SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 1 November 2016
Time: 3.00 pm
Place: New Century House, Progress Way, Windmill Lane, Denton, M34 2GP

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.

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

f) ASHTON IN-HOUSE PHARMACY 105 - 108

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

7. URGENT ITEMS

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

8. DATE OF NEXT MEETING

To note that the next meeting of the Single Commissioning Board will take place on 6 December 2016 commencing at 2.30 pm.

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

4 October 2016

Commenced: 2.30 pm **Terminated: 3.40 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
Councillor Peter Robinson – 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
Michelle Rothwell – Tameside and Glossop CCG
Anna Moloney – Public Health

APOLOGIES: Councillor Gerald P Cooney – Tameside MBC

74. WELCOME AND CHAIR'S OPENING REMARKS

In opening the meeting, the Chair made reference to the NHS Tameside and Glossop Clinical Commissioning Group's third Annual General Meeting reflecting on what had been achieved over the last year and the Tameside and Glossop Integrated Care Foundation Trust – a great marker of progress and the plans developed in 2015/16 were beginning to come to fruition. He also made reference to the Director of Public Health's Annual Report, a summary and testimony to whole system progress as we focused in on the bedrock of enabling self-care.

75. DECLARATIONS OF INTEREST

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

76. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 6 September 2016 were approved as a correct record.

77. 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 position of the economy. It provided through a presentation a 2016/17 financial year update on the month 5 financial position at 31 August 2016 and the project outturn at 31 March 2017 for each of the three partner organisations. It was explained that there was a clear urgency to implement associated

strategies to ensure the projected funding gap was addressed and closed on a recurrent basis across the whole economy.

In particular, the Board was advised of the following key messages:

- Opening commissioner financial gap of £21.5m and the total economy gap (including FT of £17.3m) was £38.8m;
- Still need to close £6.5m of the commissioner gap;
- Significant improvement in the CCG QIPP position following submission of the recovery plan to NHS England;
- Still work to do to ensure delivery of full savings target and the significant risks attached to this;
- Currently forecasting:
    - CCG to deliver 1% surplus in 2016/17;
    - keeping 1% of CCG allocation uncommitted;
    - maintaining Mental Health parity of esteem;
    - remaining within CCG running cost allocation;
    - Tameside MBC delivering a balanced budget.

In noting that the £23.3m bid for transformation funding had been approved by the Greater Manchester Health and Social Care Partnership, Board was advised and the process of determining the milestones and key performance indicators against, which the investment would be assessed was currently in progress.

RESOLVED

(i) That the 2016/17 financial year update on the month 5 financial position at 31 August 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 budget recurrent economy budget be acknowledged;

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

78. 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 July position was shown for elective care and a September "snap shot" in time for urgent care. Also attached was a CCG NHS Constitution scorecard showing CCG performance across indicators. Particular reference was made to the following:

- Performance issue remained around waiting times in diagnostics and the A & E performance;
- The number of patients still waiting for planned treatment 18 weeks and over continued to decrease and the risk to delivery of the incomplete standard and zero 52 week waits was being reduced;
- Cancer standards were achieved in July apart from 62 day upgrade and Quarter 1 performance achieved;
- Endoscopy was still the key challenge in diagnostics particularly at Central Manchester;
- A & E standards were failed at Tameside Hospital Foundation Trust;
- Attendance 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 plan.
- Ambulance response times were not met at a local or at North West level apart from CAT A 8 mins at CCG level.

Discussion ensued on the data provided specifically looking at the care homes use of urgent care systems in order that themes and trends could be identified regarding particular care home

providers. Establishing a robust and consistent dataset had been challenging and the aim of working with the relevant urgent care partners was to deliver a monthly reporting system that would allow health and social care services to interpret the data to develop appropriate support plans. Examples of data collected to date used by the Care Home Steering Group were highlighted.

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

79. PRIMARY CARE QUALITY STANDARDS REVIEW

The Director of Commissioning presented a review of the first six months of the Primary Care Quality Scheme, the underlying principle of which was to increase and sustain the infrastructure and delivery of primary care services, including parity of investment with other sectors of the economy, whilst recognising the trend of moving services out of secondary care into primary care.

The Primary Care Quality Scheme was promoted as a potential long term investment in primary care that practices could use to access additional resources and at the same time implement longer term projects to improve patient and staff outcomes and experience and to emphasis this message practices were asked to submit two year plans.

The scheme went live in October 2015 with an initial approval covering a period to the end of March 2017. Year one reports had been submitted by all 41 practices and the report discussed the progress of the Primary Care Quality Scheme to date and its positon as part of the current primary care position.

An important theme from the year one reports was that of practices engaging with their data and fully understanding their position on each indicator and consider approaches to improve or maintain that position. The scheme also recognised the individuality of each practice and the challenges faced and asked them to build their own resilience and plan for the future shape of their business in terms of succession planning. This increased the performance of all practices and reduced variation by incentivising 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. Equally important was that in the long term practices would develop and embed new behaviour, recognise areas requiring improvement and establish their own improvement aims.

The report also provided details on:

- Commissioning Improvement Scheme;
- Neighbourhood Working;
- GM Standards;
- CQC Requirements;
- Vulnerable practices;
- Outcome measures; and
- Learning and future development of the scheme.

In conclusion, it was reported that the Primary Care Quality Scheme would evolve as the landscape in which it existed evolved. Since the scheme was developed over a year ago the CCGs financial position had changes significantly. In addition, the landscape of the local health economy had change significantly. The progress made in 2016/17 would serve to influence the scheme in 2017/18 and the new scheme would be delivered within a reduced budget.

The recommendations, which had been accepted by the Professional Reference Group, could be designed to complement and align with the Single Commissioning Board's strategic direction, and

reflected the changes that had occurred in the last 18 months of its development and implementation.

RESOLVED

(i) That approval be given to the Primary Care Quality Scheme continuing in its current format to the end of 2016/17 with an active promotion of neighbourhood working.

(ii) 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.

(iii) That changes be incorporated to further support neighbourhood working, addressing the Greater Manchester Quality Standards and aligning and running parallel to reducing originating activity across the health economy, while also impacting positively on costs.

80. CONTRACT FOR THE PROVISION OF DIRECT PAYMENT SUPPORT SERVICES – INCLUSION ON LIST OF APPROVED SERVICES

The Director of Commissioning presented a report seeking authorisation under Procurement Standing Order F1.3 to extend the contract for the provision of direct payment support services for a period of 12 months as there was provision to do so in the contract.

It was explained that direct payments were an alternative to traditional care and support services providing cash payments to individuals to purchase services to meet their assessed care needs allowing the person more choice and control over how their needs were met. Recipients could choose to employ their own care workers known as personal assistants. As an employer, the individual had the usual employer responsibilities such as providing pay slips and ensuring the correct tax and national insurance payments were made. The payroll service was designed to assist people using a direct payment to employ personal assistants to manage their payroll and tax functions including professional unlimited payroll advice.

The list of approved services commenced in November 2013 with a three year contract including provision to extend for up to an additional 2 years. There were currently 5 organisations on the approved list.

The proposed extension to the contract would be funded by existing financial resources. It was anticipated that there would be a reduction in these costs after the initial 12 month period as it was intended to introduce pre-paid cards meaning that a number of current users of the payroll service would be able to manage their own finances independently or with the help of carers. Authorisation to extend the current arrangements for 12 months was being sought to enable this work to be completed.

RESOLVED

That approval be given to the extension of the contract for the provision of direct payment support services for a period of 12 months from 1 November 2016 to 31 October 2017.

81. CONTRACT FOR THE PROVISION OF SPECIALIST DAY SERVICES FOR PEOPLE WITH DEMENTIA

Consideration was given to a report seeking authorisation under Procurement Standing Order F1.3 to extend for a period of 12 months where there was provision to do so in the contract. It was explained that the service comprised of two key components:

- A building based service at Wilshaw House, Ashton-under-Lyne, providing 20 places per day, 7 days per week, 52 weeks per year;

- A community based element providing 8 places per day, 7 days per week, 52 weeks per year.

The contract commenced in December 2012 for an initial 3 years with provision to extend for up to an additional 2 years. The service had maintained a high level of performance to date reported to regular performance management meetings including case studies which reflected the positive outcomes for individuals. The findings of a validation carried out in September 2014 were extremely positive with evidence that staff had access to structured learning and development and were recruited according to employment legislation. In addition, feedback from the carers was extremely positive and they spoke highly of the staff and the benefits of the service.

In conclusion, the Board was advised that the existing service provision supported the delivery of cost avoidance to the health and social care economy the supporting details of which were contained in the report.

RESOLVED
That approval be given to the extension of contract for the provision of specialist day services for people with dementia for a period of 12 months from 2 December 2016 to 1 December 2017.

82. PROVISION OF RESPITE CARE FOR ADULTS WITH LEARNING DISABILITY AND ADDITIONAL NEEDS WITHIN A REGISTERED CARE HOME SETTING

Consideration was given to a report of the Director of Commissioning outlining options for re-commissioning short stay / respite provision for adults with a learning disability in the borough following an unsuccessful procurement exercise where both submissions received were non-compliant.

It also detailed 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 24 months as allowed for within the contract. This would allow further development in the market for the delivery of the accommodation required and commissioning intentions evaluated.

The cost of a 24 month extension to the existing contract from 1 October 2016 would continue to be financed from the Section 75 funding allocation within the Integrated Commissioning Fund.

RESOLVED
(i) That the outcome of the unsuccessful procurement exercise and the options being considered to ensure the continued provision of the service be noted, the outcome of which would be reported to the Single Commissioning Board in due course.
(ii) That authorisation be given to extend the current contract for up to 24 months.

83. COMMISSIONING DATA MANAGEMENT SERVICES

Consideration was given to a report of the Director of Public Health and Performance advising that the Tameside Single Commissioning Unit had 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 Greater Manchester Authorities. Public health intelligence required access to a range of data across the health and social care economy, including NHS secondary care data, which was essential to enable analysis of key public health indicators and the performance of the local health economy. The GM Directors of Public health agreed in principle to commission Arden and GEM CSU until 31 March 2019 to provide a Data Management Service covering access to healthcare datasets with local authority access to the datasets including:

- Secondary Uses Service;
- Payment by Results;
- Patient Demographics.

They approved a lead commissioner model rather than the previous model consisting of separate contractual agreements as a single contract reduced 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. Tameside MBC would contract with the provider for the data management service on behalf of the participating authorities but each authority would have separate processing agreement in place and as such individually responsible for their own data governance and any data breach.

In conclusion, it was stated that only Arden and Greater East Midlands CSU and NHS Oldham Clinical Commissioning Group were 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. The Tameside element of the costs associated with the contract waiver would be funded from existing resources within the Section 75 agreement of the Integrated Commissioning Fund.

RESOLVED
That a contract waiver be granted under Procurement Standing Order F1.4 to enable the direct award to Arden and Grater East Midlands CSU and NHS Oldham Clinical Commissioning Group for data management services.

84. PUBLIC HEALTH ANNUAL REPORT

The Director of Public Health and Performance submitted her Annual Report 2015/16 themed around self-care. The report emphasised that focusing on self-care would help people to increase their confidence to live well, improve their quality of life and improve the patient experience. The report highlighted existing programmes of work and showed where real opportunities existed as a result of the restructure brought about by Care Together and Greater Manchester Devolution.

Members of the Board commented favourably on the Annual Report and accompanying video presentation.

RESOLVED
That the 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.

85. URGENT ITEMS

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

86. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 1 November 2016 commencing at 3.00 pm at New Century House, Denton.

