asked to:

- Note the 2016/17 CCG Assurance position.
- Note performance and identify any areas they would like to scrutinise further.

This page is intentionally left blank

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning, Single Commissioning
Subject:	**PRIMARY CARE QUALITY SCHEME REVIEW PAPER**
Report Summary:	To present a review of the first six months of the Primary Care Quality Scheme
Recommendations:	The Single Commissioning Board are requested to approved the following relating to the Primary Care Quality Scheme: 1. That it continues in its current format to the end of 2016/2017 with an active promotion of neighbourhood working, akin to that adopted informally in year one. 2. That the remainder of the year be used to evolve the scheme based on the learning to date from the year one reports, patient feedback and practice feedback, and also to complement the current environment. 3. That changes are also incorporated to further support neighbourhood working, address the Greater Manchester Quality Standards and aligning and running parallel to reducing originating activity across the health economy, while also impacting positively on costs. These changes will also offer greater effectiveness in supporting the financial challenge across the economy.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This report is a review of the progress made during the first six months of the Primary Care Quality Scheme (PCQS) for which a budget was formally agreed at the start of the financial year. The progress made in 2016-17 will serve to influence the PCQS in 2017-18 for which an indicative budget of £1.5 million was proposed at the Extraordinary Governing Body meeting on 7 September 2016. This value is inclusive of some inherent efficiency. However, it is important that quarterly updates as to the progress made for each practice is received to ensure VfM and particularly as this is a significant component of the CCG Recovery Plan and the wider transformation within neighbourhoods which will be subject to intense scrutiny.
Legal Implications: **(Authorised by the Borough Solicitor)**	As this is a review of the previous year's performance it is difficult to draw any real conclusions around legal implications aside from to highlight the need for the service to ensure at all times going forward it works within the Constitutions of both the NHS and the Council and to ensure value for money is achieved and improved upon. Going forward, how to assess required outcomes to continually improve service and performance which will in turn reduce the potential for successful legal challenge through judicial review, the courts generally or ombudsman complaints could be factored into next year's programme.
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 and Wellbeing Strategy.

How do proposals align with Locality Plan?	To support primary care providers working together at neighbourhood level
How do proposals align with the Commissioning Strategy?	Helping to improve the quality of services delivered in primary care.
Recommendations / views of the Professional Reference Group:	PRG noted the culture shift that has taken place in order to achieve the primary care quality standards and in practices addressing their own performance and taking ownership as part of the GP forward view. PRG would like to see some rigor in developing the process without moving away from this scheme. KR requested that we link in spend with the Care Together vision and that consideration be given to the Commissioning Improvement Scheme as part of the transformational funding. Subsequently, PRG were reminded of the qipp in place on discretionary spend. PRG accepted the three recommendations set out within the report, subject to SCB approval, although highlighted the caveat of their comments made around QIPP.
Public and Patient Implications:	The general practice offer to patients will be improved by the Primary Care Quality Scheme
Quality Implications:	The Primary Care Quality Scheme is designed to improve the quality of care patients received from general practice
How do the proposals help to reduce health inequalities?	The Primary Care Quality Scheme aims to improve the quality of care patients receive from general practice by requiring practises to take a quality improvement approach to the care they deliver.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None, patients are seen by their own practice and therefore with adherence to Primary Medical Services regulations.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None, patients are seen by their own practice and therefore with adherence to Information Governance responsibilities.
Risk Management:	Risks will be managed through clear process and documentation.
Access to Information :	The background papers relating to this report can be inspected by contacting Chris Martin, Primary Care Development and Quality Manager, by:  Telephone: 0161 304 5300 or 07881 805130  e-mail: christopher.martin4@nhs.net

1. INTRODUCTION

1.1 The Primary Care Quality Scheme (PCQS) was approved in May 2015. The underlying principle of it was to increase and sustain the infrastructure and delivery of primary care services, including parity of investment with other sectors of the health economy, while recognising the trend of moving services out of secondary care into primary care.

1.2 An important part of the brief was to co-design the scheme with GPs, their teams and patients.

1.3 The scheme is the third of five strands in the Primary Care Strategy - Developing Relevant and Meaningful Outcomes for Primary Care.

1.4 Strand three complements strand one of the Primary Care Strategy - Strengthen General Practice Infrastructure and strand two - Developing Models and Pathways of Care that are Meaningful to Patients and Practices.

1.5 The scheme is designed as an alternative to "one size fits all" target driven financial rewards, recognising that each of our 41 practices faces challenges specific to them and their population. This has been achieved by designing a scheme that encourages practices to be aware of and own their practice data, identifying the improvements that are needed and trying out new approaches to encourage a positive and creative culture of improvement from both a patient and a practice perspective.

1.6 An extensive engagement exercise was undertaken during the development phase of the scheme. During the engagement practices pointed out that schemes have been introduced in the past, to be stopped after a short period of time, which it was felt prevented them being as beneficial as they could be.

1.7 Consequently the PCQS was promoted as a potential long term investment in primary care that practices could use to access additional resource, and at the same time implement longer term projects to improve patient and staff outcomes and experience. To emphasise this message, practices were asked to submit two year plans.

1.8 The scheme went live in October 2015 with the initial approval covering a period to the end of March 2017. The investment for 2015/16 was £1 million and is £2 million for 2016/17.

1.9 All 41 practices are participating and submitted plans, which were reviewed by a panel. Practices subsequently submitted a year one report, when the scheme had been running for six months. Year one reports were submitted by all 41 practices and this report discusses the progress of the Primary Care Quality Scheme to date and its position as part of the current primary care position.

2. CONTEXT

2.1 Activity in primary care has increased over a number of years – 90% of contacts with patients are within primary care, while funding, although acknowledged to be lower has reduced to only 9% (RCGP, NAPP 2013) of overall NHS funding. As demand has increased and investment decreased the general practice workforce has become demoralised and burnt out, which is reflected in the difficulties that our practices have faced over recent years (Understanding Pressures in General Practice, Kings Fund May 2016).

2.2 In addition, practices face an increase in the burden of regulation, which is reflected in our underpinning aims of trying to make primary care a better place to work, as well as a better place to access care. This is not always helped by well-intentioned national schemes that fail to fully understand their impact on general practice.

2.3 The combined issues facing general practice run the risk of creating a jaded provider, with the consequent danger that as a group it fails to engage with the CCG, negatively impacting on the CCG's plans.

3. THE BRIEF FOR THE SCHEME, ITS AIMS AND ITS CONTENT

3.1 The Tameside and Glossop Primary Care Strategy had two aims; to make primary care a great place to work and a great place to receive care. It also fulfils a number of other briefs:

- it is the CCGs major recurrent investment in primary care;
- it had to be co-designed.

3.2 It had to achieve its primary purpose of improving the quality of primary care delivered to our population

3.3 To make primary care a great place to work it could not be too administratively onerous on already overstretched practice staff

3.4 The design team recognised that fulfilling all these aims would be challenging and likely to take many years. Success is dependent upon influencing organisational culture across practices and in an every changing NHS environment, we need to provide a culture of continuous improvement where individuals within an organisation have the confidence to try new working to respond to the challenges they face.

3.5 It is a co-designed vehicle created to be different to other investments in primary care, such as the Quality and Outcomes Framework (QOF). This was a deliberate decision to engage and enthuse general practice, while also influencing the culture of general practice.

3.6 QOF undoubtedly serves the purpose it was designed for, but a local quality scheme that merely duplicates QOF is a missed opportunity to affect long term cultural change in general practice within Tameside and Glossop.

3.7 QOF directs practices to look at specific things and to report on those specific things in order to gain points until the maximum number of points, and money, are achieved. There is a danger with such schemes that only the areas specified as attracting investment will be concentrated on, at the expense of areas that are not incentivised, which ultimately does not resolve variations in care.

3.8 Detailed analysis of QOF has also shown that in its first six years, it has failed to make an impact on the mortality of the UK's population (The Lancet, May 2016). It is now widely accepted that a focus on achieving targets in discrete areas has encouraged GPs to lose sight of overall outcomes for patients.

3.9 Unlike QOF, our Primary Care Quality Scheme also had to recognise that not all practices are in the same position. At the time of design general practice in Tameside and Glossop consisted of 41 small businesses facing 41 different sets of problems, dealing with 41 different cohorts of patients, in 41 different premises, with 41 different set of partners and 41 different cultures. Two practices merged in July, which reduces the number of practices to 40.

3.10 The Primary Care Quality Scheme reflects this as it is structured to ask practices to be aware of their position in 40 indicators grouped under the five following domains:

1. Best Practice Care;
2. Patient Safety;

3. Patient Engagement, Patient Satisfaction and Patient Involvement in Service Development;
4. Access;
5. Practice Planning, Primary Care Development and Continuous Improvement.

4. HOW THE SCHEME WORKS AND PRACTICE ENGAGEMENT WITH IT

4.1 The 2015/16 investment equated to £3.91 per weighted patient. There was a split payment of the investment – an initial amount to allow practices to fund additional resources to deliver against their plan and a later payment after evaluating the subsequent report.

4.2 Once practices submitted reports, they were evaluated by a panel, with the panel particularly looking for evidence that practices were aware of their performance and had taken some positive action to address the areas identified as requiring improvement.

4.3 A similar split payment process will be followed for the 2016/17 financial year.

5. YEAR ONE REPORTS

5.1 The year one reports were exciting in the way practices engaged with the scheme, discovered the data relating to their position for each indicator and took ownership of it by making proposals for improving or maintaining their position.

5.2 This is consistent with the direction of integrated neighbourhoods currently being developed; allowing neighbourhoods to develop based on local need similar to the evolving Primary Care at Scale and Multispecialty Community Provider (MCP) proposals.

5.3 An important theme from the year one reports was that of practices engaging with their data and fully understanding their position on each indicator. This entailed the practices engaging with a wide variety of data sources, understanding their position and considering approaches to improving or maintaining that position.

5.4 This is not a top down approach to quality improvement with a one size fits all approach; it leads the practices into understanding what the data says are their particular areas that require improvement and gives them the space and freedom to implement the solution that best fits their circumstances.

5.5 By asking practices to understand their positions in each of the 40 indicators (32 of which were live in 2015/16) we are effectively providing a framework for each practice to own their position and manage the improvement or maintenance of that position in the way that best suits the practice. The scheme also recognises the individuality of each practice and the challenges they may face. It also asks practices to build their own resilience by asking them to plan for the future shape of their business in terms of succession planning.

5.6 This increases the performance of all practices and reduces variation, by incentivizing each practice to focus on improving weaker areas while maintaining stronger areas. This should eventually reduce unwarranted variation in general practice across Tameside and Glossop and reduce health inequalities.

5.7 Equally important is that in the long term, practices will develop - and embed - new behaviours. They will become more interested in their performance and be able to recognise areas requiring improvement and establish their own improvement aims, thereby having more ownership of the work they do.

5.8 It is clear that this approach is not going to be the easiest to measure or evaluate, but it is the best way of accounting for the differences amongst our practices and encouraging them to understand where they need to improve, while providing patients with better quality care. This ultimately feeds into reducing variations of care and health inequalities.

6. ALIGNMENT

6.1 There are a number of areas that the scheme aligns with and supports which can be strengthened in its next iteration.

7. COMMISSIONING IMPROVEMENT SCHEME (CIS)

7.1 This scheme has been implemented for 16/17 and aims to encourage practices to reduce their contribution to costs within other areas of the health economy. It is designed to help the CCG achieve its 16/17 QIPP target.

7.2 A number of areas within the PCQS encourage practices to be aware of the data related to their practice so that they can positively influence that data in a way that best suits each individual practice. This creates a culture where familiarity of data is encouraged, ultimately supporting the CIS, which requires knowledge and ownership of risk stratification data to achieve the aims of the CIS.

8. NEIGHBOURHOOD WORKING

8.1 The strategic direction of the CCG is to move towards working at neighbourhood level, rather than at a practice level. The PCQS was designed at practice level. The Hyde neighbourhood organised itself so that a number of the practices worked together on discrete domains of the scheme. They also hired an external consultant to aid their work on the scheme. This level of learning and co-operation is incredibly helpful in the development of more integrated, neighbourhood working within primary care.

8.2 Risk stratification data is supporting the development of neighbourhood working, and as discussed above the PCQS encourages familiarity and ownership of information and to positively influence it in a way that best fits each individual practice.

8.3 The scheme itself will develop and evolve and the next iteration will include an overt neighbourhood approach to allow us to harness its full potential.

9. GM STANDARDS

9.1 The GM Standards currently consist of 65 indicators in 9 domains. They are due to reviewed by Greater Manchester Health and Social Care Partnership so may not retain their current content. It is an expectation that all Greater Manchester CCGs will introduce the GM Standards, though there is unlikely to be additional resources attached to this.

9.2 While the Greater Manchester Quality Standards are a very different proposition to the Tameside and Glossop PCQS, a mapping exercise has shown that 52% of the GM Standards are replicated by our scheme. This could be increased in the next iteration of the PCQS, in line with the outcome of the GM Standards review.

10. CQC REQUIREMENTS

10.1 As a CCG we have had five practices receive a CQC rating of requires improvement – the majority of these were before the PCQS went live in October 2015. Several of the issues that CQC highlighted as areas requiring improvement – such as training and succession planning – are within the PCQS. The scheme supports the CQC regime and helps to maintain our practices at a standard to ensure a good CQC rating.

11. VULNERABLE PRACTICES

11.1 By attempting to make primary care a better place to work the PCQS recognises that, for various reasons, some of our practices may be vulnerable. Domain 5 – Practice Planning, Primary Care Development and Continuous Improvement – is specifically designed to support practices in developing a level of organisational resilience.

11.2 However, it is also hoped that the scheme will help us to identify those practices that require support, which can then allow the CCG to put the relevant support in place.

12. HEALTH INEQUALITIES

12.1 The PCQS also aims to support the work to reduce health inequalities within Tameside and Glossop through the process of encouraging practices to recognise where they need to improve. As practices start to improve their position for each indicator within the PCQS, addressing the specific needs of their patients, those patients should have greater access to health care with better outcomes with less unwarranted variation across Tameside and Glossop.

13. GENERAL PRACTICE FORWARD VIEW

13.1 The General Practice Forward View provides a framework of support for general practice by providing it with tools to increase resilience through additional investment and focusing on areas of vulnerability. It is believed that this will help in the face of increasing demand.

13.2 The PCQS can be the CCGs vehicle for delivering the General Practice Forward View and is already creating a framework for practices to consider resilience with its Practice Planning, Primary Care Development and Continuous Improvement domain.

14. OUTCOME MEASURES

14.1 The design of the scheme fully recognised the importance of measured outcomes for both patients and practice teams. However, the challenges faced were two-fold:

- Improvements to morbidity or mortality may take many years to be realised; and
- Organisational culture is difficult to measure and currently there are no validated tools to do this in general practice.

14.2 Albert Einstein stated that, *"not everything that can be counted counts and not everything that counts can be counted."* While part of the design of the scheme was to encourage practices to engage with their patient population by better understanding of data it was recognised that there needed to be some measures of success. The following were chosen:

- Evaluating each individual practice's achievement against the indicators by reviewing practices reports at a number of panels;

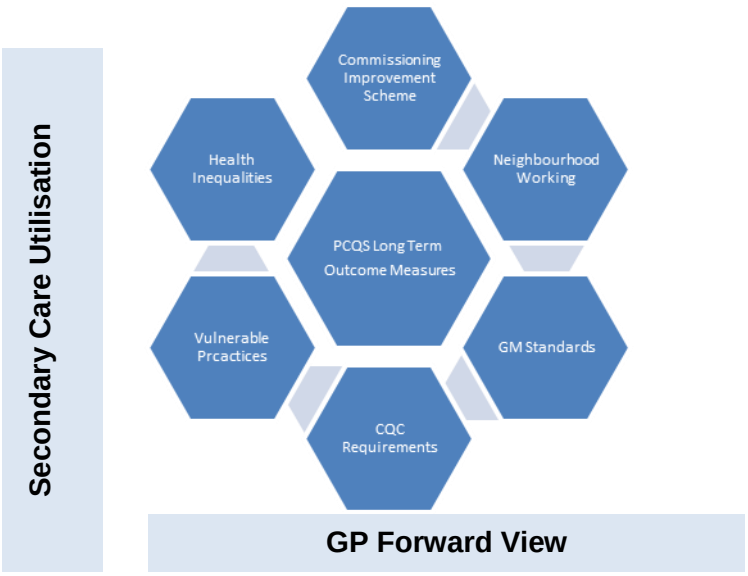
- Externally monitoring 20 indicators over a number of years to see if there is a positive impact on them, recognising that a longer timescale is required to evidence change.

14.3 These long term indicators are as follows:

- Cervical smear take up;
- Flu immunisation vaccination uptake;
- AF prevalence;
- CHD prevalence;
- Asthma prevalence;
- Diabetes prevalence;
- Dementia prevalence;
- Optimum control of blood pressure;
- Hypertension prevalence;
- Patient overall satisfaction;
- Patient satisfaction with access to General Practice;
- How confident patients feel in managing their own health;
- Clinical and Non-clinical staff satisfaction;
- Unfilled GP posts;
- Unfilled Practice Nurse posts;
- Unplanned admission rates;
- Premature mortality (improvements expected over a 5 – 10 year period);
- Healthy life expectancy (improvements expected over a 5 – 10 year period);
- Lower number of deaths in hospital as an indicator of preferred place of death;
- Low proportion of cancers diagnosed on an emergency admissions as an indicator of late diagnosis.

14.4 These indicators are consistent with the commissioning strategy of the Single Commissioning Body and can also help address utilisation of secondary care.

14.5 The diagram below indicates how the outcome measures feed into the areas of alignment, with the GP Forward View providing underpinning support and direction.



14.6 It is always difficult to collect current primary care information, as the national primary medical services contracts do not contain any reporting requirements. In addition there are information governance barriers that may prevent the extraction of data from practice clinical systems. The latter are not insurmountable and the CCG is working to resolve this.

14.7 Consequently, we have to rely upon secondary data sources, such as the Primary Care Web Tool, QOF, Public Health England's Fingertips website, the GP Patient Survey, Friends and Family Test and CQC reports.

14.8 These data sources tend to be updated on an annual basis. As such, the year one PCQS data is being treated as our baseline from which we will measure any future improvements that may occur.

15. LEARNING AND FUTURE DEVELOPMENT OF THE SCHEME

15.1 While general practice has been underfunded for a significant amount of time it is a group of providers that we as a CCG need to rely upon more and more under our integration plans by transferring activity from secondary to primary care.

15.2 It is also a group of providers that the CCG is very focused on to support the delivery of QIPP across the economy and we are working closely with our neighbourhoods to help reduce activity in secondary care.

15.3 Consequently, general practice is under pressure to be at the heart of neighbourhood working while remaining within its existing investment. Without further supportive interventions, including additional investment over and above core contract, general practice will only come under additional pressure, which may be insurmountable for some practices. This pressure on general practice risks subsequent economy wide pressures as unmet demand in primary care will transfer into the wider system.

15.4 Contracts for general practice are negotiated nationally and we have only a low level of influence over them. In addition, contracts in themselves are designed govern the relationship between the provider and the commissioner, rather than the quality aspects of delivering health care. This means limited formal influence over general practice, which is especially critical when general practice is so important to the CCGs proposals for service delivery and financial sustainability.

15.5 We have learnt that it is unwise to solely rely upon a contractual approach to improving quality. This is because it may promote a culture of ticking boxes and act as a disincentive to practices proposing and implementing creative solutions to improving patient care and outcomes. For this very reason our PCQS adopted an approach aimed at promoting a culture of continuous improvement.

15.6 The PCQS is a vehicle that is achieving several things:

- Being the vehicle for achieving the two aims of the Primary Care Strategy;
  - Making primary care a great place to work, and
  - Making primary care a great place to receive care.
- A much needed investment in general practice primary care, that provides the CCG with a level of security that the investment is being focused on patients and practice resilience.
- An initiative to reduce the variations of care across Tameside and Glossop.
- Increasing engagement and interaction with our practices, thus fostering good relations with them at a time when it will be vital to retain these relationships.
- Feeding into CQC requirements and supporting practices in achieving "good" CQC ratings.
- Encouraging practices to engage with their current strengths and weaknesses to allow them to build on the good and reduce the bad.
- Supporting greater resilience in general practice by having a domain that focuses on practice planning, primary care development and continuous improvement.

15.7 The underpinning aim of the PCQS is to change the culture of our practices and to embed quality improvement as a natural product of delivering primary care medical services. This is not a short term proposition and will take longer than two years to do this, therefore it needs to continue if it is to make the desired long term changes especially required to allow the strategic direction of Care Together to be successful.

15.8 Since the scheme was developed over a year ago the CCGs financial position has changed significantly. In addition, the landscape of our local health economy has also changed significantly. As such, the brief for a future iteration of the scheme is different to the original brief, which it fulfils.

15.9 The PCQS is an excellent vehicle for the CCG has to influence practices. While the CCG can influence locally commissioned services, it has little influence over core contracts, which are practices main income streams. This vehicle is imperative in our current financial situation where we need to maintain good relationships with our practices to achieve the financial goals we have set ourselves.

15.10 As the landscape has changed, then so should the Primary Care Quality Scheme. It should be more aligned and run parallel with the CCGs need to reduce spend within primary care and promote neighbourhood working. This does not mean that the scheme should be directly linked to any Commissioning Improvement Scheme. All referrals should always be based upon clinical need and we would wish to avoid the unfortunate national headlines that Bolton CCG suffered, earlier on this year, when the national press stated that GPs were being incentivised not to send patients to hospital.

15.11 The PCQS is a vehicle that will evolve as the landscape in which it exists evolves. Under the recommendations below, which were accepted by PRG, it can be designed to complement and align with the Single Commissioning Board's strategic direction, which will equally change as the environment changes. The recommendations below reflect the changes in the landscape that have occurred during the 18 months of its development and implementation. No doubt there will be more changes whether driven locally by the Single Commissioning Board, regionally by the Greater Manchester Health and Social Care Partnership and nationally by NHS England.

16. RECOMMENDATIONS

16.1 Set out at the front of the report.

Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Reporting Member / Officer of Single Commissioning Board	Clare Watson, Director of Commissioning, Single Commissioning
Subject:	**CONTRACT FOR THE PROVISION OF DIRECT PAYMENT SUPPORT SERVICES – INCLUSION ON A LIST OF APPROVED SERVICES**
Report Summary:	To present a report to seeking authorisation under Procurement Standing Order F1.3 to extend for a period of twelve months where there is provision to do so in the contract.
Recommendations:	That the contract is extended for a twelve months from 1 November 2016 to 31 October 2017.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The proposed extension to the contract will be funded by existing financial resources (2016-17 budget is £86,000). There will be a reduction in these costs after the initial 12 month period as pre-paid cards are introduced which will mean a number of current users of the payroll service will be able to manage their own finances independently or with the help of carers.
Legal Implications: **(Authorised by the Borough Solicitor)**	The contracts contain an in-built extension provision to extend and to implement this would not contravene the Procurement Rules or be unlawful. Better planning is required in future to ensure that decisions to extend a contract are taken at a more appropriate time as it would otherwise be difficult to re-procure or decommission a service within the remaining contract term.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	PRG supported the paper to go through to SCB.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which

	requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
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:	There are no anticipated financial risks given the very low value of the contract. The nature of the framework is such that should one provider experience problems other providers are available to take on the role at short notice.
Access to Information :	The background papers relating to this report can be inspected by contacting Dave Wilson, Team Manager, Joint Commissioning and Performance Management, by:  Telephone: 342 3534  e-mail: dave.wilson1@tameside.gov.uk

1. BACKGROUND

1.1 Direct payments are an alternative to traditional care and support services. Adult Services provide cash payments for individuals to purchase services that meet their assessed care needs. This allows the person receiving services more choice and control over how their care needs are met.

1.2 Recipients of direct payments can choose to employ their own care workers known as Personal Assistants (PA's). As an employer, the individual has the usual employer responsibilities such as providing pay slips and ensuring the correct tax and national insurance payments are made.

1.3 The payroll service is designed to assist people who use a direct payment to employ PA's to manage their payroll and tax functions and includes professional unlimited payroll advice.

1.4 An enhanced service called a managed account is provided for individuals who are unable, or lack capacity, to open or operate a bank account or where there are risks of financial abuse. With managed accounts the individual's direct payment (cash payment), is paid to the provider who holds the money in a client account and makes relevant payments from this account to employees and HMRC. This facility can also be used to pay invoices from care providers that the service user contracts with.

2. CURRENT SITUATION

2.1 There are currently five organisations on the approved list these are:

- David Howard Ltd;
- Michael Russell Partnership;
- Paypacket Ltd;
- PayPartners;
- The Rowan Organisation.

2.2 There is no guaranteed number of accounts, but commissioners, care co-ordinators and service users and their representatives have access to the list of approved services from which to choose services required.

2.3 The list of approved services commenced November 2013 with a three year contract including provision to extend for up to an additional two years.

2.4 The 2016/17 budget is £86,000.

2.5 The service is performing as required under the contract and there are no contractual compliance issues.

2.6 A piece of work is currently being undertaken which will include the use of pre-paid cards for services users personal budgets; this may reduce the need for service users to have a managed account.

2.7 Once this piece of work has been completed, there may be a reduction in the total spend on payroll services and a review of the current framework arrangement will be undertaken at that point with a view to ensuring the most appropriate mechanism – in terms of ease of use for service users and best value for commissioners – is in place. Hence, authorisation is sought to extend the current arrangements for up to twelve months to enable this piece of work to be completed.

3. GROUNDS UPON WHICH AUTHORISATION TO PROCEED SOUGHT

3.1 Authorisation under Procurement Standing Order F1.3 where there is provision within the contract to extend for a period of twelve months from 1 November 2016.

4. CONCLUSION

4.1 That the information provided in this report is considered and a decision made in relation to approval to move forward with the extension of this service.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Reporting Member / Officer of Single Commissioning Board	Clare Watson, Director of Commissioning, Single Commissioning
Subject:	**CONTRACT FOR THE PROVISON OF SPECIALIST DAY SERVICES FOR PEOPLE WITH DEMENTIA**
Report Summary:	To present a report to seeking authorisation under Procurement Standing Order F1.3 to extend for a period of twelve months where there is provision to do so in the contract.
Recommendations:	That the contract is extended for a period of twelve months from 2 December 2016 to 1 December 2017.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The proposed one year extension (December 2016 to December 2017) to the contract (£0.345 million) will be financed from the Integrated Commissioning Fund. The resource allocation is within the Adult Services revenue budget of the Section 75 pooled fund. The existing service provision supports the delivery of cost avoidance to the health and social care economy. The supporting details of the existing and the potential avoided weekly gross costs are provided within section 3.3 of the report. Whilst the contract value has not been market tested since the date of contract inception, it is recognised that the proposed gross unit cost (per day) value of the service contract extension is comparable with similar gross unit costs (per day) that have been tendered by similar providers for similar services (comparable unit cost details provided within section 3.2 of the report). It is essential that commissioning intentions beyond the proposed contract extension period are evaluated and considered at the earliest opportunity if approval is granted to the existing contract extension to 1 December 2017.
Legal Implications: **(Authorised by the Borough Solicitor)**	This is a decision for the SCB. The contract contains an in-built extension provision to extend and to implement this would not contravene the Procurement Rules or be unlawful. Better planning is required in future to ensure that decisions to extend a contract are taken at a more appropriate time as it would otherwise be difficult to re-procure or decommission a service within the remaining contract term.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.

How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	PRG supported the recommendations.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
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:	There are no anticipated financial risks given the relatively low value of the contract. There is, however, potential risk of carer stress and family breakdown requiring people to move into either temporary or permanent supported accommodation should the service not continue. The service is performance managed quarterly and regular contact maintained with the Creative Support.
Access to Information :	The background papers relating to this report can be inspected by contacting Dave Wilson, Team Manager, Joint Commissioning and Performance Management, by:  Telephone: 342 3534  e-mail: dave.wilson1@tameside.gov.uk

1. BACKGROUND

1.1 Adult Services has provided a specialist day service for people with dementia since October 1997. The overall aim of the service is to enable people to live as independent and fulfilling a life as possible in the community. The service is focused on a number of key objectives: enhancement of physical, social, mental and life skills; the provision of reliable practical, emotional or psychological support to increase people's choice and control over their daily lives; enriching the range of experiences in a service user's daily life through the opportunities and social contact offered; reducing social isolation and supporting carers in their caring role.

1.2 Originally the Dementia Day Service was delivered via two separate contracts, and two day centers, Wilshaw House in Ashton-under-Lyne and Rydal House in Hyde. By December 2012 however, in light of the significant budgetary pressures faced by the Council, provision was reduced to one provider operating from Wilshaw House.

1.3 The service was nonetheless in-line with national and local dementia strategies and to fit with emerging best practice:

- To provide a specialist day service with a capacity that delivered against actual levels of need, at a single site and for people at the higher end of their assessed need.

- To expand access to more appropriate community orientated, non-building based activities for people with a new diagnosis of dementia or early onset dementia, i.e. those people at the lower end of assessed need who may find that a specialist, building-based service does not fully address their needs. People with less complex needs would therefore be more likely to find these needs met within the community element of the service, rather than being referred straight into a building-based provision, as has been the case to date.

- To deliver savings on the current provision costs.

- To contract with a single provider for the provision of a building-based service for people at the higher end of need and for mainstream community provision suited to service users more able to access and benefit from it.

2. CURRENT SITUATION

2.1 The service is comprised of two key components:

- A building-based service based at Wilshaw House, Ashton-under-Lyne, that provides twenty places per day, seven days a week, 52 weeks a year

- A community-based element that provides eight places per day, seven days per week, 52 weeks a year.

2.2 The contract commenced December 2012 for an initial three years and with provision to extend for up to an additional two years.

2.3 The current contract price for the financial year 2016/17 is £344,720 for 28 places per day.

2.4 The contract price includes transporting service users to and from the day service.

2.5 The total number of available places per day is twenty eight equating to 196 available places per week. The number of commissioned places as of July 2016 was 166 which equates to 85% occupancy. The commissioned places Monday to Friday is 92% and is

66% on a Saturday and Sunday. There are seventy service users currently using the service and is utilised on a Saturday and a Sunday by thirty one people, six of whom attend both days.

2.6 The service is subject to six monthly performance management meetings which includes a review of performance data and case studies. It is also subject to an annual validation.

2.7 The service has maintained a high level of performance to date and this is reported well at the regular performance management meetings. Case studies which reflect the positive outcomes for individuals, levels of compliments, complaints and safeguards and details of staff training, support and supervision are detailed and discussed at the meetings. Where issues or concerns have been raised, Creative Support has dealt with these in a timely and appropriate manner.

2.8 A validation carried out in September 2014 to look at information from staff files to ensure the organisation had an effective recruitment and selection procedure and that staff were competent demonstrated findings that were extremely positive with evidence that staff had access to structured learning and development and were recruited according to employment legislation.