CHAIR

Report to:	**CARE TOGETHER SINGLE COMMISSIONING BOARD**
Date:	1 November 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 30 SEPTEMBER 2016 AND PROJECTED OUTTURN TO 31 MARCH 2017**
Report Summary:	This is a jointly prepared report of the Tameside & Glossop Care Together constituent organisations on the revenue financial position of the Economy. The report provides a 2016/2017 financial year update on the month 6 financial position (at 30 September 2016) and the projected outturn (at 31 March 2017). The Tameside & Glossop Care Together Single Commissioning Board are required to manage all resources within the Integrated Commissioning Fund. The CCG and the Council are also required to comply with their constituent organisations' statutory functions. A summary of the Tameside Hospital NHS Foundation Trust financial position is also included within the report. This is to ensure members have an awareness of the overall financial position of the whole Care Together economy and to highlight the increased risk of achieving financial sustainability in the short term whilst also acknowledging the value required to bridge the financial gap next year and through to 2020/21.
Recommendations:	Single Commissioning Board Members are recommended : 1) To note the 2016/2017 financial year update on the month 6 financial position (at 30 September 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 30 September 2016 (Month 6 – 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)	Given the implications for each of the constituent organisations it will be important that each constituent body is aware of their position and the totality.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications?	There are no information governance implications within this report and therefore a privacy impact assessment has not been

Has a privacy impact assessment been conducted?	carried out.
Risk Management:	These are detailed on slide 9 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

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position: M6

2016/17 Revenue & Capital Monitoring Statements at 30 September 2016 and projected outturn to 31 March 2017

14 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

Section 1 - Care Together Economy Revenue Financial Position

Care Together Economy Revenue Financial Position

Organisation	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Tameside & Glossop CCG	186,867	187,883	(1,016)	378,050	382,243	(4,193)	(4,790)	597
Tameside MBC	33,827	35,044	(1,217)	69,272	71,706	(2,434)	(2,060)	(374)
Total Single Commissioner	**220,694**	**222,927**	**(2,233)**	**447,322**	**453,949**	**(6,627)**	**(6,850)**	**223**
ICO Deficit			(9,223)			(17,300)	(17,300)	-
Total Whole Economy			**(11,456)**			**(23,927)**	**(24,150)**	**223**

Key Risks in Year End Forecast

- That the CCG QIPP doesn't deliver to current planned levels
- That the current level of Delayed Transfers of Care adversely impacts on the delivery of the Winter Plan with associated financial consequences

Planned Mitigations to Identified Risks

- Ownership of individual QIPP schemes together with rigorous monitoring will ensure delivery
- The Winter Plan reflects an integrated approach across the economy which is essential in managing delayed transfers of care (DTOCs) with implementation of the Home First transformation project critical to managing the level of DTOCs.

Mitigations to adverse variances contained in Year to Date Position

- Continued work to deliver improvement on the CCG QIPP position following submission of recovery plan.
- Diligent efforts in striving to deliver the savings target in full. Significant risk attached to this.
- TMBC planning to deliver balanced budget by end of year

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)

Tameside & Glossop CCG

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	99,070	99,030	40	198,339	198,387	(48)	83	(131)
Mental Health	14,510	14,654	(144)	29,019	29,094	(74)	(72)	(2)
Primary Care	40,930	41,283	(353)	81,879	82,152	(273)	(744)	471
Continuing Care	5,224	5,271	(47)	12,254	12,522	(269)	(191)	(78)
Community	13,713	13,681	32	27,539	27,574	(35)	(33)	(2)
Other	11,241	11,699	(458)	23,858	23,870	(12)	399	(412)
QIPP	-	-	-	-	4,193	(4,193)	(4,790)	597
CCG Running Costs	2,179	2,264	(85)	5,162	4,451	711	558	153
CCG Total	**186,867**	**187,883**	**(1,016)**	**378,050**	**382,243**	**(4,193)**	**(4,790)**	**597**

- Submission of recovery plan has led to increase in value of green rated QIPP schemes (£8.7m to £9.3m)
- Significant changes in outturn position by directorate:
  - **Acute**:
    Detailed breakdown of movements in acute providers detailed separately
  - **Primary Care**:
    Prescribing forecast reduced by £267k based on Month 4 actuals lower than anticipated. £200k underspend on Primary Care Quality Scheme will contribute to delivery of the recovery plan.
  - **Continuing Care**: Increase in forecast to account for overall economy pressure relating to FNC rate increase. Detailed work on value of 16/17 forecast and monitoring arrangements ongoing.
  - **Other:** Release of £526k underspend on care Together transition fund to contribute to recovery plan.
  - **Running Costs**: Value of underspend is increased to £711k as part of continued review of costs to feed into recovery plan.

- Original commissioner financial gap £21.5m. Still need to close £6.627m of this gap.
- Significant improvement in the CCG QIPP position following submission of recovery plan.
- Still work to do to ensure delivery of full savings target.
- CCG current planning to:
  - Deliver 1% surplus in 2016/17 but this is still a significant risk pending progress on the recovery plan
  - Keep 1% of allocation uncommitted
  - Maintain Mental Health parity of esteem
  - Remain within running cost allocation

Recommendations

- Note the updated M6 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

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)

Tameside MBC

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Adult Social Care & Early Intervention	20,059	20,808	(749)	41,995	43,493	(1,498)	(1,263)	(235)
Childrens Services, Strategy & Early Intervention	13,010	13,401	(392)	25,877	26,660	(783)	(510)	(273)
Public Health	759	835	(77)	1,400	1,553	(153)	(287)	134
CCG Total	**33,827**	**35,044**	**(1,217)**	**69,272**	**71,706**	**(2,434)**	**(2,060)**	**(374)**

Children's Social Care

- A number of temporary social workers have been employed to address caseload capacity issues. The associated expenditure is assumed to continue until the end of the current financial year.
- Further cost reduction options are under consideration to ensure a balanced budget will be delivered during the current financial year. The additional in-borough residential service provision capacity will contribute towards these cost reductions. However, 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.

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
- Cost projections associated with Residential and Nursing Care have increased compared to the previous month.
- 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

Recommendations

- Note the updated M6 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position

Tameside & Glossop Integrated Care NHS Foundation Trust (ICO)

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Income	101,086	102,559	1,473	202,785	204,904	2,119	204,904	0
Expenditure	105,913	107,508	(1,595)	210,707	212,826	(2,119)	212,826	0
Earnings before interest, taxes, depreciation and amortisation	(4,827)	(4,949)	(122)	(7,922)	(7,922)	0	(7,922)	0
Net Deficit after Exceptional Costs	**(9,521)**	**(9,223)**	**298**	**(17,300)**	**(17,300)**	**0**	**(17,300)**	**0**

Financial Position

- For the 6 months to September 2016, the ICO is delivering a deficit of £9.2m, 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 Efficiency savings target
  - Delivery of the Tameside and Glossop CCG block contract
  - Small over performance on all associate 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

Key Risks to the Financial Position

- Under-performance of savings target – c.£2.8m of schemes are currently rag rated medium or high risk.
- Non delivery of the A&E trajectory in Q3 and Q4 will result in the Trust not receiving £430k of STF.
- Additional unplanned expenditure due to winter pressures.
- Savings relating to transformation schemes delayed.
- Performance targets requiring unplanned expenditure to use the independent sector.

CCG – Provider Performance

Description	Year to Date			Year End Forecast		
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s
Tameside FT	63,405	63,849	(444)	127,075	127,075	0
Central Manchester	11,245	11,438	(193)	22,280	22,630	(350)
Stockport	5,960	5,646	314	11,969	11,686	283
South Manchester	3,229	3,098	131	6,568	6,773	(205)
Pennine Acute	2,021	1,875	146	4,029	3,797	232
Salford	1,614	1,734	(120)	3,226	3,464	(238)
WWL	696	607	89	1,409	1,313	96
Bolton	40	39	1	80	80	0
CCG Total	**88,210**	**88,286**	**(76)**	**176,636**	**176,818**	**(182)**

Acute Provider Drilldown

Tameside FT: Overspent by (£444k) YTD. Showing as breakeven by year end due to the expectation that transformational schemes will be realised. Pressures driven by:

- Elective & DC Admissions: Particularly T&O (£499k) / GS (£161k)
- Ambulatory: Pulmonary embolism (£134k) / DVT (£103k)
- Maternity / Gynaecology (£124k)

- **Central Manchester**: Pressures driven by macular activity (£251k YTD) / Critical Care – AKU (£67k YTD) / Day cases for cardiology (£44k) & Ophthalmology (£37k)
- **South Manchester**: Pressures due to Critical Care patient (£69k) / Day cases on vascular (£99k) & plastic surgery (£64k)
- **Salford**: Pressures due to Devices (£46k) / Pain Management (£34k)
- **Stockport / Pennine Acute:** SFT underspend continues due to Stroke £117k / Critical Care £27k and Pennine underspend continues due to a reduction in elective and daycase activity £74k

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 £17.3m

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.
- £2m would potentially take the form of a loan requiring repayment in 17/18.
- More work required to identify recurrent, activity backed, transformational schemes which will contribute towards the residual gap of £15.1m (inc. optimum bias) 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	0	**1,393**
PRIORITY 2 - Effective Use of Resources / Prior Approval	0	500	0	**500**	0	1,500	0	**1,500**
PRIORITY 3 - Demand Management	96	265	0	**361**	0	1,886	0	**1,886**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	172	504	**676**	0	571	438	**1,009**
PRIORITY 5 - Back Office Functions and Enabling Schemes	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	742	**742**	0	2,100	0	**2,100**
Mental Health	0	0	232	**232**	0	1,000	232	**1,232**
Acute Services - Elective	0	310	500	**810**	0	1,165	0	**1,165**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,000	240	**1,240**
Technical Finance & Reserves	0	244	4,231	**4,475**	0	0	0	**0**
Other efficiencies	0	1,088	2,638	**3,726**	0	0	28	**28**
Grand Total:	96	4,308	9,307	**13,711**	1,000	12,166	1,168	**14,334**
Including adjustment for Optimum Bias:	10	2,154	9,307	**11,470**	100	6,083	1168	**7,351**
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:				2,030				15,134

Financial Risk within the ICF

- Main financial risks within 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 M5.
- Significant risks include:
  - CCG's ability to maintain spend within allocation and deliver a surplus in 16/17: The financial recovery plan submitted to NHS England is being constantly updated to demonstrate how we meet business rules but there is still potentially £2m which may require repayment in 17/18. We now need to focus on the successful delivery of this plan with minimal requirement for loaned funds.
  - 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 in 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 – BCF & Devo

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**

Derbyshire Better Care Fund

- Derbyshire Better Care Fund for 16/17 has also been approved by NHS England.
- Plan meets all requirements and funding has been released subject to spend being consistent with final approved plan.