2.9 The Performance Officer has seen evidence from the carers that both they and the service users who attend the day centre clearly value the staff and the service that they receive. Feedback from the carers is extremely positive regarding service user and carer outcomes and quality of service received, they speak highly of all the staff and have stated that they feel that their lives and their loved one's lives benefit from using the service.

2.10 Creative Support have been able to demonstrate that as a result of using this service people with dementia, including where their dementia is quite advanced and/or complex, have been able to remain living at home longer. Carers routinely report that the respite provided by the service for them means that they are better able to continue supporting their family member at home; clearly a good outcome for individual's and their carers as well as keeping people out of more expensive services – nursing care, day hospital or hospital wards included – for longer.

2.11 The Performance Officer reports that this is a lively and vibrant day service where service users are actively encouraged to participate in the activities, their opinions are sought and they are encouraged to express their opinions. There are regular service user and carer meetings.

2.12 Service users are treated with dignity and respect by staff and they demonstrate that they are committed to the service. The staff team appear enthusiastic and focused on improving the lives of the people who attend the day service.

2.13 The service is performing as required under the contract and there are no contractual compliance issues.

2.14 The contract commenced 2 December 2012 for a period of three plus two years. Clause 3.2 of the contract allows for an extension for up to two years. Authorisation was given to extend the contract for twelve months to 1 December 2016.

2.15 The overall service has developed well with joint working across all parties.

2.16 Whilst commissioning intentions beyond this extension are yet to be confirmed, there is a strong body of evidence that daytime support like this provides much needed respite for families and carers, prolonging the time their family member with dementia remains living at home.

3. GROUNDS UPON WHICH AUTHORISATION TO PROCEED SOUGHT

3.1 Authorisation under Procurement Standing Order F1.3 where there is provision within the contract to extend for a period of twelve months from 2 December 2016.

3.2 There is evidence that although not market tested since the contract was tendered in the summer of 2012, the gross unit cost for this service which is £33.82 per person per day remains consistent with unit costs that have been tendered by similar providers for similar services. For example the list of approved day services which provides day time activities for people with lower level needs than those at Wilshaw House has a gross unit cost of £30.60 per person per day.

3.3 This service plays a key role in cost avoidance/cost delay. Use of the service over five days a week costs £170. There is strong evidence that this service provides considerable respite for families and carers and that without it people would require more expensive, alternative care; 28 hours homecare per week would cost £383 (gross), for example, whilst gross residential dementia care costs £545 per week and gross nursing dementia care £710 per week.

4. RECOMMENDATION

4.1 As stated on the report cover.

This page is intentionally left blank

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Reporting Member / Officer of Single Commissioning Board	Clare Watson, Director of Commissioning, Single Commission
Subject:	**TENDER FOR THE PROVISION OF RESPITE CARE FOR ADULTS WITH A LEARNING DISABILITY AND ADDITIONAL NEEDS SUCH AS PHYSICAL / SENSORY / MENTAL HEALTH WITHIN A REGISTERED CARE HOME SETTING**
Report Summary:	The report details the outcome of an unsuccessful procurement exercise and seeks authority to extend the current contract for a period of up to twenty four months where there is provision to do so in the contract whilst options are considered to ensure the longer term continued provision of the service.
Recommendations:	(1) To note the outcome of the unsuccessful procurement exercise and the options being considered to ensure the continued provision of the service. The outcome of which will be reported back the Single Commissioning Board in due course. (2) That authorisation is given to extend the current contract for up to twenty four months.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	It is recognised that soft market testing has indicated that the current contract price of £0.250m is reasonable compared to other similar contract specifications currently being delivered. The associated cost of a 24 month extension to the existing contract from 1 October 2016 will continue to be financed from the Section 75 funding allocation within the Integrated Commissioning Fund. It is essential that commissioning intentions beyond the proposed contract extension period are evaluated and considered at the earliest opportunity if approval is granted to the existing contract extension up to 30 September 2018 at the latest.
Legal Implications: **(Authorised by the Borough Solicitor)**	This is a decision for SCB. The contract contains an in-built extension provision to extend and to implement this would not contravene the Procurement Rules or be unlawful. The SCB needs to ensure that an appropriate property is sought as soon as possible to ensure that regulatory requirements are met in full. If a property can be sourced, in the absence of acceptable bids from the recent procurement exercise the Council would be entitled to rely on Regulation 32 of the Public Contracts Regulations 2015 which permits the use of the negotiated procedure without the prior publication of a notice in the Official Journal of the Economic Union and make a direct award. This will only apply where the initial conditions of the advertised contract are not substantially altered. Further

	governance would be required as a result of Procurement Standing Order F1.4 to make a direct award.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	PRG agreed with recommendations.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act. The service will be available to Adults with a learning disability regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	There are no anticipated financial risks given the very low value of the contract. There is, however, potential risk of carer stress and family breakdown requiring people to move into either temporary or permanent supported accommodation, should the service not be extended whilst arrangements are made regarding the longer term provision of respite care.

Access to Information :

The background papers relating to this report can be inspected by contacting Denise Buckley, Planning and Commissioning Officer, Joint Commissioning and Performance Management, by:


Telephone: 342 3145


e-mail: denise.buckley@tameside.gov.uk

1. INTRODUCTION

1.1 The purpose of this report is to outline options for re-commissioning short stay/respite provision for adults with a learning disability in the borough following a procurement exercise where both submissions received were non-compliant.

1.2 The report details the background to the changes to the delivery of the service and procurement exercise undertaken, whilst seeking permission to extend the current service contract, under Procurement Standing Orders F1.3, for up to twenty four months as allowed for within the contract.

2. BACKGROUND

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

2.2 The respite/short stay service was originally provided as a Council run service by Adult Social Care staff until 1995 when the service was placed out to tender and has since been delivered by external providers. The service was originally based in hostel accommodation on two sites, and was then transferred as demand increased, to two bungalows provided by registered social landlord, Regenda.

2.3 A Key Decision was approved in August 2012 for the Council to consult on the future provision of respite/short stay services for adults with a learning disability.

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

2.5 The current contract commenced on 1 December 2013 for a period of three years with the option to extend for up to an additional two years. The contract was awarded to Community Integrated Care (CIC).

2.6 At this point, considerable investment was made by the Council to the property following representation from CIC to ensure compliance with Health and Safety requirements and other significant works around building maintenance, repairs, equipment and cosmetic work.

3. CURRENT SITUATION

3.1 The current contract was tendered on the basis of the delivery of a respite service using a domiciliary model of provision. The contract commenced on this basis, but representation was made by the provider CIC who challenged the basis of the contract indicating they believed that the provision should be registered with the Care Quality Commission (CQC) as residential care rather than domiciliary care. CIC approached the CQC to discuss their views and get clarification on the registration of the service.

3.2 This instigated discussions between officers of the Council CQC advisors who have indicated that they feel that the Council's current model of respite care provision is contrary to their regulations for the provision of care and support and have confirmed their view that respite care should be provided in an establishment that has been registered with the CQC to provide such care and support.

3.3 Following legal advice, it was established that if the Council intended to continue to provide respite care then it must change its current model to one that is CQC registered.

3.4 Extensive discussion with CIC and the CQC informed the Executive Board decision of January this year and as a result the service was re-designed to incorporate the necessary registration requirements. Remaining at the current service accommodation at Cumberland Street was not an option as this would not meet registration requirements in terms of room size.

3.5 A procurement exercise was therefore undertaken for the tender of the redesigned service within a registered care home and this commenced April 2016. The service tendered was required to offer accommodation to deliver a service for four beds plus an emergency bed that was a stand-alone facility/build or offer a separate annex within a larger home.

3.6 Although the tender was widely advertised through the Official Journal of the European Union, the very specific requirements regarding registered accommodation meant that the majority of potential suppliers faced particularly tight timescales with respect to assuring the Council that suitable accommodation would be available and ready in time for a 1 October 2016 start.

3.7 Two bids were received:

- The Lakes submitted a tender at a cost of £338,000 per annum (£1,300 per bed per week) with TUPE or £286,000 per annum (£1,100 per bed per week) on a non-TUPE basis. Advice from Legal was that TUPE would apply.

- CIC submitted a bid of £247,822 or £950 per bed per week (TUPE and non-TUPE). Given the nature of the tender however, the bid was deemed non-compliant as it did not include provision of a building base.

3.8 It was clear following subsequent dialogue with The Lakes that costings on their bid were, at £1,100 per week, £51,000 over the available annual budget, prohibitive.

4. OPTIONS APPRAISAL

4.1 The main options moving forward with this service redesign project are:

- Close the service down;
- Continue with the existing service;
- The Council looks to secure investment to design and build a purpose built respite facility
- The Council sources an existing building within the Borough with local Registered Social Landlords
- The Council extends the current contract with CIC for up to two years in line with the contract terms to allow further development in the market for the delivery of the accommodation required.

Service closure

4.2 Evidence from assessment information shows that there is a high demand for this service. Detailed consultation was carried out in 2012 with service users and carers and further consultation carried out in 2015; both indicated that people felt there was a great deal of importance in the need for the continuation of respite services.

4.3 Issues/concerns raised included:

- Carer fatigue and break-down leading to costly permanent care
- Alternative respite/short-say options do not work for families
- Increasing demand over time

4.4 Hence the conclusion that service closure not a viable option.

Continue with the existing provision

4.5 Current provision meets the needs of both individuals and their family/ carer and reduces the risk of carer breakdown which could result in the need for more long term admission to permanent residential care for the individual. The work done over many years to develop respite/short stay care and support has been very successful in meeting service user and carers needs. The service, however, cannot continue to operate in the current building as it will not meet CQC registered standards, or continue with the care and support registered with the Care Quality Commission under Domiciliary Care regulations.

4.6 Based on advice from the CQC and Legal Services, it is concluded that this is not a viable option.

The Council sources an existing building within the borough with a local Registered Social Landlord

4.7 The Council works with a number of local and regional Registered Social Landlords and communication has taken place but in sharing the specification it is clear that there are no suitable buildings available that would meet the CQC care home regulatory requirements. The particular problem is in relation room size as all available housing stock is of a domiciliary nature.

4.8 Based on the absence of a property of the size and specification required being available it is concluded that this is not a viable option.

The Council looks to secure investment to design and build a purpose-built respite facility

4.9 Given the lack of available existing properties that meet the specification in the Borough, the option of designing and building a property has been considered. Under this option, the Council would seek sufficient capital monies that would enable us to work with partners to design and build a new facility. The building would incorporate technologies and adaptations that would meet the needs of the current and future users of this service and meet all CQC registration requirements.

4.10 The real difficulty with this option is the time it will take to actually deliver such an ambitious project; the build time alone, once capital has been secured and permissions to build have been secured, is in the opinion of developers likely to be around twelve months. The difficulty is that the service is currently working outside CQC regulations so a quicker solution to this situation is required.

4.11 Based on the time it would take to deliver a property in this option it is concluded that this is not a viable option at this time.

The Council extends the current contract with CIC for up to two years in-line with the contract terms to allow negotiations with CIC regarding securing a property that would meet the requirements of the service and registration with the CQC

4.12 Commissioners commence negotiations with CIC has per their recent tender submission to fully explore the option of CIC finding and securing a suitable property.

4.13 In the meantime, the CQC have indicated that the current arrangement will suffice whilst alternative, registered accommodation is sourced.

5. RECOMMENDATION

5.1 As stated on the report front-sheet.

This page is intentionally left blank

Report to:	**CARE TEGETHER SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Reporting officer of Single Commissioning Board	Anna Moloney - Consultant Public Health Medicine
Subject:	**COMMISSIONING DATA MANAGEMENT SERVICES**
Report Summary:	Tameside single commissioning unit have been tasked by the Greater Manchester Directors of Public Health to commission the provision of data management services from Arden and Gem CSU on behalf of the ten GM Authorities. Arden and Gem CSU are the local provider of data services for NHS Digital and the holder of local NHS Secondary care Data. A Waiver to Procurement Standing Orders is required to allow direct of award of contract.
Recommendations:	That a waiver is granted under Procurement Standing Order F1.4 to enable the direct award to Arden and Greater East Midlands (AGEM) CSU and NHS Oldham Clinical Commissioning Group for the above services.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Decision of the SCB as the Tameside element of the costs associated with the contract waiver (£3,232.53) will be funded from existing Public Health resources which are within the Section 75 agreement of the Integrated Commissioning Fund. Access to shared data across GM will support future investment decisions to improve the health and wellbeing of the population.
Legal Implications: **(Authorised by the Borough Solicitor)**	The SCB is obliged to follow procurement standing orders which include provision to make a direct award where the SCB requirements the can only be met by a single bidder because competition is absent either for technical reasons or due to the protection of exclusive rights, including intellectual property rights and no reasonable alternative or substitute exists. This provision mirrors Regulation 32 of the Public Contract Regulations 2015 however the Public Contract Regulations 2015 are not engaged as the above contracts are below the relevant threshold. Only Arden and Greater East Midlands (AGEM) CSU and NHS Oldham Clinical Commissioning Group are able to provide these services as a result of their relationship with NHS Digital and being commissioned host of the Greater Manchester Shared Services respectively. It would not be unreasonable in this case to make a direct award under procurement standing order F1.4.
How do proposals align with Health & Wellbeing Strategy?	The service will enable access to NHS secondary care data for Tameside and the rest of Greater Manchester. Analysis of data is required to inform plans to improve local health and social care services.
How do proposals align with	The service will enable access to NHS secondary care data

Locality Plan?	for Tameside and the rest of Greater Manchester. Analysis of data is required to inform plans to improve local health and social care services.
How do proposals align with the Commissioning Strategy?	Allows access to timely raw data for the whole of Greater Manchester that enables analysis and reporting on priorities.
Recommendations / views of the Professional Reference Group:	The Cauldicott Guardian, suggested that a PIA form be completed otherwise it was supported.
Public and Patient Implications:	The service will allow timely analysis of data to inform commissioning decisions and improve service delivery.
Quality Implications:	The service will enable the same access as the CCGs across Greater Manchester enabling bench marking and profiling. It will enable reconciliation that enables data quality checks to happen.
How do the proposals help to reduce health inequalities?	Access to timely data that includes local geographies allows analysis to take place for different groups and areas for bench marking purposes and service development.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Whilst the service will be procured on behalf of the ten greater Manchester authorities, each authority will retain responsibility for information governance and enter into separate data processing agreements with the provider. Access is via secure N3 connection.
Risk Management:	An agreement will be entered into by all participating Local Authorities detailing their responsibilities. The contract with the provider clearly states that Tameside will not be responsible for any IG, data processing or access issues on behalf of the other participating Authorities.
Access to Information :	The background papers relating to this report can be inspected by contacting Jacqui Dorman, Public Health Intelligence Manager:  Telephone: 0161 304 5303  e-mail: jacqui.dorman@tameside.gov.uk

1. BACKGROUND

1.1 The Greater Manchester Public Health Intelligence Network (GMPHIN) represents public health intelligence professionals from all 10 local authorities within the Greater Manchester conurbation. It provides the collective voice of public health intelligence across Greater Manchester and champions and provides evidence of best practice in the use of local data to help inform plans to improve the health of the population and support the Joint Strategic Needs Assessment process. The GMPHIN reports to the Greater Manchester Directors of Public Health Group.

1.2 Public Health intelligence requires access to a range of data across the health and social care economy. One of these sources of data is NHS secondary care data, including hospital admissions, emergency department attendances and outpatient appointments. This data is essential to enable analysis of key public health indicators and the performance of the local health economy.

1.3 NHS secondary care data is managed by NHS Digital (formerly the Health and Social Care Information Centre) regional arms "Data Services for Commissioning Regional Offices" (DSCROs), (previously known as Data Management Integration Centres DMICs) which are hosted within NHS Commissioning Support Units. The host for the North West DSCRO is Arden and Greater East Midlands (AGEM) CSU.

1.4 The GM Directors of Public Health agreed in principal to commission Arden and GEM CSU until 31 March 2019 to provide a Data Management Service that covers access to healthcare datasets with local authority access to the datasets via an SQL platform, including:

- Secondary Uses Service (SUS);
- Payment By Results (PBR);
- Patient Demographics.

1.5 The Greater Manchester Directors of Public Health Group approved a lead commissioner model rather than the previous model consisting of separate contractual agreements. A single contract with a lead commissioner will reduce the overall operational burden on both Local Authorities and the provider with a reduction in contract price, administration costs and a clearer channel of communication for contract monitoring and review purposes.

1.6 Tameside were asked to be lead commissioner for:

- Provision of Data Management Services (Arden and GEM CSU).
- Provision of IM&T Services (GM Shared Services). This is a necessary prerequisite to the Arden and GEM CSU contract and will increase the cost of the Data Management Service for each LA.

1.7 As part of NHS Digital, the DSCRO are required to implement 'patient objections' and remove the details of patients who have 'objected' from any of the national datasets that are provided by the DSCRO (e.g. SUS data), unless there is an exemption in place. CCGs will typically be exempt from this arrangement because a complete set of (pseudonymised) patient level data is needed in order to carry out patient checks, accurately confirm activity and make direct payments to providers for the care received by the patients for which a CCG is responsible.

1.8 Access to data is via a secure N3 connection which is managed by Greater Manchester Shared Services. GMSS is hosted by NHS Oldham Clinical Commissioning Group on behalf of the twelve CCGs in Greater Manchester. Tameside will also commission the additional aspects this service and recharge other Local Authorities.

1.9 Whilst Tameside MBC will contract with Arden and Gem CSU for the data management service on behalf of the participating Authorities, each Authority will have separate data

processing agreement in place such that they will be individually responsible for their own data governance and any data breach.

1.10 A collaboration agreement will be put in place between the participating Authorities detailing responsibilities and obligations including payments and data governance.

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

2.1 Procurement Standing Order F1.4 requires that, where the procurement rules apply, all direct awards are to be approved by the Executive Director, Governance, Resources and Pensions, the Assistant Executive Director, Finance the First Deputy Finance and Performance and the relevant service Executive Member. As this service falls within the integrated funds, this delegated function now rests with the Single Commissioning Board.

3. VALUE OF CONTRACT

3.1 The value of the contract with Arden and GEM CSU for Data management Services will be £27,985 per annum.

3.2 The value of the contract with GM Shared Services will be £6,200 per annum.

3.3 The respective contribution of each Local Authority, including Tameside MBC is detailed below:

Arden and GEM CSU Provision of Data Management Services
Total Annual Contract Value: £27,985.40

GM Shared Services (GMSS) Provision of Information Management and Technology (IM&T)
Total Annual Contract Value: £6,152.45

Total cost of data management and IT services per local authority
2016/17

Local Authority	Service Element				**Total cost 2016/17 (£)**
	Data Management Services (AGEM)			IT Services - Core and non-core	
	SUS	PDS	Total		
Bolton	2110.40	764.60	2,875.00	606.99	**3,481.99**
Bury	2110.40	764.60	2,875.00	663.12	**3,538.12**
Manchester	2110.40	764.60	2,875.00	606.99	**3,481.99**
Oldham	2110.40	764.60	2,875.00	877.49	**3,752.49**
Rochdale	2110.40	764.60	2,875.00	301.40	**3,176.40**
Salford	2110.40	764.60	2,875.00	550.86	**3,425.86**
Stockport	2110.40	764.60	2,875.00	800.32	**3,675.32**
Tameside	2110.40	764.60	2,875.00	357.53	**3,232.53**
Trafford	2110.40	764.60	2,875.00	780.76	**3,655.76**
Wigan	2110.40	0.00	2,110.40	606.99	**2,717.39**
Total	**21,104**	**6,881.40**	**27,985.40**	**6,152.45**	**34,137.85**

4. GROUNDS UPON WHICH WAIVER / AUTHORISATION TO PROCEED SOUGHT

4.1 The requirements can only be met by a single organisation, Arden and GEM CSU, as they hold the data to which access is sought.

4.2 Under Regulation 32 of the Public Contracts Regulations 2015 contracting authorities can use the negotiated procedure without prior publication where services can be supplied only by a particular economic operator where competition is absent for technical reasons or for the protection of exclusive rights, including intellectual property rights. Only Arden and Greater East Midlands (AGEM) CSU and NHS Oldham Clinical Commissioning Group are able to provide these services.

5. STRATEGIC FIT

5.1 Provision of the service will enable the work of the GMPHN.

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

6.1 The joint commissioning arrangements lead by Tameside will reduce the overall operational burden on both Local Authorities and the provider with a reduction in costs and a clearer channel of communication for contract monitoring and review purposes.

6.2 The previous contract arrangements the costs to Tameside for access to data were £7,600, under the proposed joint arrangements the cost will reduce by £4,368 to £3,232.

7. INTEGRATED COMMISSIONING FUND

7.1 As set out at the front of the report**.**

This page is intentionally left blank

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	4 October 2016
Reporting Officer of Single Commissioning Board	Angela Hardman – Director of Public Health
Subject:	**PUBLIC HEALTH ANNUAL REPORT 2015-16**
Report Summary:	The Director of Public Health's Annual Report 2015-16 is themed around Self-Care. The Report emphasises that by focusing on self-care we can help to increase people's confidence to live well, improve their quality of life and improve the patient experience. Together we can create an environment which promotes self-care through healthy lifestyle choices, based on local leadership within communities. We can see a fundamentally different relationship between public services, residents and local communities by working locally to enable people to build their skills and confidence and improve self-care in all its forms.
Recommendations:	Single Commissioning Board are asked to: • Note the recommendations listed in section 3 of the report. • Agree that the report's recommendations and the proposed approach and actions highlighted in the report, be used to inform service development and commissioning of the system wide self-care programme.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Whilst there are no direct financial implications arising from the report, it should be recognised that initiatives to improve the health and wellbeing of residents of the borough will potentially lead to a reduced demand on health and social care services and associated costs incurred. This will therefore contribute towards the delivery of future year efficiency savings alongside reduced resource allocations within the economy. It is essential these initiatives are stringently monitored to ensure efficiencies are realised.
Legal Implications: **(Authorised by the Borough Solicitor)**	The publication of this report fulfils a statutory requirement of Tameside's Director of Public Health and sets out an approach to meet our Health and Wellbeing Strategy.
How do proposals align with Health & Wellbeing Strategy?	This Public Health Annual Report is relevant to all aspects of the Health and Wellbeing Strategy. In particular the recommendations align to the principles of the Health and wellbeing Strategy: • Focusing on prevention and early help; • Working together to tackle inequalities; • Integration;

	• Value community assets. All actions by the public, private and voluntary sectors should build on the strengths, support, skills and knowledge already in communities, be responsive to the priorities of local communities, accountable to them and involve them in planning and development.
How do proposals align with Locality Plan?	The locality plan is built on values that support people with long term conditions or on-going care needs, and their carers, to self-care more effectively and engage proactively in their own health and care. Enabling self-care: improving skills, knowledge and confidence of people with long-term conditions or with on-going support needs to self-care and self-manage, is one of the six transformation programmes outlined in the plan.
How do proposals align with the Commissioning Strategy?	The Commissioning Strategy aims to increase community resilience and support communities to use their own assets (skills, strengths and resources) to tackle the issues that affect their lives. The Report concludes that through self-care we can realise these bold ambitions of the Tameside and Glossop 'Care Together' Programme: - "We aim to raise healthy life expectancy to the North West average within five years." - "We then will continue to drive our ambition to achieve the England average within the subsequent five years."
Recommendations / views of the Professional Reference Group:	Not been presented to PRG.
Public and Patient Implications:	Self-care will build skills, knowledge and confidence to self-manage conditions, building individual and population resilience. Local people have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health.
Quality Implications:	A focus on self-care will provide opportunities for improving quality through the provision of information and support that empowers service users and drives quality improvement.
How do the proposals help to reduce health inequalities?	Action on the wider determinants of health requires joint approaches across public, private and voluntary sectors and with resident themselves in order to fully address the causes of poor health and wellbeing.
What are the Equality and Diversity implications?	The report does not have any policy implications for equality and diversity.
What are the safeguarding implications?	The report does not have any policy implications for safeguarding.

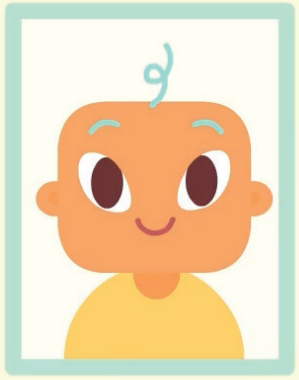
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The report does not have any policy implications for information governance or privacy.
Risk Management:	The Annual Report of the Director of Public Health is being presented to Board for their information.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant in Public Health Medicine, by:  Telephone: 0161 342 4251  e-mail: gideon.smith@tameside.gov.uk

This page is intentionally left blank

SELF-CARE FOR LIFE

ANNUAL REPORT FROM THE DIRECTOR OF PUBLIC HEALTH FOR TAMESIDE 2015-16

CONTENTS



FOREWORD

Angela Hardman
Director of Public Health, Tameside Council

Welcome to my third annual report as Director of Public Health in Tameside. This year's report brings an important focus on self-care.

Self-care is everybody's business. It's about creating a culture where we work together to be the best that we can. That's not just about self-care for us as individuals, it's also about self-care in our families and communities and in our health and care services.

By giving people and communities the power and control to make good choices, to look after themselves and their families and use the right services at the right time, we can start to make a real difference to health and well-being.

My hope is that by focusing on self care we can help to increase people's confidence to live well and improve the quality of their life. The report shares examples of the great work already in place to support people to be the best they can and shows where real opportunities exist to embed self care into all that we do.

Together we can create an environment which promotes self-care through healthy lifestyle choices, based on local leadership within communities.

We can see a fundamentally different relationship between public services, residents and local communities by working locally to enable people to build their skills and confidence and improve self-care in all its forms.

My ask of you in reading this report, is that you take the opportunity to reflect and consider self care firstly from your own personal perspective and secondly, in terms of how you can champion self care to others - members of your family, friends, neighbours, work colleagues; and if you are in a position to influence self care in your business endeavours how you can take this forward. Myself and my team would be more than happy to explore ideas and opportunities to encourage self care across the workforce and wider community.

Thank you to everyone involved in planning and delivering self care.

SELF-CARE SUPPORTING EACH OTHER TO GOOD HEALTH AND WELLBEING.

EXECUTIVE SUMMARY

A lot of people in Tameside get sick earlier in life than in other places in the UK, and some of us will die younger than we should. The picture is similar across Greater Manchester. This is unfair and we want to change it. Self-care is one of the ways we can do that.

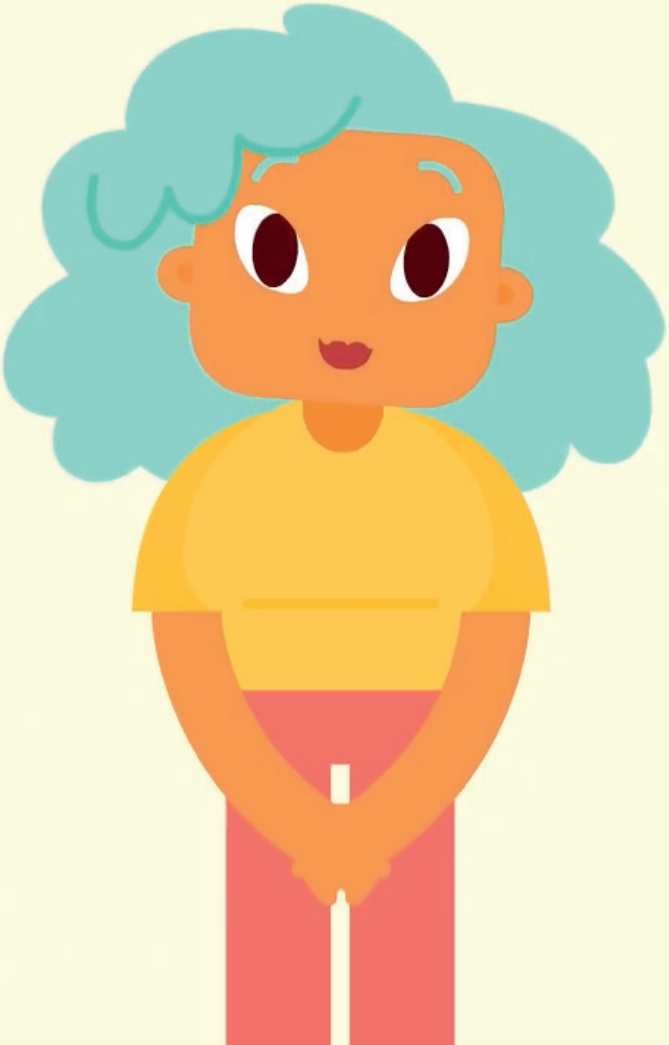
Self-care is the key to better health. By focusing on self-care, we can increase people's confidence to live well and improve their quality of life and experiences.

Most of the time, most of us are able to take care of ourselves and our families. From the start of life through our working years and into old age, we use our skills and knowledge to maintain good health, prevent illness and manage long-term conditions.

Self-care focuses on the things that matter to us, like being independent or staying in work, as well as clinical issues. It is also about being empowered to make changes in our lives, and be in control of our health. When we take care of ourselves, we understand better our strengths and abilities, and that enables us to reach our goals and stay healthy and well.

The more of us who take charge of our health early, the fewer of us will need 'big help' later in life, like an unplanned operation or long-term medication. That's good news for individuals, families and health services.

Our health and social care services are under a lot of pressure. People are living longer, but often with more health problems, and there is less money to spend on services. Focusing on self-care means that over time, the money saved when people stay well, rather than becoming ill, can be spent elsewhere.



The key to a healthier Tameside is to get as many people feeling confident to manage their own health as possible. We want people in our communities to know how to look after their body and mind, and to know the people and places that can support them to be happy and healthy for life.

We are going to do that by making the most of the changes happening through the Tameside & Glossop Care Together programme and Greater Manchester Devolution. We have developed a new model of care, that will champion self-care as an integral part of all our lives.

We will change the relationship between people and their health, and between people and health and care services, by using an asset based approach. This means helping people and communities to develop resilience and become more capable of looking after themselves.

The focus is on preventing ill health, rather than treating illness. That means looking at mental as well as physical health, and managing long-term conditions as well as promoting healthy lifestyles.

Changing our focus is going to mean a fundamental shift in our thinking; blending evidence-based public health approaches and interventions, developing our staff and adopting place-based community approaches. We need to provide a range of options that can respond flexibly to the needs of different people, in different places, at different stages of life.

We have some bold ambitions for the Tameside and Glossop 'Care Together' Programme. We want to raise healthy life expectancy to the North West average within five years. In the subsequent five years we aim to reach the average England life expectancy.

PROMOTING SELF-CARE IS AT THE HEART OF THIS AMBITION

RECOMMENDATIONS

We already focus on self-care, but we want, and need, to do more.

An important part of our Care Together Programme is about changing the relationship between individuals and their health, and between people and their health and care services. Our recommendations for future work centre around this. To begin this work in earnest, there are two important foundations to lay down. Firstly, using asset based approaches, which identify and utilise the strengths, skills, capacities and resources which individuals and communities have. Secondly, we must do more to involve residents, co-producing our services with the people who use them.