Funded Nursing Care

- 40% increase in health contribution toward FNC cases has been agreed nationally. The impact to the whole economy and individually on T&G CCG and TMBC is in the process of being determined.
- This was an interim change until December 2016 pending the outcome of a national review into FNC charges. There is an element of the rate for agency nursing staff (which could lead to a reduction of the rate in the future regional variation)

Transformation Funding

- Transformation funding of £23.2m has been approved by Greater Manchester Health & Social Care Partnership. The Investment Agreement that will support the release of the funding is in the process of being developed. It is anticipated that the Investment Agreement will be signed on 18th November

Integrated Commissioning Fund 2016/17

Description	Year to Date			Year End Forecast			Movement	
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s	Previous Month £'000s	Movement in Month £'000s
Acute	99,070	99,030	40	198,339	198,387	(48)	83	(131)
Mental Health	14,510	14,654	(144)	29,019	29,094	(74)	(72)	(2)
Primary Care	40,930	41,283	(353)	81,879	82,152	(273)	(744)	471
Continuing Care	5,224	5,271	(47)	12,254	12,522	(269)	(191)	(78)
Community	13,713	13,681	32	27,539	27,574	(35)	(33)	(2)
Other	11,241	11,699	(458)	23,858	23,870	(12)	399	(412)
QIPP	-	-	-	-	4,193	(4,193)	(4,790)	597
CCG Running Costs	2,179	2,264	(85)	5,162	4,451	711	558	153
CCG sub-total	**186,867**	**187,883**	**(1,016)**	**378,050**	**382,243**	**(4,193)**	**(4,790)**	**597**
Adult Social Care & Early Intervention	20,059	20,808	(749)	41,995	43,493	(1,498)	(1,263)	(235)
Childrens Services, Strategy & Early Intervention	13,010	13,401	(392)	25,877	26,660	(783)	(510)	(273)
Public Health	759	835	(77)	1,400	1,553	(153)	(287)	134
TMBC sub-total	**33,827**	**35,044**	**(1,217)**	**69,272**	**71,706**	**(2,434)**	**(2,060)**	**(374)**
Grand Total	**220,694**	**222,927**	**(2,233)**	**447,322**	**453,949**	**(6,627)**	**(6,850)**	**223**
A: Section 75 Services	**114,542**	**115,472**	**(931)**	**232,236**	**235,204**	**(2,968)**		
CCG	94,022	94,098	(76)	190,216	191,440	(1,224)		
TMBC	20,519	21,374	(855)	42,020	43,764	(1,744)		
B: Aligned Services	**90,508**	**91,650**	**(1,142)**	**183,435**	**186,589**	**(3,154)**		
CCG	77,200	77,980	(780)	156,183	158,647	(2,464)		
TMBC	13,308	13,670	(362)	27,252	27,942	(690)		
C: In Collaboration Services	**15,644**	**15,805**	**(161)**	**31,650**	**32,156**	**(505)**		
CCG	15,644	15,805	(161)	31,650	32,156	(505)		
TMBC	-	-	-	-		-		

Section 2 - Care Together Economy Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total £'000s	Approved 2016/2017 Allocation £'000s	Expenditure to Month 6 £'000s	Projected Expenditure to 31 March 2017 £'000s	2016/2017 Projected Outturn Variation £'000s	Comments
Childrens Services - In Borough Residential Properties	912	912	595	675	237	Purchase of 2 additional in-borough properties including associated property adaptations. An Edge of Care establishment is yet to be purchased
Public Health - Leisure Estate Reconfiguration	20,268	5,203	2,828	4,064	1,139	**Active Dukinfield** - The scheme is on budget with an anticipated opening date of 2 January 2017. **Active Longendale** - The scheme is on budget with an anticipated opening date of 21 November 2016. **Active Hyde** – Work due to start on site in late January 2017 with completion scheduled for October/November 2017. **Denton Wellness Centre** – Layout plans and development agreement being established. Facility to be completed late 2018. The programme total of all schemes includes the sum of £ 2.650 million which will be wholly financed by Active Tameside.
Adult Services - Disabled Facilities Grant - Adaptations	1,978	1,978	519	1,978	0	
Total	**23,158**	**8,093**	**3,942**	**6,717**	**1,376**	

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Report to: **SINGLE COMMISSIONING BOARD**

Date: 1 November 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 August position is shown for elective care and an October "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 format of this report now includes elements on quality from the Nursing Quality directorate.

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	**92.1%**	**1**	**1.20%**	**87.84%**

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 August. 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 2016/17	Oct to 9th 2016/17
89.03%	92.46%	92.16%	86.61%	84.98%	90.48%	82.78%	80.35%

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

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

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

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

Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2016/17
Access to Information :	The background papers relating to this report can be inspected by contacting

Ali Rehman

Telephone: 01613663207

e-mail: alirehman@nhs.net

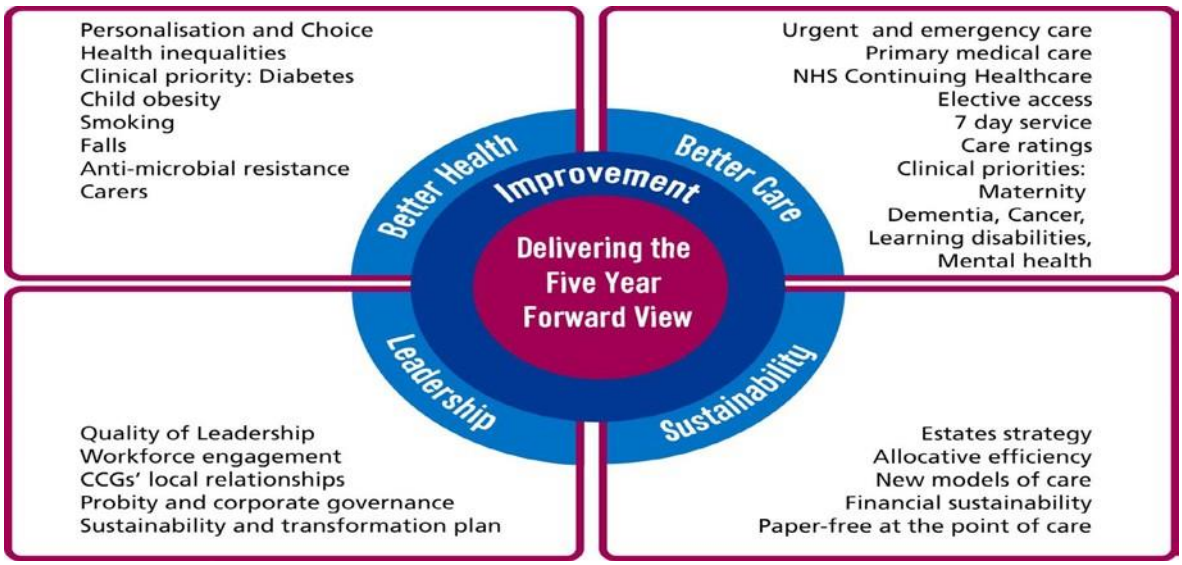
1. INTRODUCTION

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

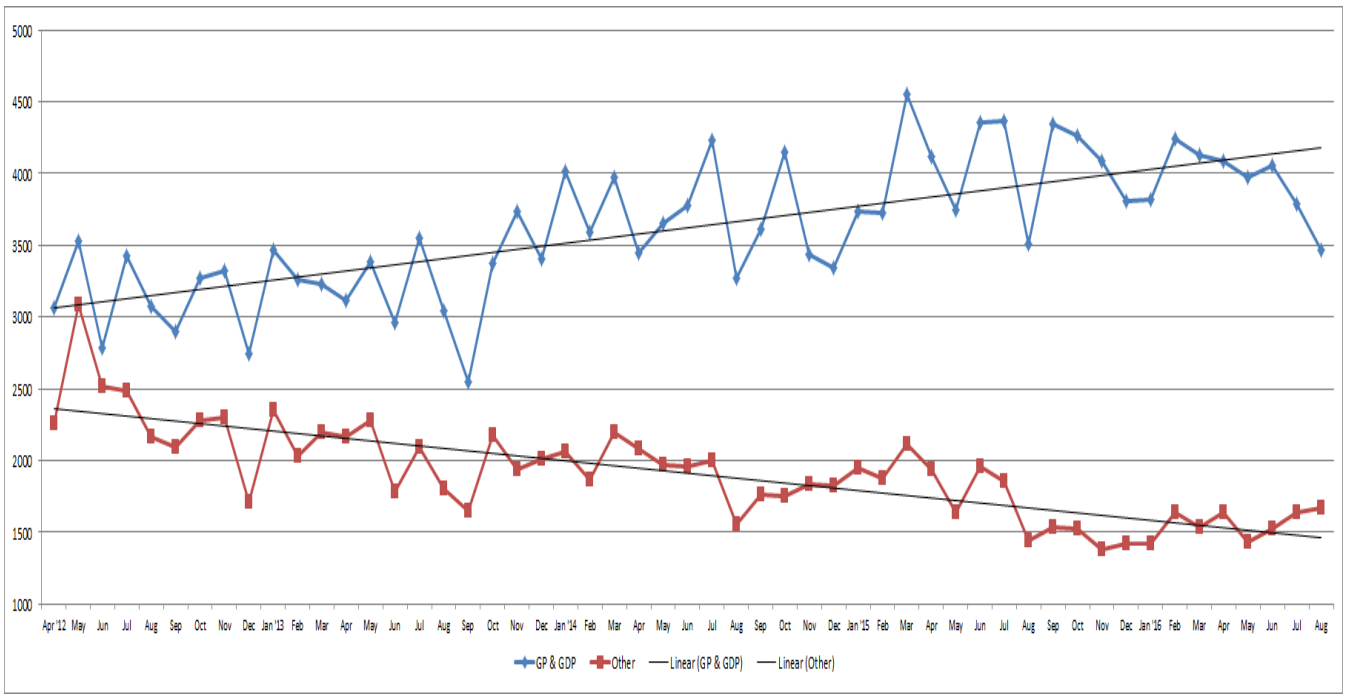
2.1 The assurance framework for 2016/17 has been published nationally however, we are awaiting the framework from GM Devolution. A recent WebEx led by NHS England provided further info on the new assessment framework for 16/17. CCGs will be assessed in relation to four key areas of their functions and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