Changing relationships between people and their health, and between people and services, will also mean:

1. Developing the skills, knowledge and confidence that individuals need in self-care.

Our focus should be on:

- providing local self-management programmes for people with long-term health conditions.
- developing a Patient Activation Measure (PAM) based evaluation and research programme, which will encourage people to become more engaged in their health and wellbeing.

2. Creating effective peer support and building strong and resilient communities.

Through Care Together we will continue to develop:

- A broad wellbeing service, which focuses on mental as well as physical health.
- Asset-based approaches.
- Social prescribing and risk stratification; identifying and supporting those who use services most, or are likely to use services a lot in future.
- 'Good work' programmes that support employers and employees to promote and adopt healthier lifestyles and better self-care.
- A 'find and treat' programme to find people with serious but unidentified health problems.

You can read more about these approaches, and how they are working in Tameside, in Chapter 3 of the report.

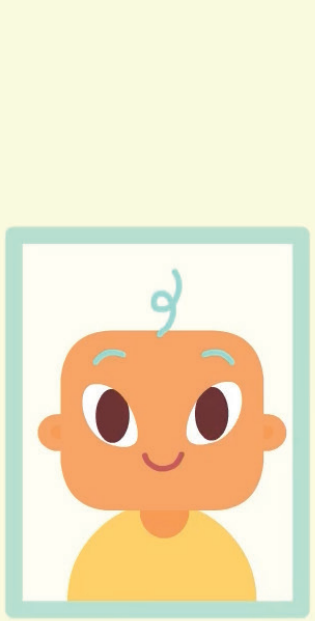
3. Creating a skilled and knowledgeable workforce both now and in the future, so that self-care becomes a golden thread running throughout all our prevention, treatment and care services.

CALL TO ACTION

Self-care is at the heart of what we do. Across Tameside, organisations are already working together to deliver effective self-care programmes and strategies. Tameside residents are playing their part too, embracing self-management and prevention and adopting healthier lifestyles.

But we want to do more. We all have a responsibility to take care of ourselves and our communities.

- We want to build on our success so far, expanding and improving what we do to reach more people.
- We want to create a social movement for behaviour change, self-care and self-management, where we fundamentally change the relationship between people and health and social care services.
- We want to build strong and resilient communities, where people are well supported and motivated to make lifelong changes to their health and wellbeing.
- We want to increase the life expectancy of people in Tameside, and create fair and responsive services that drive progress and improve both quality of life and health.



1 CHAPTER 1: ABOUT SELF-CARE

"Self-care is a deliberate action that individuals, family members and the community should engage in to maintain good health. Ability to perform self-care varies according to many social determinants and health conditions"

World Health Organisation

Although we might sometimes use health services, such as our GP or local hospital, most of the time, most of us are able to take care of ourselves and our families. We clean our teeth, we treat coughs and colds with medicines from the pharmacy, take regular exercise, choose healthy eating options and we ensure we get enough sleep. This is called self-care, and it's by far the best way to stay healthy, prevent illness and live a long life.

Self-care is about individuals, family members and their communities doing all the things that help us to maintain good health. The services we use can help too; by providing us with good information, by encouraging and motivating us and by making it as easy as possible to choose the healthy options. Self-care is a life-long activity, because we look after ourselves and our families from the start of life, through our working years, right into old age.

Whether you're able to look after yourself in this way, and how well you're able to it, is affected by many things. These include where you're born, whether you have a job or are disabled, and even whether you are managing long-term health problems.

This is what else we know about self-care:

- **There is a lot of it happening already**. In fact, around 80% of all health care is self-care.
- **Most of us are already doing it.** Most of the time, people manage their own health and wellbeing, rather than seeing a health professional or using a health service. Most of us feel comfortable managing everyday minor illnesses like coughs and colds; particularly when we're confident about the symptoms and treatments.
- **It focuses on the things that matter to us,** like being independent or staying in work, as well as clinical issues.
- **It's about empowering people to make changes in their lives,** and to be in control of their health. When we take care of ourselves, we understand better our strengths and abilities, and that enables us to reach our goals and stay healthy and well.

THE BEST PERSON TO LOOK AFTER OUR HEALTH IS US

There are four main features of self-care:

1. **Regulatory self-care** is about the basic things we do, like making sure we eat well and get enough sleep.

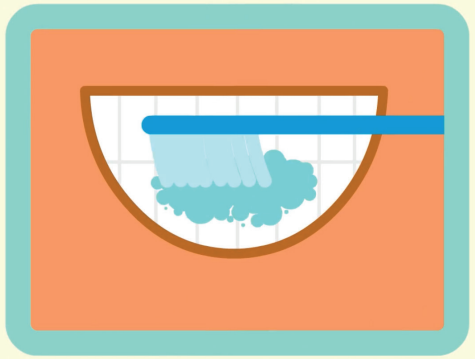
2. **Preventative self-care** is stopping health problems before they start, like our brushing teeth to prevent decay, or being active to build our strength.

3. **Reactive self-care** is about taking care of ourselves when we get sick, for example, buying cough medicine from the chemist or visiting NHS Choices to look for health information.

4. **Restorative self-care** means managing any long-term health problems so that we stay well, like taking medications as prescribed, or quitting smoking.

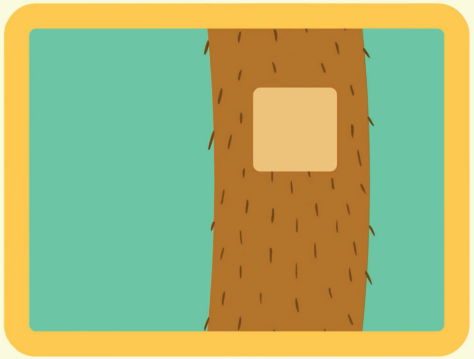
You can find out more about what we're doing in Tameside in these four areas on page 26 of the report.

REGULATORY



PREVENTATIVE

REACTIVE



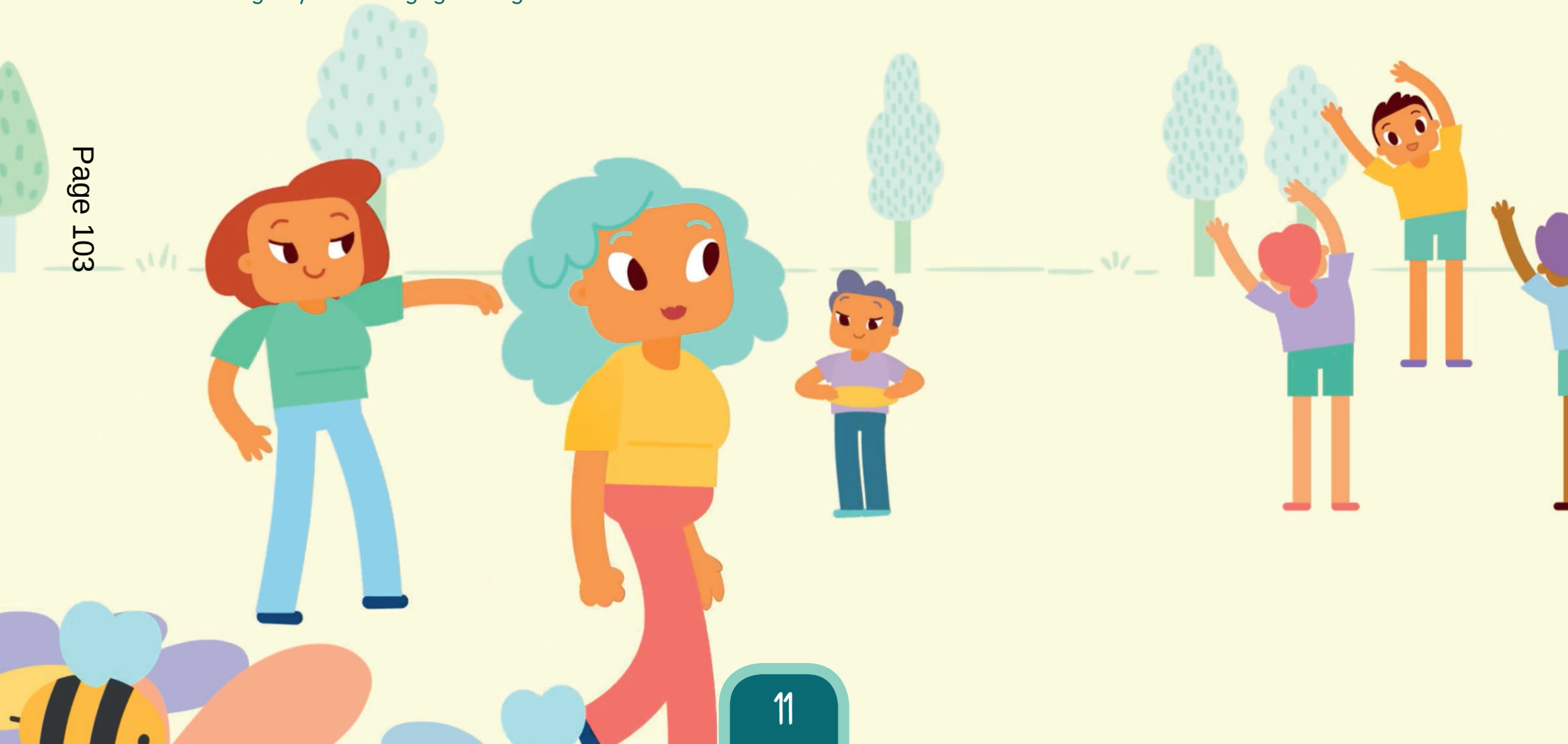
RESTORATIVE

WHY IS SELF-CARE SO IMPORTANT?

The more of us who take charge of our health early, the fewer of us will need 'big help' later in life, like an unplanned operation or long-term medication. That's good news for individuals, families and health services.

Self-care can lead to better health and a better quality of life. So, for example, good self-care by taking medicines correctly can mean long-term conditions like asthma are better controlled. That in turn means fewer visits to accident and emergency when things go wrong.

Our health and social care services are under a lot of pressure. People are living longer, but often with more health problems, and there is less money to spend on health services. Focusing on self-care means that over time, the money saved when people stay well, rather than becoming ill, can be spent elsewhere. This means more money to spend on new medicines and technology, and improving the experience for those who have to be in hospital or care.



2 CHAPTER 2: REALISING OUR AMBITION - EXPANDING SELF-CARE THROUGH DEVOLUTION AND INTEGRATION

A lot of people in Tameside get sick earlier in life than in other places in the UK, and some of us will die younger than we should. The picture is similar across Greater Manchester. That isn't fair, and we want to change that. Self-care is one of the ways we can to do it.

The key to a healthier Tameside is to get as many people feeling confident to manage their own health as possible. We want you to be know how to look after your body and mind, and to know the people and places within your community that can support you to be happy and healthy for life.

Our mission is to make a trip to the GP something you rarely have to do, and a stay in hospital even rarer.

How are we going to do that? By making the most of change.

Tameside is going through a significant and wide-ranging restructure of services and organisations. So, now is a great time to make changes. Decisions about our health and care can now be made in a different way, through the Care Together programme and Greater Manchester Devolution.

"We believe everyone living in Tameside and Glossop should be supported to live a long, healthy and fulfilling life. We are committed to changing the way we organise, provide and fund public services to ensure we achieve this aim." Also, "Our ambition for the public sector across Tameside and Glossop is bold. We aim to raise healthy life expectancy to the North West average within five years. By 2020, a male in Tameside and Glossop can expect to have an additional 3.3 years of healthy life expectancy and women an additional 3.2 years. We then will continue to drive our ambition to achieve the England average within the subsequent five years."

A Place-Based Approach to Better Prosperity, Health and Wellbeing: Tameside and Glossop Locality Plan, November 2015

TAMESIDE AND GLOSSOP CARE TOGETHER PROGRAMME

This programme is bringing about integrated health and social care. That means bringing together hospital and community care, as well as health and social care. By doing this, we have an opportunity to change the way health services are delivered and encourage self-care by bringing health and well-being into homes and communities.

Our focus is on:

- Empowering individuals to stay healthy, by giving individuals confidence and skills.
- Providing self-care courses for people diagnosed with a long-term condition.
- Giving individuals the right information and support to manage their own health and seek the best help when needed.
- Developing effective community leadership, which promotes a 'bottom up' approach to encouraging us to make healthy lifestyle choices.
- Building strong communities, led and influenced by their members.
- Creating a website that Tameside residents can use to find information about health and wellbeing services in their local area.

More broadly, we are changing the way we plan and deliver services. We will:

- Use an asset based approach. This means helping people and communities to develop resilience and become more capable of looking after themselves.
- Build and support a thriving voluntary, community and faith sector.
- Put co-production with service users at the heart of developing services.
- Change the way we commission services, for example by using the Joint Strategic Needs Assessments (JSNA) to underpin our decisions.
- Train and develop the skills of our staff so that they can support self-care.

We will use risk stratification to identify people who are high intensity users of health and social care services, or who have the potential to have high level needs in future. This will enable us to improve quality of life by effectively targeting our services, and supporting people to manage their conditions better through self-care.

THE HEALTHY LIVES WORK STREAM

The Healthy Lives work stream is part of the Care Together strategy. It aims to improve healthy life expectancy for the people of Tameside and Glossop, by working across all health and social care organisations and services to embed preventative thinking and practice.

The focus is on preventing ill health, rather than treating illness. That means looking at mental as well as physical health, and managing long-term conditions as well as promoting healthy lifestyles.

Changing our focus is going to mean a fundamental shift in our thinking; blending evidence-based public health approaches and interventions, developing our staff and adopting place-based community approaches. We need to provide a range of options that can respond flexibly to the needs of different people, in different places, at different stages of life.

As part of this work we can look for opportunities to encourage self-care and prevent ill health in all of our contacts with individuals and their families. We will create prevention pathways and link these to existing care pathways. As and when new models of care develop, prevention will be built into these new care pathways too.

We are exploring the use of social prescribing, which links people with health problems with non-medical support and services in their community. Last year, Tameside and Glossop CCG funded a pilot project of social prescribing involving 8 GP practices. The project had a significant impact on those who took part, with almost half saying they felt safer and more positive as a result, and a quarter feeling more able to look after themselves. It was so well received, that we will be extending it out to neighbourhood teams.

If we are going to provide services differently, then communities need to grow and develop at the same time. We will ensure that local communities are supported and nurtured by:

- increasing and improving the participation of local people in shaping their services
- developing new peer support mechanisms, focused on managing long-term conditions
- creating resources to help people self-care
- addressing low health literacy.

GREATER MANCHESTER DEVOLUTION

As well as changes to local health and social care services, devolution across Greater Manchester also creates opportunities for us to work together and innovate.

The Greater Manchester Health and Social Care Devolution Strategy 'Taking charge of our health and social care in Greater Manchester' includes a commitment to upgrade prevention and self-care.

As with the changes happening in Tameside, the strategy is proposing to change the way you, the people of Greater Manchester, view and use public services; creating a new relationship between people and the care system. Part of this vision will see the development of population wide Find and Treat programmes aimed at finding the 'missing thousands' who have diseases, but don't yet know it.

Other elements of the strategy include:

- Working with Health Innovation Manchester to develop digital technologies that allow people to track and analyse their own health data and to share this with others. This can help people to manage long-term conditions and stay healthy and well.

- Social marketing programmes. These use insights into people's behaviour to engage them to become active participants their own and others' health.

- Developing a Greater Manchester framework for 'patient activation' - motivating people to take control of their health and supporting work places to tackle health inequalities.

- Increasing the range and profile of self-care support programmes, and training our staff to deliver them.