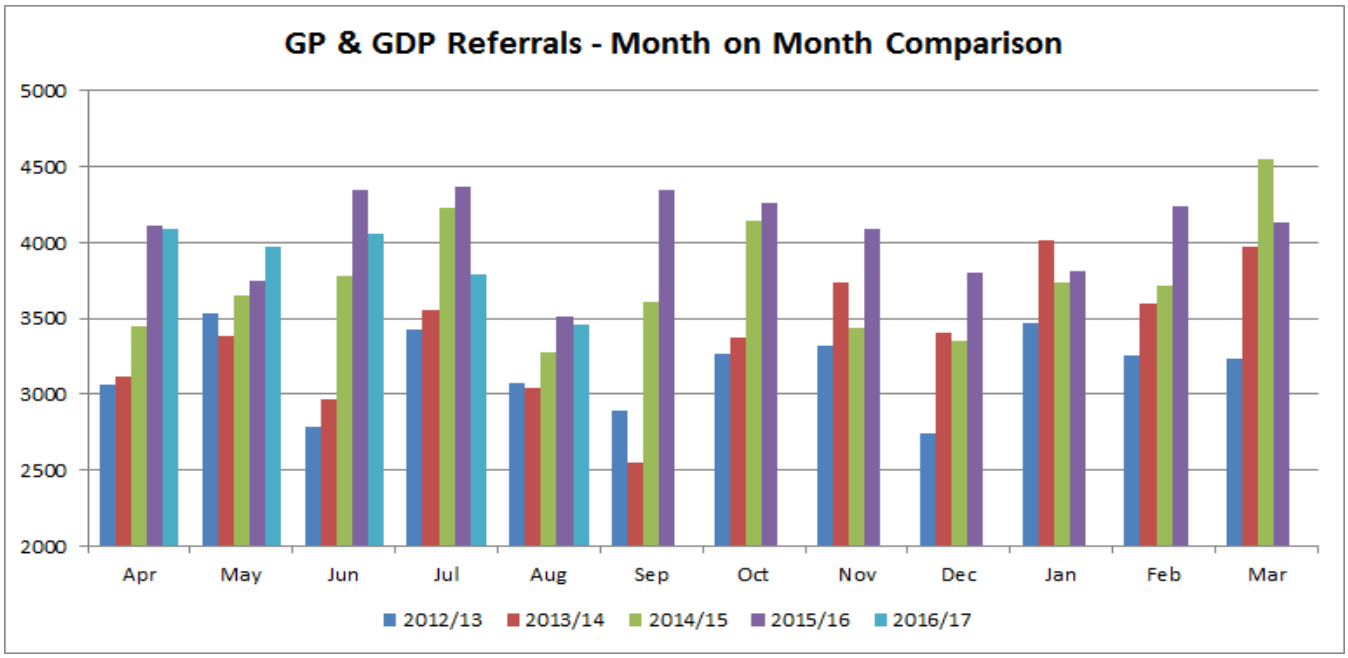


3. CURRENT CCG PERFORMANCE

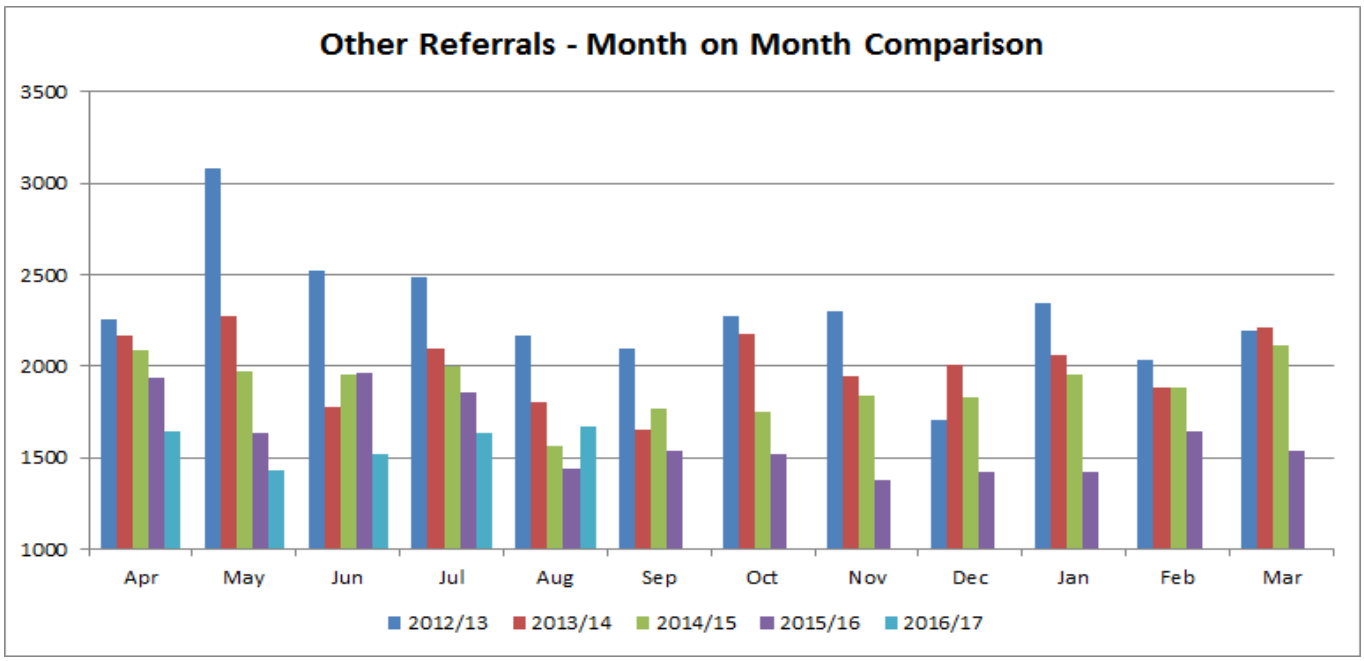
Referrals

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



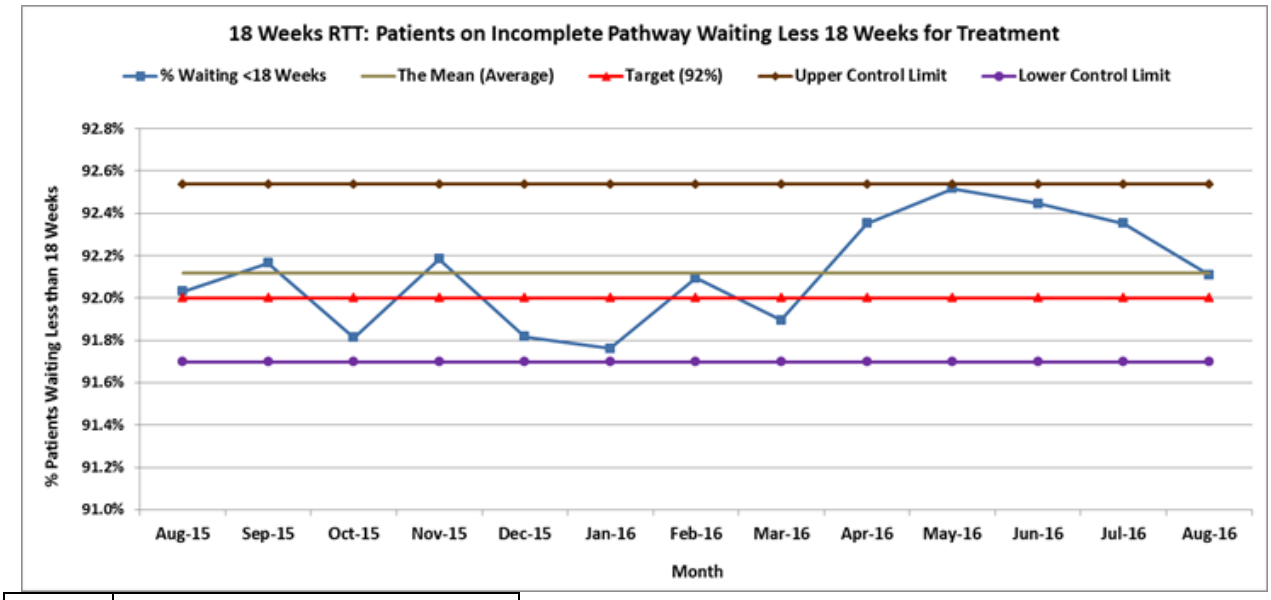


3.2 Other referrals (TFT only) have decreased during the month of August compared to the same period last year. This is a continuing trend.



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

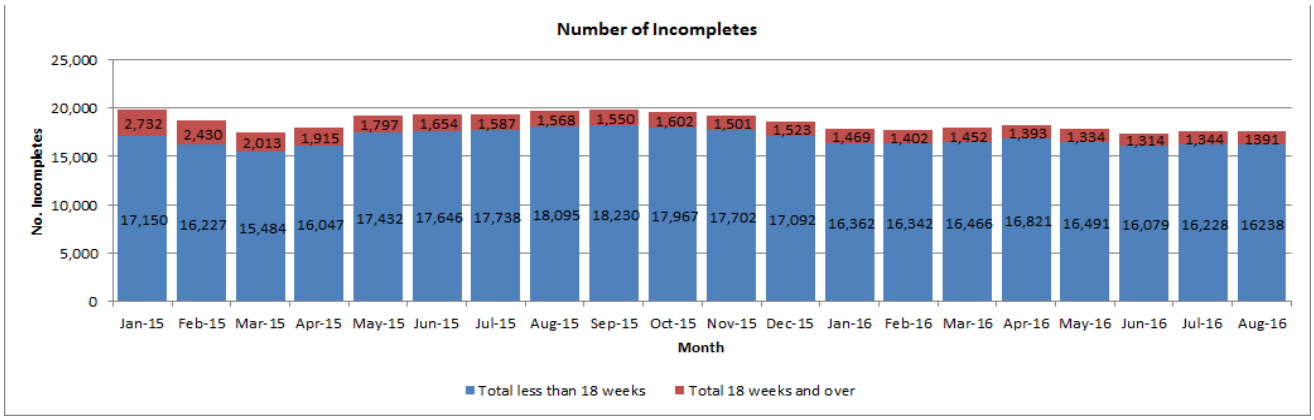
3.3 In July the CCG achieved the incompletes standard at 92.35% and THFT continued to achieve at 93.06%. The National RTT stress test demonstrates the trust are continuing to reduce the risk of failing RTT, this will have a positive impact on CCG performance.



	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%
Aug	92.1%	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 increased.



	T&G Patients at all Providers																			
Weeks Wait	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
52+ Weeks	29	18	6	6	5	1	1	0	1	2	0	1	0	2	0	1	0	0	1	1
40+ Weeks (inc. 52+	149	118	90	126	101	92	61	45	39	30	28	42	47	51	49	34	31	24	28	35
28-40 Weeks	680	642	512	525	486	422	307	300	307	272	295	341	339	255	245	265	274	251	243	274
18-27 Weeks	1903	1670	1411	1264	1210	1140	1219	1223	1204	1300	1178	1140	1083	1096	1158	1094	1029	1039	1073	1082
14-17 Weeks	2395	1959	1884	1254	1828	1987	1890	2039	2242	2288	2038	2051	2191	1930	1836	1424	1670	1591	1415	1546
0-13 Weeks	14755	14268	13600	14793	15604	15659	15848	16056	15988	15679	15664	15041	14171	14412	14630	15397	14821	14488	14813	14692
Total	19882	18657	17497	17962	19229	19300	19325	19663	19780	19569	19203	18615	17831	17744	17918	18214	17825	17393	17572	17629

3.5 There was one patient waiting more than 52 weeks for treatment at UHSM, this patient has now been seen.

3.6 Tameside expects to report zero 52-week waits for September. However the risk of 52 week waiters remains with ten patients at 43 to 47 weeks. Also there are 47 patients waiting over 36 weeks without a decision to admit. Earlier this year the University Hospitals of South Manchester FT identified a data quality issue of patients who had been waiting >52 weeks not being identified. UHSM, NHSE, Monitor, and SMCCG have been addressing this matter. Following identification of this issue earlier this year, intensive validation work was carried out at the Trust and are still finding new >52 week pathways. As of 06 October 2016, eight patients had been waiting longer than 52 weeks when treated. Zero patients 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 Weeks
	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	1037	56	38	11	7	4	0	0	1	2.0%
Cardiothoracic Surgery	48	6	4	4	2	1	0	0	0	10.8%
Dermatology	1015	16	4	2	2	0	0	0	0	0.4%
Ear, Nose & Throat (ENT)	1330	45	21	16	2	2	0	0	0	1.4%
Gastroenterology	664	24	11	3	0	1	0	0	0	0.6%
General Medicine	990	23	19	10	4	2	0	0	0	1.5%
General Surgery	1873	70	45	15	3	4	1	1	0	1.2%
Geriatric Medicine	13	1	1	0	0	0	0	0	0	0.0%
Gynaecology	1224	55	33	19	6	2	0	1	0	2.1%
Neurology	5	0	0	0	0	0	0	0	0	0.0%
Neurosurgery	18	3	1	0	0	0	0	0	0	0.0%
Ophthalmology	1172	22	1	4	2	1	1	0	0	0.7%
Oral Surgery	4	1	1	0	0	0	0	0	0	0.0%
Other	2677	119	63	31	13	10	4	0	0	2.0%
Plastic Surgery	175	10	4	8	1	1	1	0	0	5.5%
Rheumatology	261	6	4	3	2	2	0	0	0	2.5%
Thoracic Medicine	178	15	7	4	1	1	0	0	0	2.9%
Trauma & Orthopaedics	2542	130	82	38	16	9	2	0	0	2.3%
Urology	1012	107	34	15	9	3	1	0	0	2.4%
Total	**16,238**	**709**	**373**	**183**	**70**	**43**	**10**	**2**	**1**	**1.8%**

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.

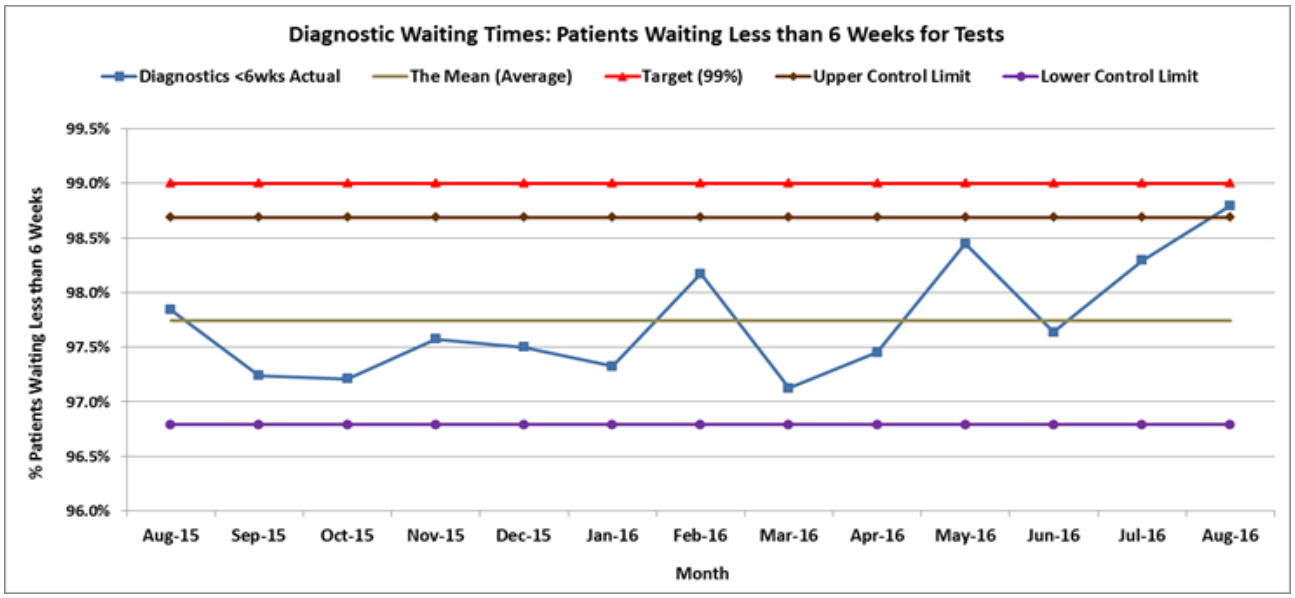
% of Patients waiting less than 18 weeks, by speciality, from All	Incomplete	Clearance Rates	
	Threshold 92%	Threshold 10-12 weeks	Change from last month
Cardiology	89.86%	19.64	⇧
Cardiothoracic Surgery	73.85%	14.44	⇧
Dermatology	97.69%	15.51	⇩
Ear, Nose & Throat (ENT)	93.93%	9.85	⇩
Gastroenterology	94.45%	7.77	⇧
General Medicine	94.47%	14.56	⇩
General Surgery	93.09%	7.37	⇧
Geriatric Medicine	86.67%	30.00	⇧
Gynaecology	91.34%	10.06	⇧
Neurology	100.00%		
Neurosurgery	81.82%	17.60	⇧
Ophthalmology	97.42%	10.28	⇩
Oral Surgery	66.67%	12.00	⇧
Plastic Surgery	87.50%	11.27	⇧
Rheumatology	93.88%	11.58	⇩
Thoracic Medicine	86.41%	9.81	⇩
Trauma & Orthopaedics	90.17%	10.68	⇧
Urology	85.69%	14.63	⇩
Other	91.77%	12.18	⇩
Total	**92.11%**	10.96	⇧

3.8 Five of these are the specialities where THFT also failed the standard and still have a backlog. Whilst reducing the backlog for Gynaecology and Urology there appears to be a small backlog in Oral Surgery Orthopaedics has stayed static. Overall the backlog at THFT has decreased by 11.

Specialty	Incomplete Performance	> 18 Weeks	< 18 Weeks	Total	August Backlog	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
General Surgery	94.00%	124	1941	2065											10	40	70	90
Urology	89.94%	71	635	706	15		9	7	7	30	30	40	20	5	25	10		
Orthopaedics	86.99%	239	1598	1837	92	100	100	100	89	120	130	140	160	150	180	210	210	190
ENT	92.25%	66	786	852														
Ophthalmology	99.46%	3	550	553														
Oral Surgery	93.52%	32	462	494		2												
Neurosurgery	89.47%	2	17	19	1			2	1									
Plastic Surgery	86.11%	5	31	36	2		2	1						7	30	15		
CT Surgery	100.00%	0	2	2							5			1				
Adult Medicine	94.60%	52	911	963														
Gastroenterology	94.29%	38	627	665									6	30				10
Cardiology	92.76%	71	910	981									6		10	40	40	100
Dermatology	97.89%	23	1065	1088					9									
Rheumatology	94.04%	13	205	218														
Gynaecology	90.04%	109	985	1094	21	40	44	50	70	60	25							
Other	95.70%	67	1491	1558														
Trust	**93.03%**	**915**	**12216**	**13131**	131	142	155	160	176	210	190	180	192	193	255	315	320	390

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

3.9 In July we failed the diagnostic standard at 1.20% against 1.0% Standard for waiting 6 or more weeks. This was primarily due to Tameside Trust. This month we have seen a further decrease in over 6 week waiters at Care UK and Pioneer Healthcare as well as Central Manchester Trust.



Financial Year	2016 - 2017	Reporting Month	August	Choose Trust	All

Diagnostic Waiting - All Providers

	All Providers	June 2016				July 2016				August 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	579	0	0	0.0%	507	0	0	0.0%	527	6	0	1.1%
	CMMC	28	3	3	17.6%	44	1	3	8.3%	50	5	1	10.7%
	Pennine Acute	9	3	0	25.0%	10	4	0	28.6%	8	2	3	38.5%
	Salford	3	0	0	0.0%	2	1	0	33.3%	4	0	0	0.0%
	South Mc.	5	0	0	0.0%	5	0	0	0.0%	7	0	0	0.0%
	Stockport	18	0	0	0.0%	23	1	0	4.2%	20	0	1	4.8%
	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%	11	0	0	0.0%	8	0	0	0.0%
	Other	2	0	0	0.0%	4	1	0	20.0%	3	0	0	0.0%
	Total	**651**	**6**	**3**	**1.4%**	**606**	**8**	**3**	**1.8%**	**627**	**13**	**5**	**2.8%**
Non-Endoscopy	THFT	2654	28	0	1.0%	2677	31	0	1.1%	2475	18	5	0.9%
	CMMC	340	16	5	5.8%	313	4	4	2.5%	339	2	3	1.5%
	Pennine Acute	69	0	0	0.0%	73	0	0	0.0%	44	0	0	0.0%
	Salford	131	0	0	0.0%	149	0	0	0.0%	157	0	0	0.0%
	South Mc.	100	0	0	0.0%	58	1	0	1.7%	88	0	0	0.0%
	Stockport	204	1	0	0.5%	171	0	0	0.0%	170	0	0	0.0%
	Ashton Primary Care Centre	54	0	0	0.0%	32	0	0	0.0%	13	0	0	0.0%
	Care UK	709	50	0	6.6%	524	24	0	4.4%	601	8	0	1.3%
	Other	91	12	0	11.7%	68	6	0	8.1%	89	1	1	2.2%
	Total	**4352**	**107**	**5**	**2.5%**	**4065**	**66**	**4**	**1.7%**	**3976**	**29**	**9**	**0.9%**
	Overall Position	**5003**	**113**	**8**	**2.36%**	**4671**	**74**	**7**	**1.70%**	**4603**	**42**	**14**	**1.20%**

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 and August performance has increased.

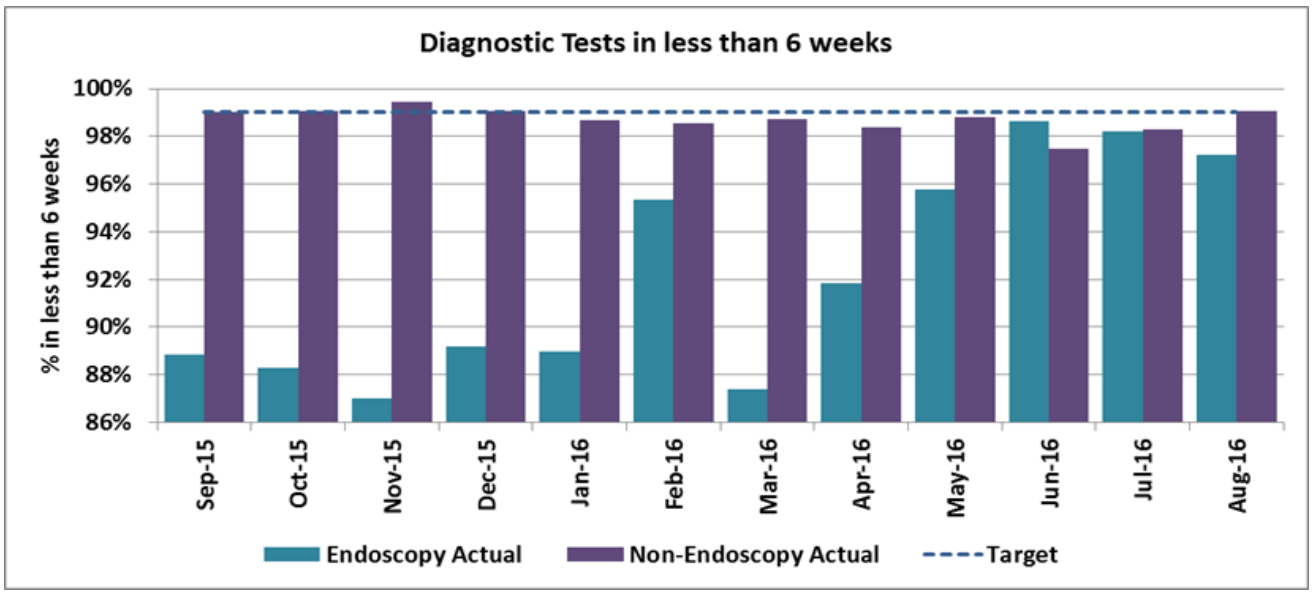
3.11 At the end of August 56 patients were waiting 6 weeks and over for a diagnostic test, 14 of which were over 13 weeks. 10 were at Central Manchester Trust.