- Working with Health Education England to give our public sector staff more skills in self-management education, shared decision making, health coaching and patient activation.

"60-70% of premature deaths are caused by behaviours that could be changed, and around 70-80% of all people with long-term conditions can be supported to manage their own condition."

Taking charge of our health and social care in Greater Manchester

3 CHAPTER 3: SELF-CARE PROGRAMMES AND INTERVENTIONS IN TAMESIDE

There is a great deal of self-care already happening in Tameside. This part of the report highlights some of the amazing work being led by Public Health, working collaboratively with partners, community groups, local agencies and organisations.

A SELF-CARE AT INDIVIDUAL, FAMILY, GROUP, COMMUNITY AND SERVICE LEVEL

INDIVIDUAL SELF-CARE: ONE YOU

By the time we reach our 40s and 50s, many of us will have dramatically increased our chances of becoming ill later in life. Whether we are eating the wrong things, drinking too much alcohol, smoking or not being active enough, all of these small things can add up. Making better choices now can have a huge influence on our health; it could prevent diseases such as type 2 diabetes and it could help us to stay independent in later life.

'One You', is the first nationwide campaign aimed at preventing health problems in adults. Set up by Public Health England, the campaign encourages adults, particularly those in middle age, to take control of their health by supporting them to make simple changes.

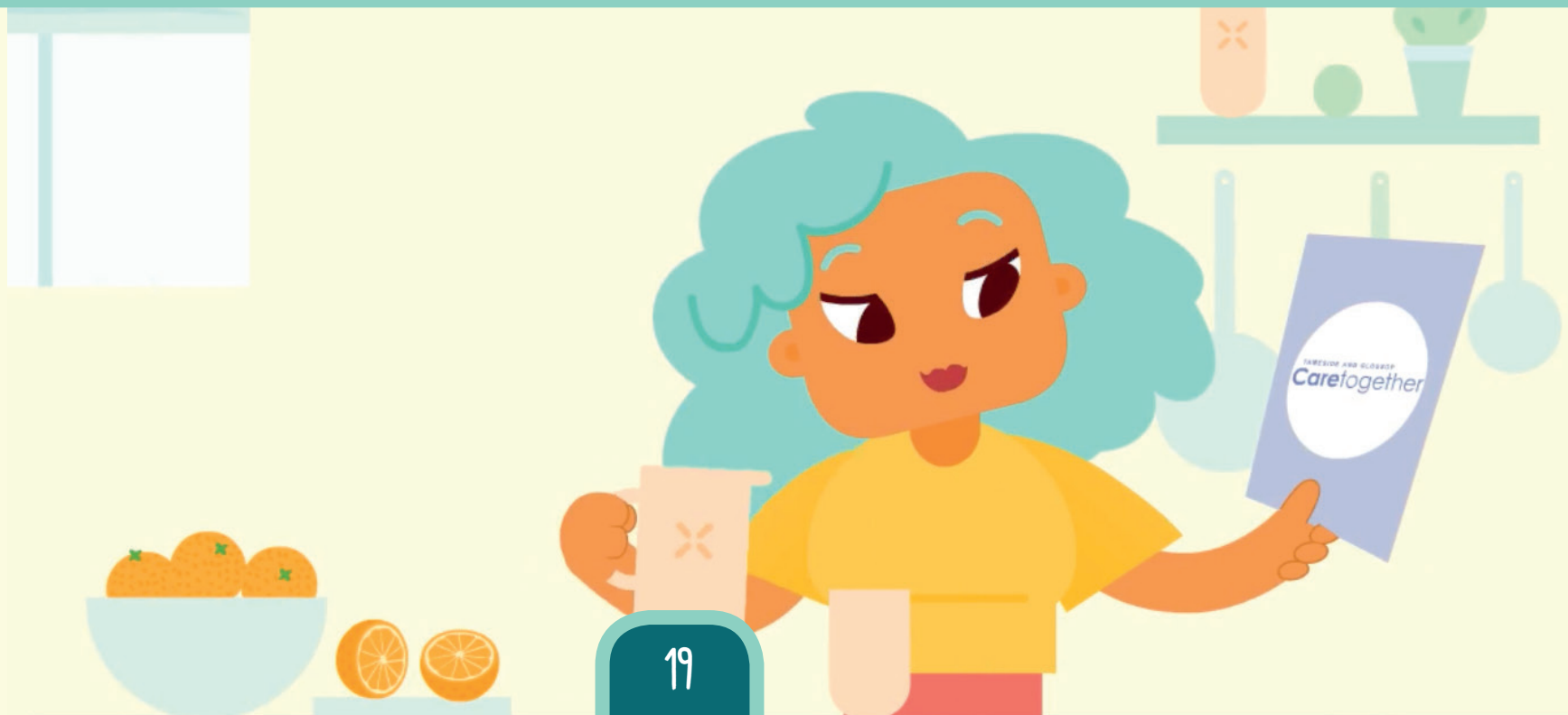
One You provides tools, support and encouragement, to help adults to move more, eat well, drink less and be smoke free. One You also provides information on how people can reduce their stress levels and sleep better. In Tameside Be Well Tameside, Active Tameside, Tameside and Glossop CCG, Tameside Council and Tameside Hospital all promote the 'One You' initiative.

www.nhs.uk/oneyou

CASE STUDY: ONE YOU IN TAMESIDE

One You was launched at our popular Grafton Centre in Hyde. We ran sessions for their middle-aged membership, including an aerobics class and an outdoor walk in a local park, while a team of health professionals held a small marketplace in the community centre's bistro. Representatives from our local sports trust, Active Tameside, were on hand to talk about physical activity and the programme for people with long-term conditions. Our 'Be Well' Service did blood pressure checks, and offered advice on maintaining a healthy weight and stopping smoking. Staff from our local alcohol service were also on hand to talk about sensible drinking.

Following on from this successful local launch, Be Well Tameside, Active Tameside, Tameside and Glossop CCG, Tameside Council and Tameside Hospital will all be promoting 'One You' as an effective tool for local people to use to take control of their health.



INDIVIDUAL SELF-CARE: SELF-CARE WEEK

Self-care week is a national campaign that runs every November and focuses on embedding support for self-care across communities, families and generations. The campaign is run by the Self Care Forum, a group of organisations dedicated to embedding self-care into everyday life. They include the NHS Alliance, Royal College of Nursing, National Association of Primary Care, National Association of Patient Participation and the Proprietary Association of Great Britain (PAGB).

In 2015, Self-Care week focused on the broad topic of 'Self Care for Life'.

In Tameside, we supported and promoted the campaign through our social media, websites and services. Haughton Thornley Patient Participation Group held an event to highlight medication passports, and there was also an open introduction to the local self management course programme for people with long term health conditions held in Ashton Library.

By engaging health and social care providers, community organisations and individuals locally and across the country, Self-Care Week is making an important contribution to enabling a self-care culture in families and communities.

www.england.nhs.uk/2015/09/self-care-week/

FAMILY SELF-CARE: EARLY YEARS NEW DELIVERY MODEL

Our vision is that all children and young people in the borough are happy, safe and healthy, inspired and enabled to succeed and ready to learn at school and beyond.

Sadly, inequalities in learning can start early, with the gap between those from deprived and less deprived homes opening up in the first two years of a child's life. So, early help and early intervention is vital in preventing poor health, social, emotional and educational outcomes.

We want every child to achieve their full potential. In Tameside we are creating high quality, child focused services that target those most in need.

We are working to train our early years staff and develop their skills. Our early years services will be integrated and delivered by health, education, social care, private and voluntary service partnerships.

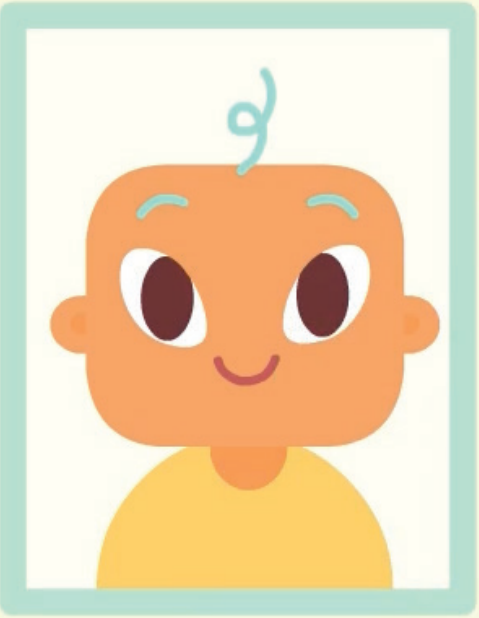
Joined-up services make it easier to provide the right information and support at the right time. That in turn helps parents and carers feel confident, competent, well-informed and secure in their role. By doing that, we enable children to thrive in an environment where they are encouraged and supported to reach their potential.

- The Health Visiting Service delivers the full Healthy Child Programme (HCP) to every child (0 to 5 years) and their family in Tameside, supporting self-care.

- The Tameside 'Babies Can't Wait' agreement means that all pregnant women or those with children under the age of two years and their partners can access the adult Healthy Minds service directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health.

- Parenting courses for families with children aged 0-5 are focused on relationship building between parent/carer and child, enabling parents to support and care effectively. We utilise the Solihull Approach and Solihull Parenting course to meet the needs of our families. A further parenting course called Mellow Parenting is now being introduced specifically to support parents and children with a higher level of need.

- A network of partners and organisations in Tameside are working hard to support new and expecting mother to initiate breastfeeding, and to keep it up for as long as possible.



PEER GROUP SELF-CARE: YOUTH FORUM: L.G.B.T. OUTLOUD TAMESIDE YOUTH SERVICE

If you're misunderstood or stigmatised, it can affect your confidence and self-esteem, and this can stop you getting the support you need. If you feel like this, you're also much less likely to take care of yourself.

If you're young and lesbian, gay, bisexual or transgender (LGBT) then you're also more likely to be depressed or anxious. This can lead young people to consider suicide or to self-harm.

To provide some much needed support, Tameside Youth Service set up and are running a project called L.G.B.T OUTLOUD, which creates a safe, friendly and confidential environment for young people. It's a place where they can meet new friends, be themselves, get involved in projects, get support and advice, and most importantly have fun.

www.tameside.gov.uk/youthservices/boroughwideactivities

CASE STUDY: ADAM

Adam [not his real name] is 14 years old, struggling with his sexuality and gender identity and suffering severe bullying at school. He feels isolated, worthless, alone and in desperate need of love and affection. He can't find support at school and his one friend isn't welcome in his home.

Adam decides to look for friends online, and he soon connects with lots of people who he talks to about his inner self and feelings. He arranges to meet one of his new friends in Manchester, but they turn out not to be who they say they are. Adam ends up being sexually assaulted.

A year on from that, Adam regularly attends the LGBT OUTLOUD support group. His confidence has grown and he is rebuilding his self-respect. He has settled well at college, he no longer puts himself in such risky situations and he has developed healthy relationships with friends his own age.

COMMUNITY SELF-CARE: ASSET BASED COMMUNITY DEVELOPMENT

Traditionally, health and social care have used a deficit model approach to planning services. This means we have focused on problems and how to fix them. This can lead to a 'top down', professional led approach, which doesn't always encourage or enable people to look after themselves.

An asset based approach does the opposite. It focuses on the strengths, skills, capacities and resources which individuals and communities have, and how these can enhance their capability and capacity to sustain health and wellbeing. By using this approach, we can bring about effective and sustainable improvements in mental and physical wellbeing.

Over the past eighteen months, we have been working in partnership with neighbourhood services and Community and Voluntary Action Tameside (CVAT) on an Asset Based Community Development (ABCD) programme.

These are some of the partnership's achievements:

- Collating good practice to help us deliver an ABCD programme in Tameside.
- Establishing a network for community development practitioners, including volunteers, working directly with local people and groups.
- Delivering ABCD Training for managers and front-line staff.
- Engaging community members in deciding how to spend part of a public budget.
- Researching how best to identify changes in community resilience and social value and developing an evaluation framework.

The concepts that underpin all of our work are:

- Voice and control. This means shifting power and enabling participation at an individual and collective level.
- Making health and access to services fairer and reducing avoidable inequalities.
- Social connectedness, which is leading to healthier and more cohesive communities.

COMMUNITY SELF-CARE: TIME TO CHANGE

One in four of us will be affected by mental illness in any year. The effects are as real as a broken arm, even though there isn't a sling or plaster cast to show for it. Yet mental illness is still surrounded by prejudice, ignorance and fear. The attitudes people have towards those of us with mental health problems can mean it is harder for them to work, make friends and in short, live a normal life. Nine out of ten people with mental health problems say that stigma and discrimination has a negative effect on their lives.

Time to Change is a national campaign run by Mind and Rethink Mental Illness, which aims to end the stigma and discrimination faced by people who experience mental health problems.

The campaign is working with organisations, young people and African and Caribbean communities; to set up a network of grassroots activists combating discrimination and is running a pilot scheme working with mental health professionals and attitudes towards mental health.

Residents, community groups, schools and other organisations in Tameside are making a difference, by giving pledges about mental health and stigma.

Reducing stigma makes a key contribution to enabling the confidence and skills for self-care.

Residents, community groups, schools and other organisations in Tameside are making a difference, by giving pledges about mental health and stigma. Nearly 100,000 people across the country have made a pledge to date.

You can do this at: **www.time-to-change.org.uk**

time to change

let's end mental health discrimination

SELF-CARE WITHIN SERVICES: MAKING EVERY CONTACT COUNT

Making Every Contact Count (MECC) is a national initiative, which is also running in Tameside.

MECC is about making the best of every opportunity we have to raise the issue of healthy lifestyles, by talking to people about their lifestyle choices and offering appropriate information or support. The aim is to improve lifestyles and reduce inequalities in health.

MECC offers lifestyle advice and support around alcohol, healthy eating, physical activity, smoking and mental wellbeing. This kind of approach can be a challenge though. Some people have difficult and complex lives, and finding space to talk about and makes changes to lifestyle can be hard. Our staff also need to have the right training and support.

In Tameside, the Council, hospital, primary care, community health and third sector providers and volunteers all provide MECC advice. Health and Wellbeing Board partners signed up to a MECC Pledge in 2013, and the programme has been building year on year since, with over 30 local organisations now involved.

CASE STUDY: SARAH

Sarah (not her real name) had been homeless in the North of England after escaping domestic violence in 2011. On returning to the Tameside area, she was assessed and supported by Foundation, and other various agencies, to help her deal with alcohol and drug addiction. This support was at a high level of intervention and Sarah needed on-going support.

Throughout her support for drug and alcohol addiction, the Foundation staff continued to see Sarah as someone who would benefit from general information about healthy living.

By taking a holistic attitude and putting into practice the MECC approach, Foundation have been successful in supporting Sarah to begin to turn her life around for the better – she has successfully completed detox and is now engaging well in a rehabilitation program. MECC is a stepping stone on the road to helping people to consider their own lifestyles, and the risks they may be taking.

www.foundationuk.org

B THE FOUR ASPECTS OF SELF-CARE

REGULATORY OR BASIC SELF-CARE: FIVE WAYS TO WELLBEING

The Five Ways to Wellbeing are a set of simple actions that people can do to improve their health and wellbeing. In Tameside, our health organisations, schools and community projects are using them to help people take action to improve their wellbeing.

These are the Five Ways:

Connect	Feeling close to, and valued by, other people is important to all of us. Social relationships are essential for our wellbeing, and act as a buffer against physical and mental ill health for people of all ages.
Be active	Being active regularly is linked with lower rates of depression and anxiety for all of us.
Take notice	Reminding ourselves to 'take notice' can strengthen and broaden awareness. Being aware of what is taking place in the present directly improves our wellbeing, and savoring 'the moment' can allow us to make positive choices based on our own values and motivations.
Keep Learning	Learning through life boosts self-esteem and encourages our social interaction and a more active life.
Give	Giving and participating with others makes us feel happy, which is good for our health. The smallest act of 'giving' can count; even giving a smile to someone can make a big difference.