Provider	Test	Total 6-13 weeks	13+ Weeks
CMMC	Cardiology - echocardiography	0	3
	Flexi sigmoidoscopy	1	0
	Gastroscopy	4	1
	Magnetic Resonance Imaging	2	0
	Total	**7**	**4**
Pennine Acute	Colonoscopy	0	2
	Gastroscopy	2	1
	Total	**2**	**3**
Stockport	Colonoscopy	0	1
	Total	**0**	**1**
THFT	Audiology - Audiology Assessments	14	5
	Colonoscopy	3	0
	Computed Tomography	3	0
	Gastroscopy	3	0
	Non-obstetric ultrasound	1	0
	Total	**24**	**5**
Care UK	Audiology - Audiology Assessments	4	0
	Magnetic Resonance Imaging	4	0
	Total	**8**	**0**
	Neurophysiology - peripheral neurophysiology **(NEY Pioneer Healthcare Limited)**	1	1
	Total	**1**	**1**
	Total	**42**	**14**

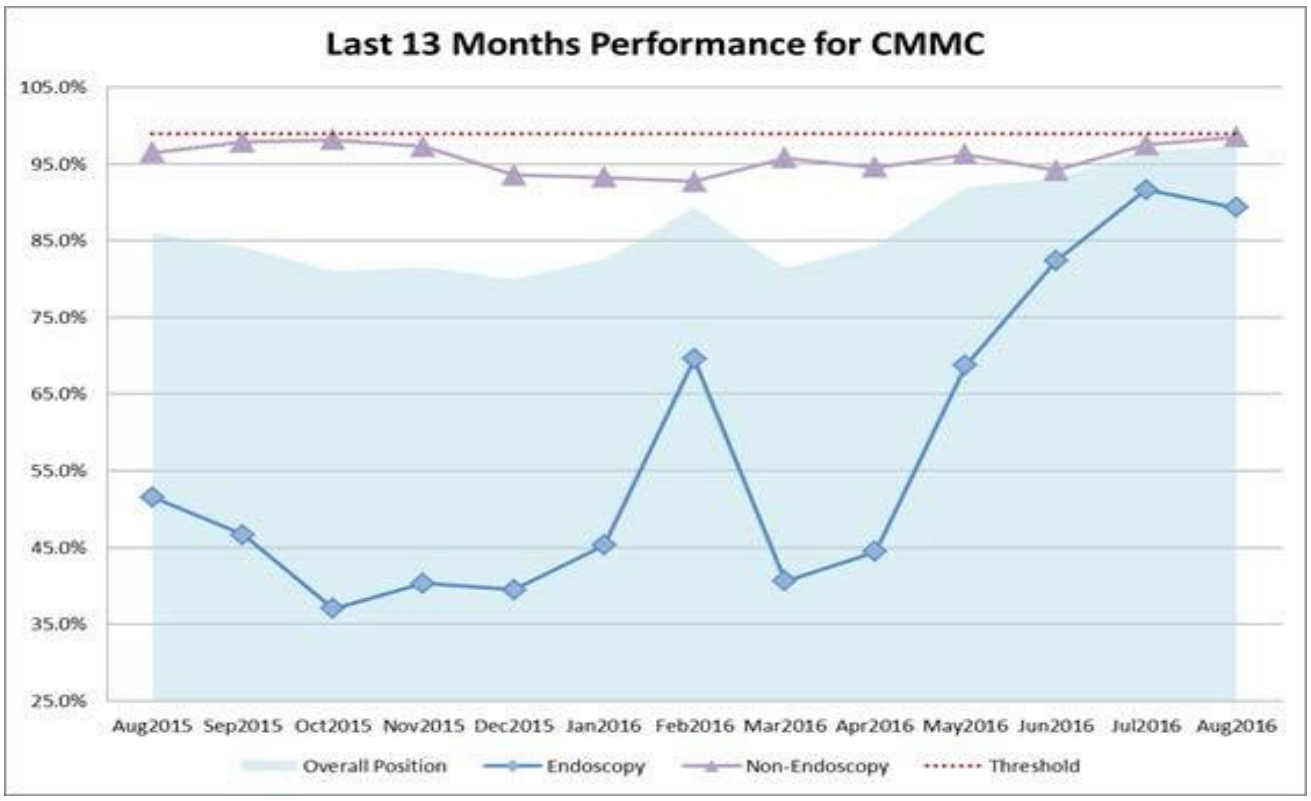
3.12 The backlog in endoscopy appears to have decreased and now accounts for 32% of breaches. Central Manchester Trust has agreed with a private provider to undertake additional activity to help with the backlog clearance.

Diagnostic Waiting - All Tests for All

	All Providers	June 2016				July 2016				August 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	281	4	3	2.4%	256	5	3	3.0%	270	3	3	2.2%
	Cystoscopy	52	0	0	0.0%	45	0	0	0.0%	51	0	0	0.0%
	Flexi sigmoidoscopy	61	0	0	0.0%	79	0	0	0.0%	75	1	0	1.3%
	Gastroscopy	257	2	0	0.8%	226	3	0	1.3%	231	9	2	4.5%
	Total	651	6	3	1.4%	606	8	3	1.8%	627	13	5	2.8%
Non-Endoscopy	Audiology - Audiology Assessments	329	21	0	6.0%	433	29	0	6.3%	345	18	5	6.3%
	Barium Enema	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Cardiology - echocardiography	515	8	4	2.3%	407	1	3	1.0%	473	0	3	0.6%
	Cardiology - electrophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%
	Computed Tomography	831	2	0	0.2%	781	0	0	0.0%	695	3	0	0.4%
	DEXA Scan	108	0	0	0.0%	78	0	0	0.0%	56	0	0	0.0%
	Magnetic Resonance Imaging	1320	59	0	4.3%	1146	27	0	2.3%	1226	6	0	0.5%
	Neurophysiology - peripheral neurophysiology	158	15	0	8.7%	160	7	0	4.2%	169	1	1	1.2%
	Non-obstetric ultrasound	1059	1	0	0.1%	1031	2	0	0.2%	986	1	0	0.1%
	Respiratory physiology - sleep studies	30	0	0	0.0%	23	0	0	0.0%	24	0	0	0.0%
	Urodynamics - pressures & flows	2	1	1	50.0%	6	0	1	14.3%	2	0	0	0.0%
	Total	4352	107	5	2.5%	4065	66	4	1.7%	3976	29	9	0.9%
	Overall Position	5003	113	8	2.36%	4671	74	7	1.70%	4603	42	14	1.20%

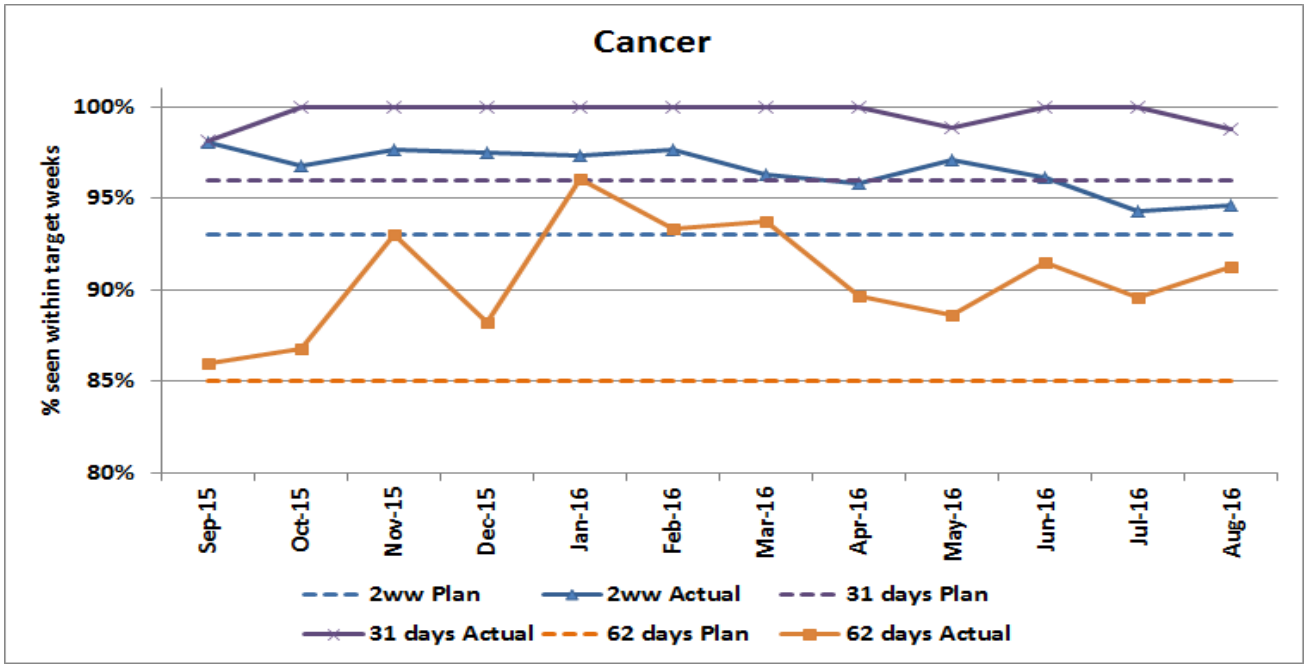


3.13 THFT performance in endoscopy has stayed the same as last month and Central Manchester showing an increase in performance.



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

3.14 We achieved all the standards In August and achieved all standards in Quarter 1.



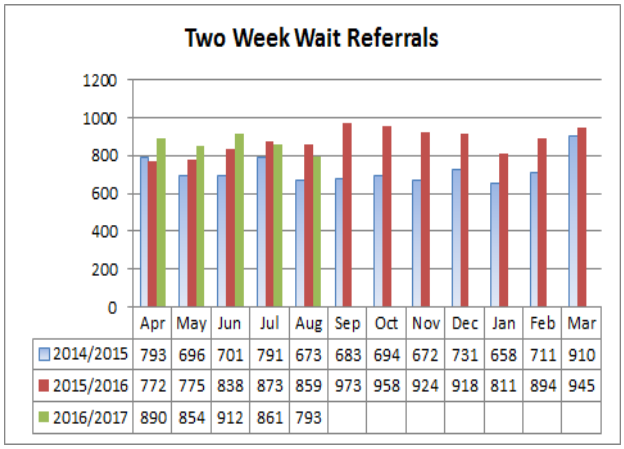
3.15 Our full performance is shown below with all standards achieved. Quarter 1 standards achieved.

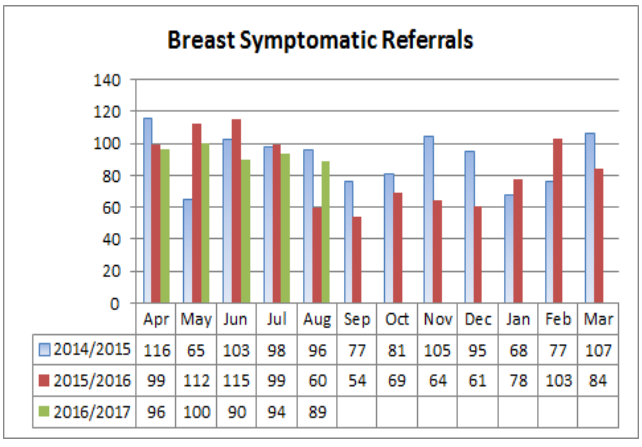
		Performance							No. of patients not receiving care within standard in August
Indicator Name	Standard	March 15/16	April 16/17	May 16/17	June 16/17	Q1 16/17	July 16/17	August 16/17	
Cancer 2 week waits	93.00%	96.3%	95.82 %	97.07 %	96.12%	96.34%	94.32%	94.64%	39
Cancer 2 week waits - Breast symptoms	93.00%	98.88 %	93.88 %	98.00 %	95.79 %	95.92 %	94.00 %	96.66 %	3
Cancer 62 day waits – GP Referral	85.00%	93.75 %	89.66 %	88.64 %	91.49 %	90.00 %	89.58 %	91.30 %	4
Cancer 62 day waits - Consultant upgrade	85.00%	88.24 %	83.33 %	86.67 %	94.44 %	88.24 %	82.35 %	100%	0
Cancer 62 day waits - Screening	90.00%	100%	100%	100%	60.00 %	87.50 %	100%	100%	0
Cancer day 31 waits	96.00%	100%	100%	98.89 %	100%	99.65 %	100%	98.81 %	1
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	100%	100%	0