In Tameside, our local organisations and services have been supporting people and communities to embrace the five ways to wellbeing:

- Action Together offer volunteering opportunities, and help people teach their skills to others. For example, they manage the Volunteer Centre Tameside on Penny Meadow in Ashton that promotes volunteering opportunities, recruits and places volunteers and supports organisations that would like to involve volunteers in their work.

- Tameside, Oldham and Glossop Mind have been helping people to connect, feel less isolated and learn mindfulness. For example: volunteers can get active in the kitchen garden that provides produce for the café and helps to connect with others; or learn new skills to maintain resilience and/or learn how to teach others to do the same.

- Tameside Metropolitan Borough Council and community groups run a wide range of sports and activities for all ages, and for all abilities. For example:
  - led walks in the borough, whether it is a 30 minute walk and talk, a health walk which could last up to 90 minutes or a longer walk with the Tameside ramblers.
  - learn to run with 'couch to 5k', either through the NHS website or with Active Tameside and then take part in the weekly Parkrun at Stamford Park.
  - Tai Chi or walking football session.
  - for the currently inactive who also suffer from a long term condition, the live Active Service designed to get active safely.
  - For more information on all these activities go to **livewelltameside.com.**

PREVENTATIVE SELF-CARE: TURNING THE CURVE

Some health problems in Tameside are going in the wrong direction; the number of people with them is going up, rather than down. So, we want to 'turn the curve' on these problems.

Tameside Health and Wellbeing Board identified three priorities that will have the biggest impact on local health inequalities;

- reducing smoking
- increasing physical activity
- controlling high blood pressure.

SMOKING

Around one in four Tameside adults smoke. This is significantly higher than the national rate of just under one in five (19.5%). We also have the highest rate of smoking in pregnancy in Greater Manchester.

Tameside Tobacco Strategy is delivered via the Tameside Tobacco Alliance partnership. Our partnership is made up of staff from Public Health, Tameside Metropolitan Borough Council, Community for Voluntary Action Tameside, Pennine Care NHS Foundation Trust, Stockport NHS Foundation Trust, NHS Tameside and Glossop Clinical Commissioning Group and Greater Manchester Fire and Rescue Service.

Over the last year, Tameside residents have been able to access services and support to stop smoking in a number of ways, including:

- A local Stop Smoking Service and enhanced services available at pharmacies and GP surgeries
- Smoking cessation support in workplace.
- A 'Stop Smoking in Pregnancy' midwife.
- A smoke free playground campaign.

Every year, the number of people who smoke in Tameside goes down. Compared to the rest of England, we are seeing faster reductions in the number of women smoking in pregnancy and the overall percentage of people smoking.

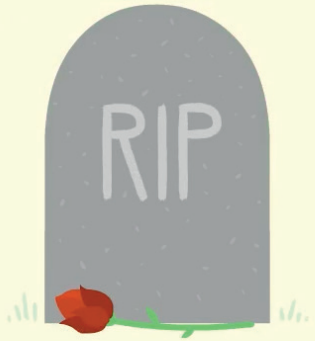
We also run a national campaign in our local area, called 7 Steps Out.

The campaign focuses on second-hand smoke, and the harm it causes to babies and children when adults smoke indoors. The campaign encourages parents, grandparents and carers to 'Take 7 Steps Out' right outside the home before smoking.

For more information about 7 Steps Out, please visit -

www.take7stepsout.co.uk/

Or if you would like support to quit smoking, please call the Health and Wellbeing Service on 0161 716 2000



PHYSICAL INACTIVITY

Here in Tameside we have one of the worst levels of physical activity in the country. In fact, about one third of us is inactive. That lack of activity has a high cost; in terms of individual health and wellbeing, as well as the cost to health services and society generally.

Across Tameside there is a now a Physical Activity Strategy, which is focused on reducing the number of people who are physically inactive.

We want to be better than the national activity average by 2020. It is an ambitious target.

But by working together and by offering a range of different approaches, we are confident that we can increase healthy life expectancy, reduce health inequalities and improve overall quality of life in Tameside.

"If exercise were a pill, it would be one of the most cost-effective drugs ever invented"

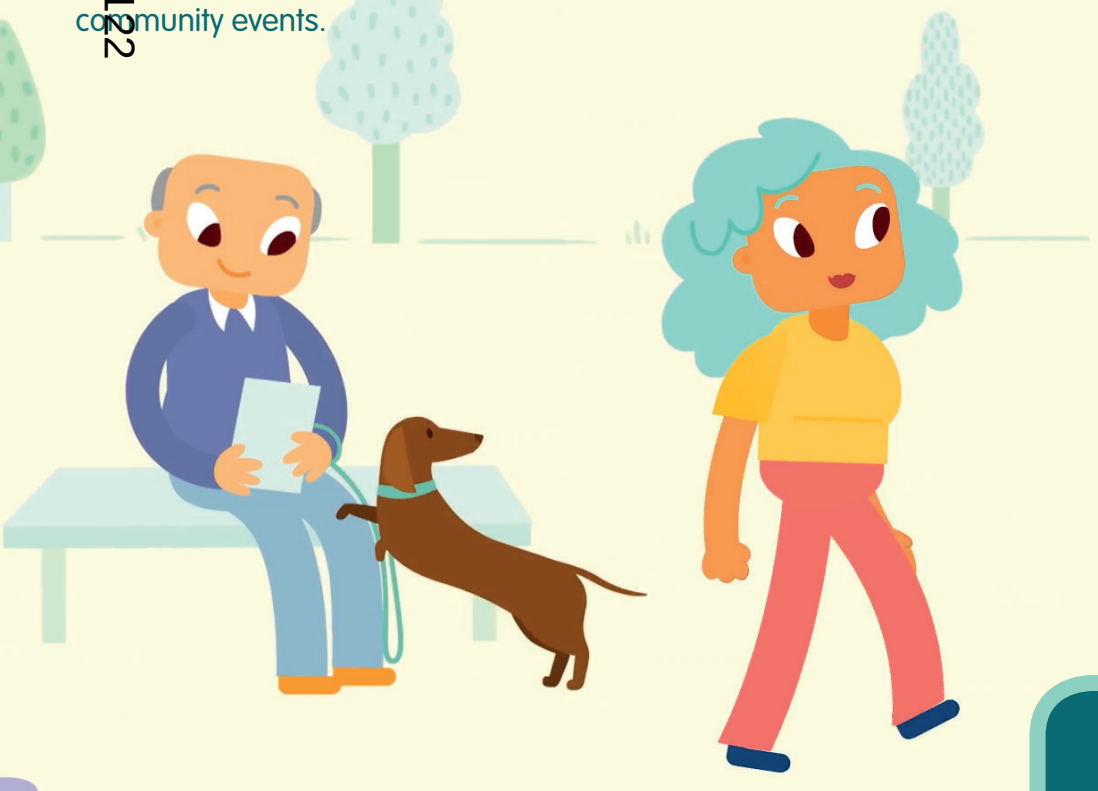
Dr N Cavill, health promotion consultant

HIGH BLOOD PRESSURE

Tameside has one of the highest levels of heart disease in England. One way to prevent heart disease and stroke is by controlling blood pressure.

Around one in three people in Tameside have raised blood pressure. However, high blood pressure often has no symptoms, so without a blood pressure check, many people won't know that they have it. High blood pressure is treatable, but in Tameside we estimate that four in every 10 people with it have not yet been identified. We know that if the number of people with high blood pressure in Tameside was on a par with the national average, we would see 30 fewer deaths from related illnesses each year.

The 'Check it!' social marketing programme has been drawing attention to the importance of blood pressure this year, and the Tameside and Glossop Health Improvement Team have been offering opportunities for checks at community events.



You can now get a blood pressure check at a:

- leisure centre
- pharmacy
- GP practice
- 'Check it!' programme event

More than 1300 people had a blood pressure check over a three-month period, and 100 of these were recommended to see their GP. A survey after the campaign showed that 40% of local people recognised the campaign.

Building on this success we are planning to continue the 'Check it!' programme because it so important that local people understand the risks from high blood pressure, get themselves checked and take action if they need to.

REACTIVE SELF-CARE: PATIENT ACTIVATION

The Tameside and Glossop Care Together Programme and the Greater Manchester Devolution 'Taking Control' strategy, both encourage the development of patient activation.

To successfully self-care, and to manage our health well, we need to be active about it. We need knowledge, we need to develop new skills and we need to be confident about what we're doing. This is patient activation.

Helping people to be more active about self-care, and to develop the knowledge and skills they need, improves their engagement and health outcomes. By tailoring the way our services are delivered, according to how engaged someone is and what their patient activation level is, ensures that the level of support given matches the needs of the individual. That makes our services more efficient, productive and effective.

For example, we know that:

- Patient activation is a better predictor of health outcomes than socio-demographic factors such as ethnicity and age.
- People who are active and engaged are significantly more likely to attend screenings, check-ups and immunisations. They are also more likely to adopt positive, healthy behaviours and have body mass index, blood sugar levels, blood pressure and cholesterol in the normal range.
- Studies of interventions to improve activation show that people who start with the lowest activation scores tend to increase their scores the most, suggesting that effective interventions can help engage even the most disengaged. This is a great opportunity to achieve behaviour change and champion healthy lifestyle choices and direct support.

Within Care Together we will be promoting patient activation and making use of a Patient Activation Measure provided by NHS England to enable service providers and users to enhance confidence and skills for self care.

REACTIVE SELF-CARE: DRUG AND ALCOHOL SERVICE TRANSFORMATION

Our Alcohol Strategy for 2015 – 2020 aims to reduce alcohol related harm in Tameside. It has is a programme of activity that covers four strategic priorities, which include:

- challenging local attitudes towards alcohol
- providing exceptional Drug and Alcohol services, which maximise the chances of long-term recovery.

Our local substance misuse services have been recommissioned, and the new provider, Lifeline, will focus on a recovery model of care and provide a more substantial service to alcohol users. The new service is organised around three teams: Early Intervention and Prevention; Recovery and Aftercare.

It includes services for Under 19s, 18 to 28 year olds, family support, and a range of group work, as well as one to one counselling, support and clinical services.

Through the focus on prevention and treatment we expect to see fewer people needing treatment, and fewer people needing treatment for long periods. And at the same time seeing less alcohol harm to the lives of everyone in Tameside.

Advice and support around drugs or alcohol, please visit LifeLine Tameside at:

Katherine Cavendish House
Katherine Street,
Ashton-under-Lyne
OL6 7DB

Phone: 0161 672 9420

REACTIVE

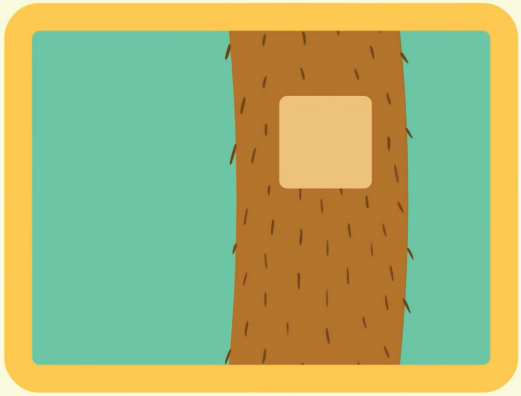
RESTORATIVE SELF-CARE: EXPERT PATIENT

Tameside and Glossop Clinical Commissioning Group (CCG) commission Self-Management UK to deliver 'Self-Management for Life' courses for local people with long-term conditions. The courses help people to become confident, knowledgeable and skilled in managing their condition.

To get on one of the courses, people can ask their GP for a referral or can sign themselves up. The courses run once a week for three hours, over a period of six weeks. Participants include people with conditions such as diabetes, arthritis and heart disease.

Since 2012, there have been four courses a year. Five courses have been commissioned for 2016/17, to be run in each of the five areas of the CCG.

This year we will be focusing on high blood pressure, to fit with local initiatives.



RESTORATIVE

CASE STUDY:

Self Management UK Course hosted at Ingeus Tameside as part of the Working Well Programme: – feedback from two participants who now have the confidence to find the right job whilst living with chronic fatigue and arthritis.

KAREN

"I attended the Self Management Course in June. It was very informative and extremely helpful. I learnt a helpful breathing technique that helps with relaxation. Each session was on different subjects that I found really interesting e.g. Goal setting, exercise and healthy eating. A lot of people started the course and there was still a lot at the end. We all received a certificate which I thought was very nice. If there was another I would definitely attend."

HELEN

"The group sessions were excellent. A non- pressured environment which helped open up my thinking, bringing calm redirection. Looking at the group reactions, people were uplifted, not hounded. It disentangled a lot of fear and presumptions I had because of a long term illness. It also reinforced realistic expectations rather than self-pity. Thank you Ingeus for arranging."

STARTING WELL: SCHOOL RESILIENCE WORKSHOPS

Mental health disorders in young people, such as anxiety and depression, are surprisingly common. Poor mental health has an impact on every aspect of a young person's life including their ability to engage with education, make and keep friends and participate in family life.

Resilience is a self-care skill that young people need to help them overcome challenges. In Tameside, we have commissioned Mind to deliver a resilience programme in primary and secondary schools, working with teachers, young people and their parents.

This programme includes:

- mental health and emotional wellbeing assemblies
- resilience workshops for pupils
- staff training sessions
- parent training sessions.

A total of 30 primary and secondary schools have been involved, over a thousand pupils have attended resilience workshops and nearly 12,000 attended a resilience themed assembly. Feedback from young people who have attended the sessions has been positive. They felt generally better after sessions and felt they would be better able to cope if problems did arise.

For more information and mental health support for young people, please visit - **www.mind.org.uk**

CASE STUDY: FEEDBACK FROM SCHOOL/ PUPILS

SECONDARY PUPIL FEEDBACK

- "I can now cope better with my problems"
- "I feel a lot better and less stressed than I was before"
- "It taught me to be calm when I go through problems which stress me out"

PRIMARY PUPIL FEEDBACK

- "Really helpful at teaching us to deal with our feelings"
- "It gives you ways to cope and help others"
- "It was brilliant because I know how to calm myself down so I can now handle issues in my life"

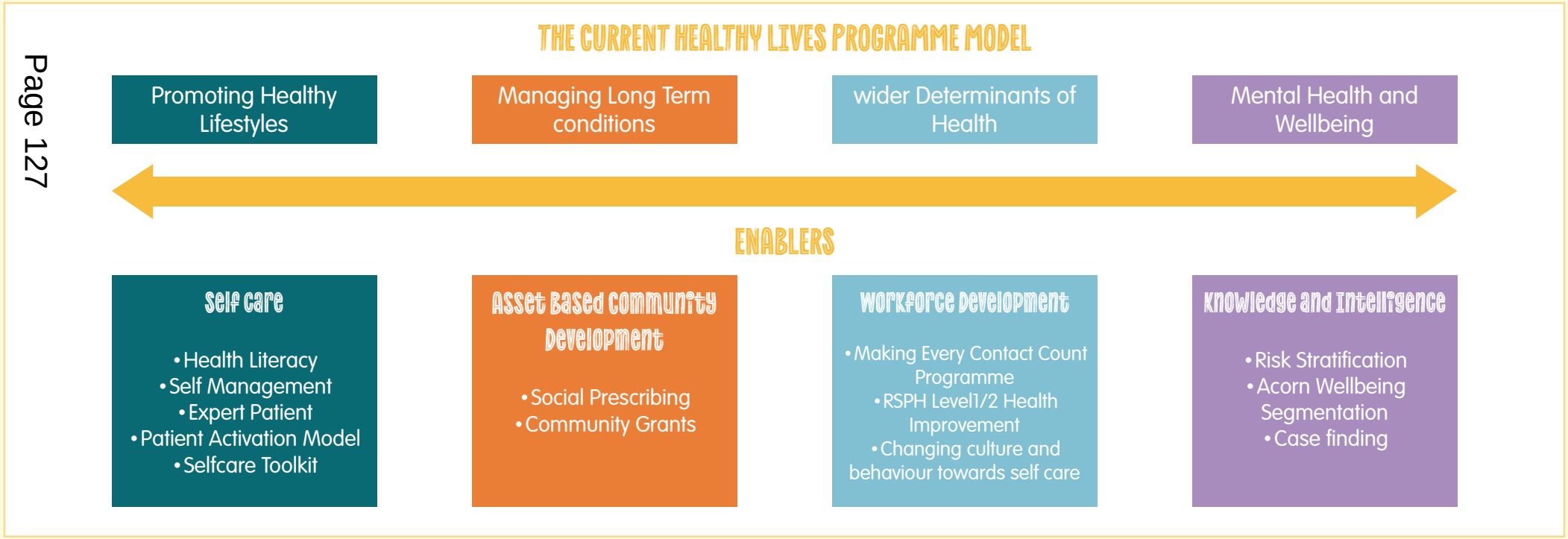
LIVING WELL: WELLNESS OFFER

Tameside Wellness Offer supports people to live well, by:

- addressing the factors that influence their health
- enabling them to be independent and resilient
- helping people to support themselves and those around them.