3.16 Tameside achieved all the standards.

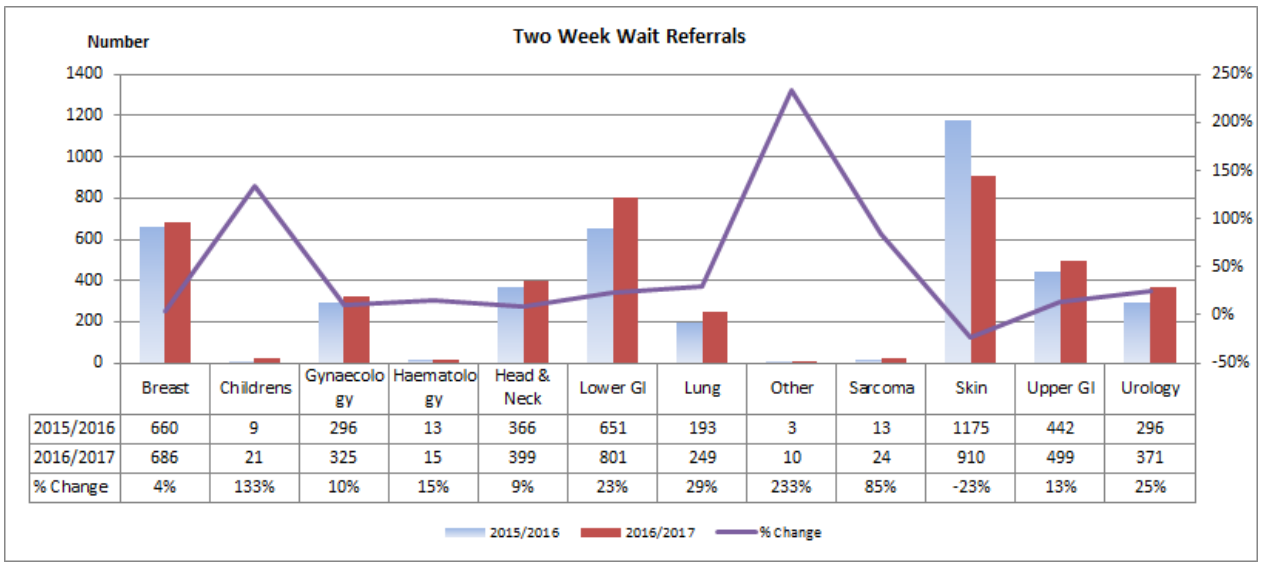
		Performance							No. of patients not receiving care within standard in August
Indicator Name	Standard	March 15/16	April 16/17	May 16/17	June 16/17	Q1 16/17	July 16/17	August 16/17	
Cancer 2 week waits	93.00%	95.8%	95.8 %	97.1 %	96.6%	96.5%	94.8%	95.4%	44
Cancer 2 week waits - Breast symptoms	93.00%	98.8 %	93.8 %	98.0 %	94.4 %	95.5 %	94.7 %	94.3 %	2
Cancer 62 day waits – GP Referral	85.00%	95.9 %	91.3 %	87.7 %	91.0 %	90.2 %	88.2 %	92.3 %	3
Cancer 62 day waits - Consultant upgrade	85.00%	87.1 %	89.5 %	84.6 %	93.5 %	89.5 %	86.1 %	100%	0
Cancer 62 day waits - Screening	90.00%	100%	N/A	N/A	100%	100%	N/A	N/A	0
Cancer day 31 waits	96.00%	100%	98.6 %	100%	100%	99.5 %	100%	100%	0
Cancer day 31 waits - Surgery	94.00%	100%	100%	100%	100%	100%	100%	100%	0
Cancer day 31 waits - Anti cancer drugs	98.00%	100%	100%	N/A	100%	100%	100%	100%	0
Cancer day 31 waits - Radiotherapy	94.00%	100%	100%	100%	100%	100%	100%	100%	0

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





3.18 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	660	9	296	13	366	651	193	3	13	1175	442	296
2016/2017	686	21	325	15	399	801	249	10	24	910	499	371
% Change	4%	133%	10%	15%	9%	23%	29%	233%	85%	-23%	13%	25%

Urgent Care – please note position reported is at 9 October 2016

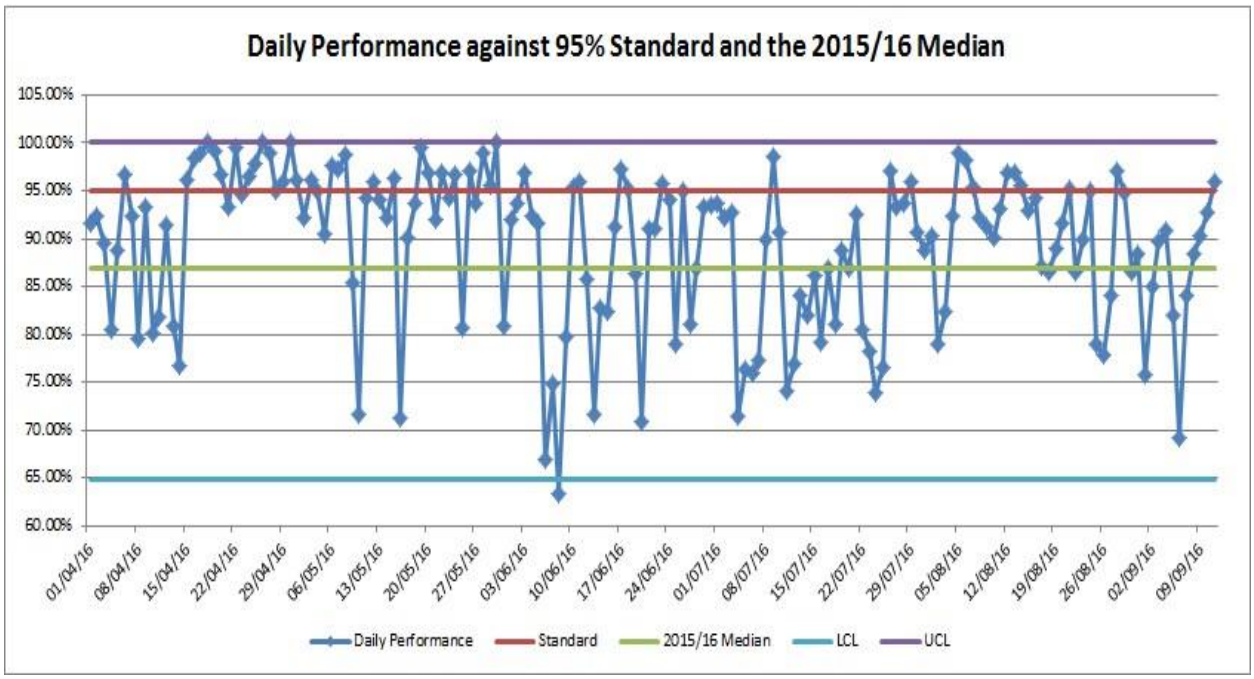
3.19 THFT A&E performance is as below.

Apr-16	May-16	Jun-16	July-16	Aug-16	Sept-16
92.46%	**92.16%**	**86.61%**	**84.98%**	**90.48%**	**82.74%**

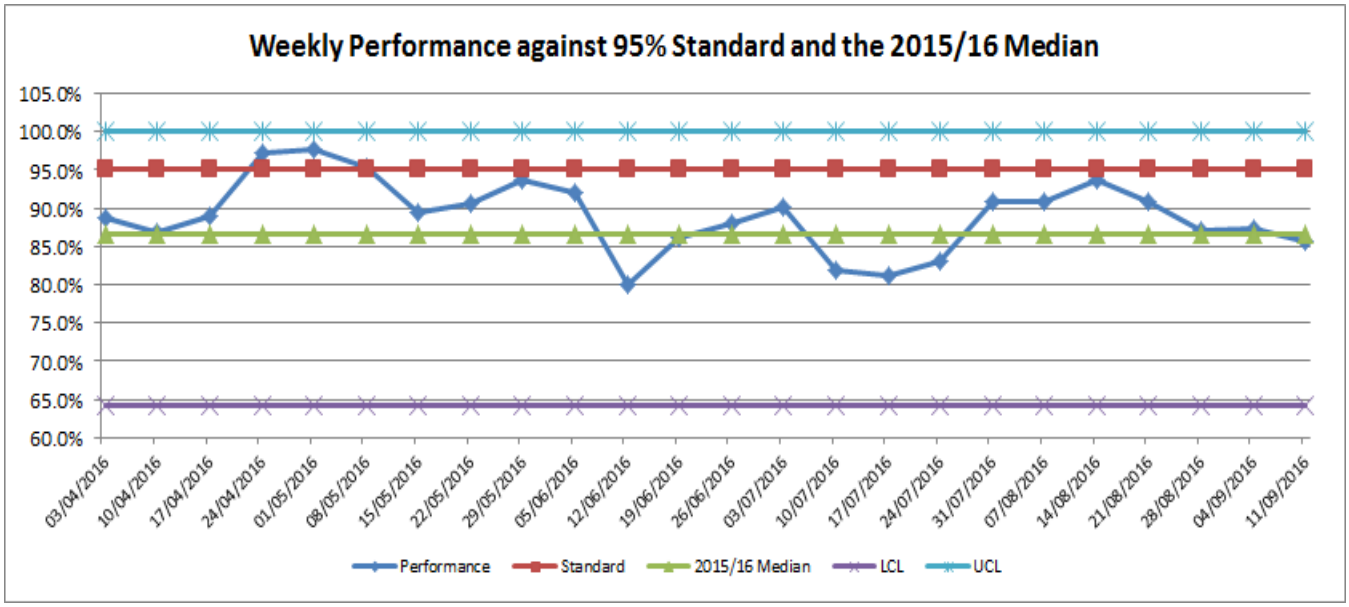
3.20 We are currently the third best performer across the GM trusts YTD, reported through Utilisation Management. Our June and July, August performance and September performance to the 09th has not achieved the standard.

	Financial Year to 09 October 16	April 2016/17	May 2016/17	June 2016/17	July 2016/17	August 2016/17	September 2016/17	Oct to 09th 2016/17
Wigan	**91.65%**	**92.93%**	**90.30%**	**93.87%**	**89.67%**	**92.04%**	**91.97%**	**94.16%**
Salford	**89.88%**	**92.52%**	**90.21%**	**94.05%**	**81.69%**	**89.80%**	**91.70%**	**89.42%**
Tame side	**87.84%**	**92.46%**	**92.16%**	**86.61%**	**84.98%**	**90.48%**	**82.74%**	**79.82%**
Oldham	**86.59%**	**86.89%**	**90.39%**	**86.58%**	**83.72%**	**88.64%**	**84.31%**	**85.47%**
Bury	**84.64%**	**82.72%**	**84.74%**	**86.35%**	**82.90%**	**82.57%**	**87.58%**	**86.90%**
Bolton	**83.43%**	**80.25%**	**81.29%**	**85.33%**	**81.94%**	**86.13%**	**87.03%**	**92.98%**
Stockport	**79.34%**	**79.31%**	**81.59%**	**85.26%**	**81.51%**	**77.11%**	**71.17%**	**78.09%**
North Manchester	**77.32%**	**80.20%**	**77.90%**	**75.11%**	**71.24%**	**83.27%**	**77.04%**	**80.15%**

3.21 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.



3.22 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.