The Tameside Wellness Offer goes beyond looking at single issue, healthy lifestyle services with a focus on illness, and instead, it aims to take a whole person, family and community approach to improving health.

Our vision is a person centred, not programme focused approach. We want to develop support based on a community approach, building your capacity to self-care and live healthy lives by addressing the factors that influence your health and wellbeing.



That means providing integrated services that promote self-care through;

- coaching
- structured decision making
- skilled, knowledgeable and confident staff who can to support individual self-care and community level self-care by building relationships and capacity within communities.

Consultation with the people of Tameside showed us clearly that most people want support with diet and activity. Support for mental health issues such as anxiety and mild depression was popular too; residents described lack of confidence as a huge barrier to accessing health and social opportunities.

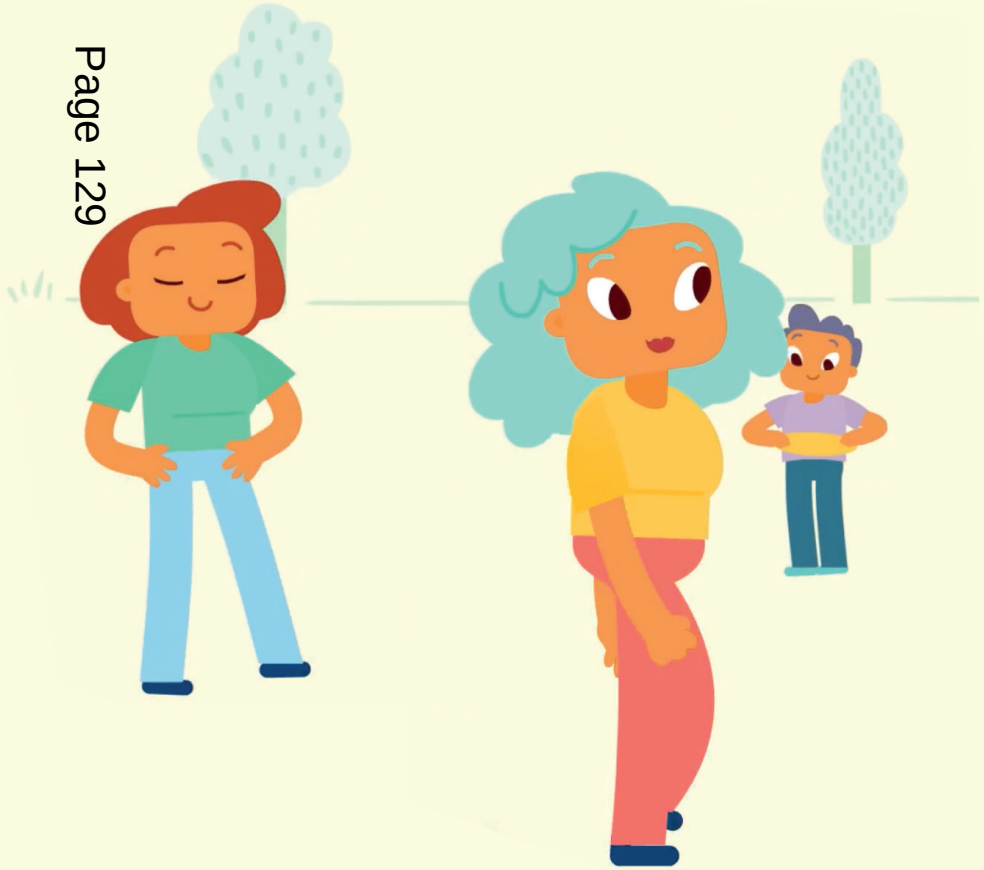
However, the consultation also showed us that people are confident in their ability to self-care, and to support each other and your community. There is support too for integrated services and a single place to go to, where people can get the help they need.

The Tameside Wellness Offer will also be accessed through the Healthy Lives programme of Care Together.

WORKING WELL: 'GOOD WORK' PROGRAMME

We know that healthy staff are vital for a strong economy, and a strong economy is better able to provide good work for people. Having a strong economy supports self-care, as it increases employment and incomes and widens people's opportunities and choices.

Whether its paid or unpaid, full-time or a few hours a week, being at work can help you on the road to recovery after being off. Working can also be a good way to keep well if people have a long-term condition like diabetes, COPD, heart disease, depression, stress, asthma or back pain.



In Tameside, there are a range of programmes that support employers and employees to promote and take up more healthy lifestyles and better self-care. One of these is the Workplace Wellbeing Charter. Any organisation can use the charter and it provides an easy and clear guide on how to make workplaces a supportive and productive environment in which employees can flourish.

Healthy Hattersley is a pilot programme building on the success of the Working Well programme, which supports the long term unemployed back into the workforce. In Hattersley, GPs are able to refer patents that are unemployed and have health issues for additional support to address mental and physical health needs and skills development.

Skills for Employment is another form of support that is available to local people to help them return to work. The focus is on developing the skills needed to return to work such as confidence, literacy, customer services etc.

Please visit **www.wellbeingcharter.org.uk** for more information.

AGING WELL:
SMALL THINGS STORYBOX AND MANCHESTER CAMERATA

There are currently 85,000 people in the UK living with dementia. It can be a difficult condition to live with and manage, particularly if the person with dementia develops challenging behaviour. This is made more problematic by the lack of really effective treatment. Many people take anti-psychotic medicines to control behaviour, and these come with the risk of serious side-effects.

Small Things and Manchester Camerata provide an alternative approach, which helps to reduce the over prescribing of anti-psychotic drugs. The projects have brought music, literature and art to people with dementia and their carers, reducing their feelings of isolation.

Small Things run a project called StoryBox, which engages and communicates with people with dementia by using collaborative story making. It provides sensory and fun experiences where games are played and stories are made up to encourage togetherness, improve concentration and lift mood.

Manchester Camerata brings together trained music therapists and musicians to work with individuals and groups through music therapy. Their local project, Tameside Opera group for older people, has proved a great success, and we are keen to build further similar projects local on this innovative programme.

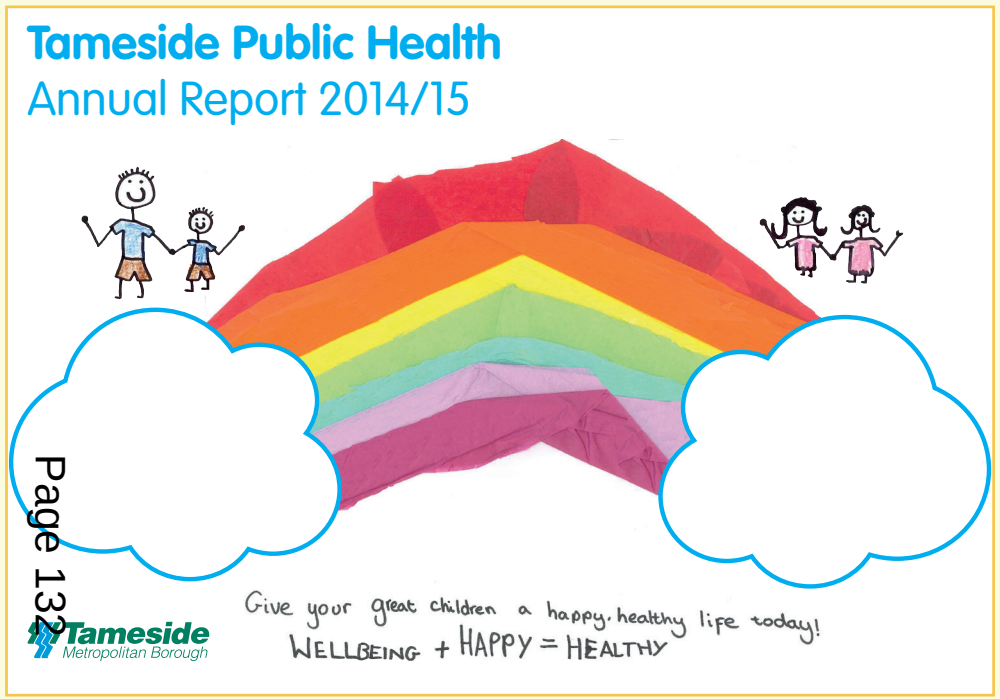
CASE STUDY: DONALD

Donald took part in the Tameside Opera. He has a learning disability and dementia which affects his social skills and his confidence. Donald gradually spent less and less time with other people, he stopped making eye contact and in the end would barely speak or take part in a conversation.

Joining the Tameside opera group has changed everything. Since he started music sessions, Donald now actively takes part, enjoys being in the group and has the confidence to help others to take part in different sessions within the scheme. Donald now has a girlfriend, and both enjoy music sessions together.

For more information about Dementia, please visit - **www.alzheimers.org.uk**
To become a Dementia Friend, please visit - **www.dementiafriends.org.uk/**
http://www.manchestercamerata.co.uk/learning/health/dementia
https://smallthings.org.uk/public-projects/storybox/

UPDATE FROM THE 2014/15 ANNUAL REPORT: HANDS UP FOR HEALTH!



Last year the Public Health Annual Report put the spotlight on Children and Young People, emphasising the important foundations for development that are laid down in childhood.

The report made a number of recommendations. This is what we achieved:

SCHOOL READY

- The number of children who are 'school ready' in Tameside has increased from 52% in 2014 to 58% in 2015.
- Health Visiting teams and private day-care providers now use an evidence-based developmental screening tool called ASQ 3 for our 0-3 year olds. This helps us to identify any developmental delay early.
- Mellow Parenting has started, in partnership with Early Attachment Service, Health Visiting, HomeStart and Children's Centres.
- New learning classes have been introduced in the Children's Centres.
- Working with Future Gov, we have talked to parents who find it hardest to find and use our services, to find out how we can make them more accessible.

YOUNG MOTHERS

- The Family Nurse Partnership is working with teenage parents.
- We developed a young parent pathway to make sure the needs of all our young parents are met.

ACTIVE TAMESIDE

- Lifestyle advisors have been trained in pre/post-natal exercise. They will offer support to any woman who wants to be active during pregnancy.
- We are testing and evaluating the Active Mama course.

BREASTFEEDING

- Our maternity, community health visiting and children's centres settings have the Baby Friendly Accreditation.
- HomeStart is providing a peer support breastfeeding programme.

EMOTIONAL WELLBEING

- We are developing a Transformation Plan for Children and Young People's emotional health and wellbeing.
- Young MIND are providing mental health awareness assemblies, resilience workshops and one to ones in every secondary school.

SCHOOLS

- Half of Tameside's Schools have been supported to complete a School Online Health Check.
- A Sex and Relationship Education (SRE) Group is looking at the issues surrounding SRE in Tameside Schools.
- A local Learning Mentor has produced a video explaining her journey of delivering SRE - **www.youtube.com/watch?v=ZUzh9FLfnWA**
- A 'Let's Talk About Sex' workshop in the summer will build on our assets and provide the much needed resource to enable schools to engage more effectively with sexual health issues.
- We are supporting young people to gain skills and enter the workplace.

ACKNOWLEDGMENTS

Writing this report has been a collaborative effort. I would like to thank everyone who has contributed their time and expertise to the production.

Self-Care
Liz Harris
Anna Moloney
Pamela Watt
Katie Flynn
Charlotte Lee
Kate Benson
Dan Clark
Angela Wild
Debbie Watson
Jacqui Dorman
Gideon Smith
Ruth du Plessis

Intelligence
Jacqui Dorman

Report Co-ordination
Gideon Smith
Ruth du Plessis
Charlotte Lee
Katie Flynn
Annette Turner

Editing
Sarah Smith

REFERENCES

What do we mean by self-care and why is it good for people? Self-care Forum **http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/** accessed August 2016

A practical guide to self-management support. Key components for successful implementation. Health Foundation 2015 **http://www.health.org.uk/sites/health/files APracticalGuideToSelfManagementSupport.pdf**

What do we mean by self-care and why is it good for people? Self-care Forum **http://www.selfcareforum.org/about-us/what-do-we-mean-by-self-care-and-why-is-good-for-people/,** accessed August 2016

A practical guide to self-management support. Key components for successful implementation. Health Foundation 2015 **http://www.health.org.uk/sites/health/files/APracticalGuideToSelfManagementSupport.pdf**

A practical guide to self-management support. Key components for successful implementation. Health Foundation 2015 **http://www.health.org.uk/sites/health/files/APracticalGuideToSelfManagementSupport.pdf**

Barofsky I. Compliance, adherence and the therapeutic alliance: steps in the development of self-care. Soc Sci Med 1978;12:369-376.

Purdy S. Avoiding hospital admissions. What does the research evidence say? Kings Fund 2010

Centre for Reviews and Dissemination 2015 Evidence to inform the commissioning of social prescribing **https://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf**

Youth Chances. Summary of First Findings: the experiences of LGBTQ young people in England. Metro. 2014 **http://www.youthchances.org/wp-content/uploads/2014/01/YC_REPORT_FirstFindings_2014.pdf**

Time to Change. Mind. **http://www.time-to-change.org.uk/what-is-stigma,** accessed 22 July 2016

Tameside Public Health Intelligence Team

Key data on adolescence. Association for Young People's Health.2015 **http://www.youngpeopleshealth.org.uk/key-data-on-adolescence**

GLOSSARY

JSNA (Joint Strategic Needs Assessment): a comprehensive description of the current health and wellbeing of the population of Tameside and recommendations for action that will lead to improvements. **www.tameside.gov.uk/puplichealthreports/JSNA-Report-201516.pdf**

Patient Activation Measure (PAM): a short questionnaire that measures an individual's knowledge, skill, and confidence for self-management.

Risk Stratification: aims to identify individuals in, or segments of, the population, who are high intensity users of health and social care services, or have the potential to have high level needs in the future. This can enable the targeting of services to improve health and wellbeing and to support people to manage their conditions better through self-care enabling them to have a better quality of life.

Social Prescribing: identifying and addressing social needs of health service users.

Published September 2016

New Century House | Windmill Lane | Denton | Tameside | M34 2GP

This page is intentionally left blank