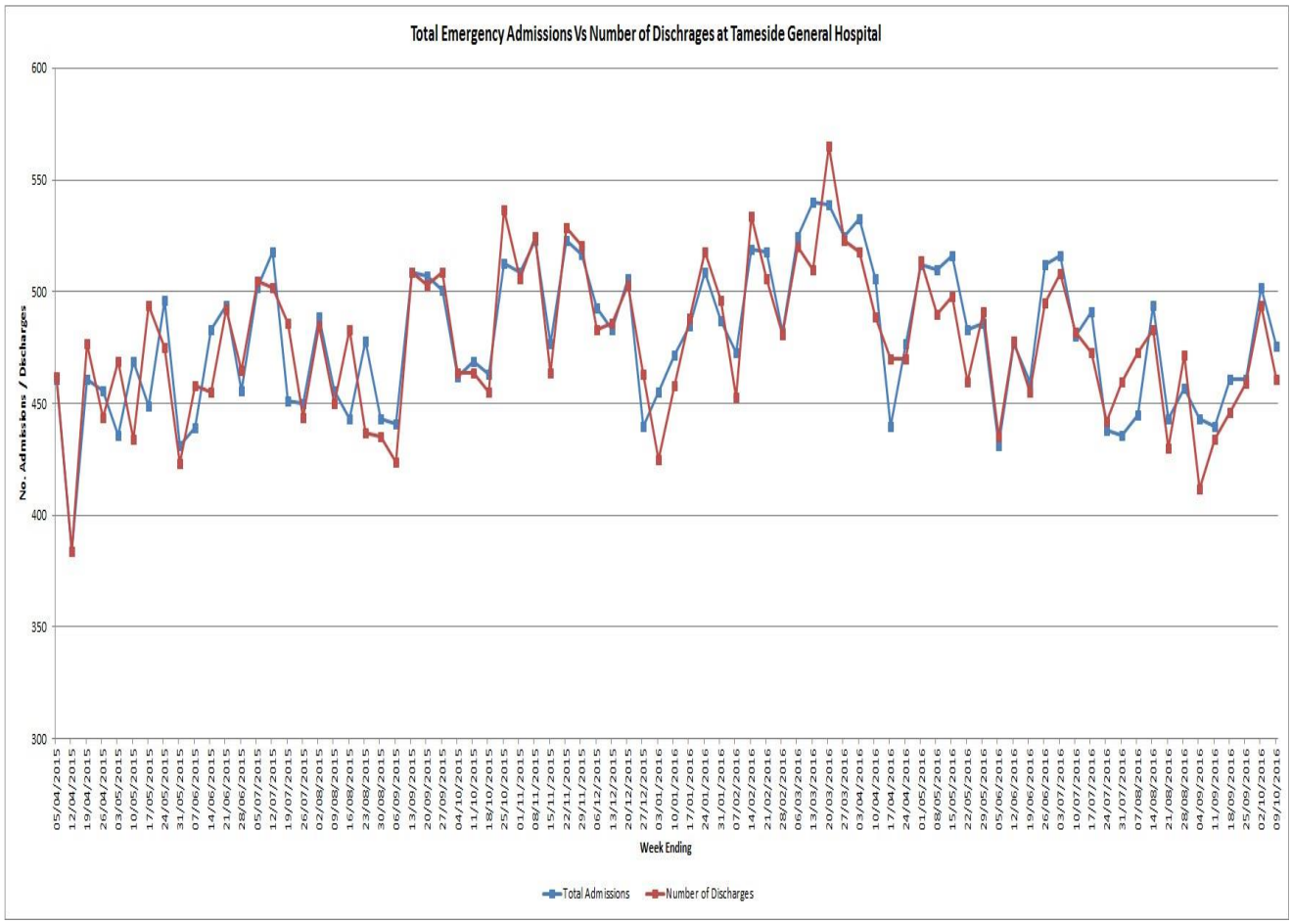


3.23 There has previously been considerable variation on a daily basis with no clear reason, but more recently that has stabilised. During April the standard was achieved but May, June, July, August and September has seen a drop in performance.

3.24 During June, July August and September 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	w/e 18 Sep	w/e 25 Sep	w/e 2 Oct	w/e 9 Oct	Cumulative
Awaiting bed	27	51	66	100	24	34	15	51	54	72	38	91	70	120	103	3951
Specialty Delay	18	20	26	21	24	20	18	17	19	14	18	54	13	29	37	1249
Delayed Medical Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	510
Other	2	5	5	7	0	8	2	4	2	5	1	11	8	9	13	683
Late First Assessment	94	211	215	146	85	61	27	39	85	77	136	174	99	102	191	5594
Clinical	18	19	15	11	11	9	24	20	20	20	20	17	20	26	25	1049
CT Delay	1	0	0	1	1	1	4	1	1	1	5	4	4	3	0	201
Late Referral to Specialty	3	3	3	4	3	0	2	8	13	1	8	10	10	9	11	366
Seen after 4 hours	0	0	0	0	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	3	3	9	4	243
Pathology Delay	0	0	0	0	1	0	1	0	1	0	2	0	2	0	0	66
XR Delay	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	21
Unknown	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	85
Total	**166**	**310**	**335**	**296**	**154**	**137**	**95**	**141**	**198**	**194**	**231**	**364**	**229**	**307**	**385**	**14041**

3.25 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.



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

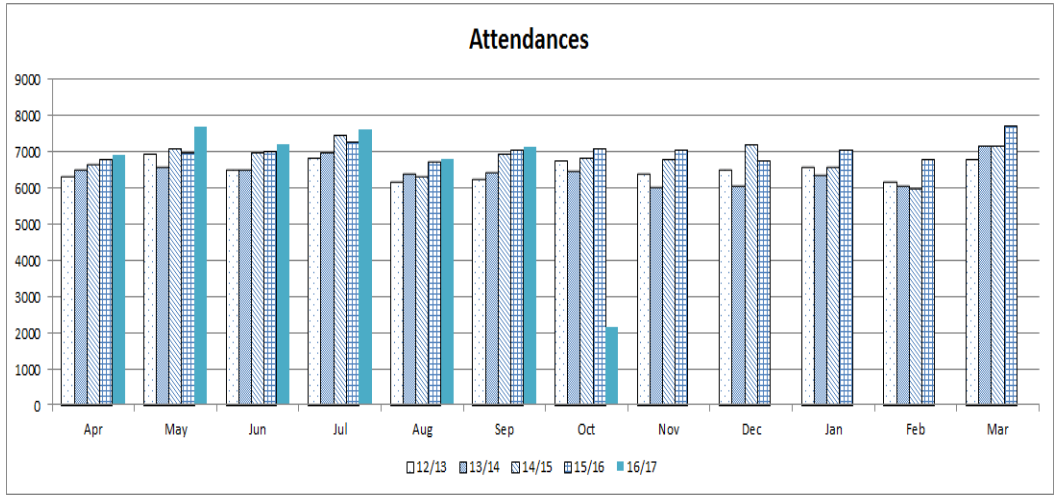
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
A&E Attendances	6890	7680	7182	7609	6799	7109
4 hour Breaches	523	602	963	1144	647	1227
% Seen within 4 hours	92.41%	92.16%	86.59%	84.97%	90.48%	82.74%
Admissions via A&E	1764	1885	1773	1776	1767	1705
Other Emergency Admissions	309	309	303	267	267	280
All Emergency Admissions	2073	2194	2076	2043	2034	1985
Discharges	2037	2091	2098	2027	2031	1899

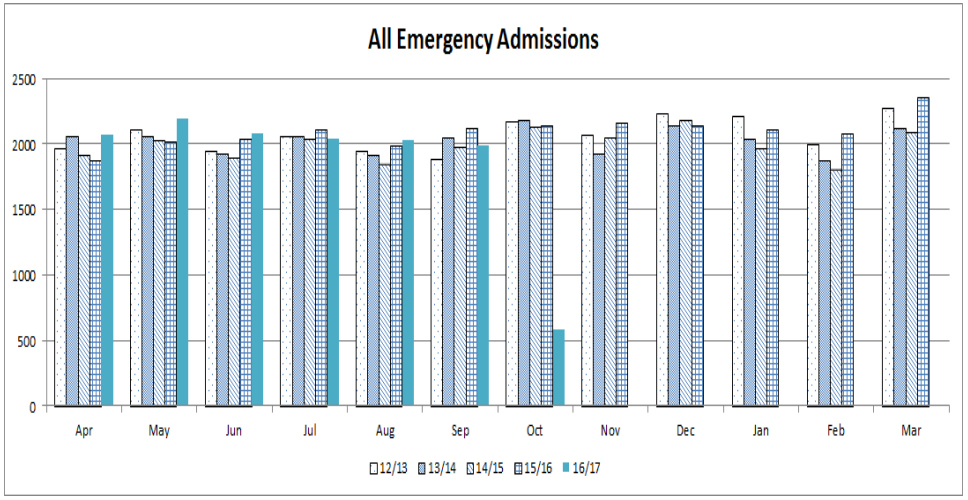
Variance

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
102	715	155	348	62	72
-402	157	499	548	-83	364
174	201	53	-15	86	-59
16	-30	-19	-58	-40	-86
190	171	34	-73	46	-145
117	83	55	-133	85	-206

% variance

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1.5%	10.3%	2.2%	4.8%	0.9%	1.0%
-43.5%	35.3%	107.5%	91.9%	-11.4%	42.2%
10.9%	11.9%	3.1%	-0.8%	5.1%	-3.3%
5.5%	-8.8%	-5.9%	-17.8%	-13.0%	-23.5%
10.1%	8.5%	1.7%	-3.4%	2.3%	-6.8%
6.1%	4.1%	2.7%	-6.2%	4.4%	-9.8%



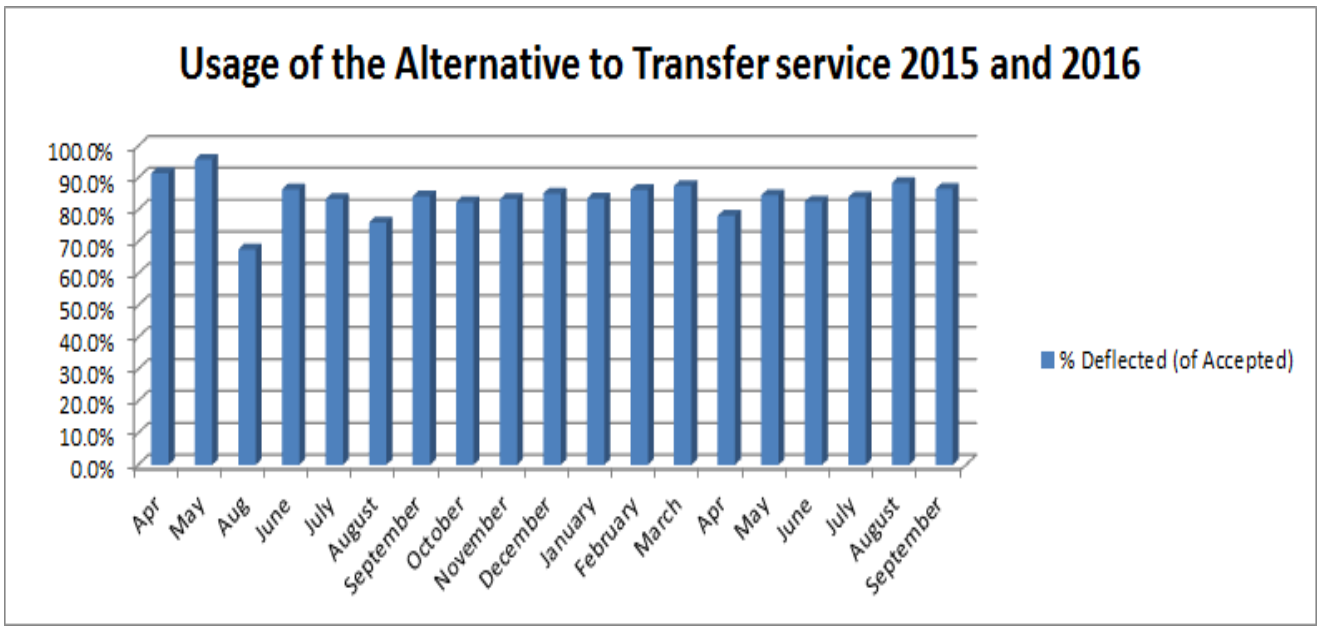


3.27 Since September 2015 there has been considerable variation in the numbers of attendances and admissions and breaches have risen significantly. During April this had stabilised and breaches had reduced, which now look to have increased during May, June, July August and September.

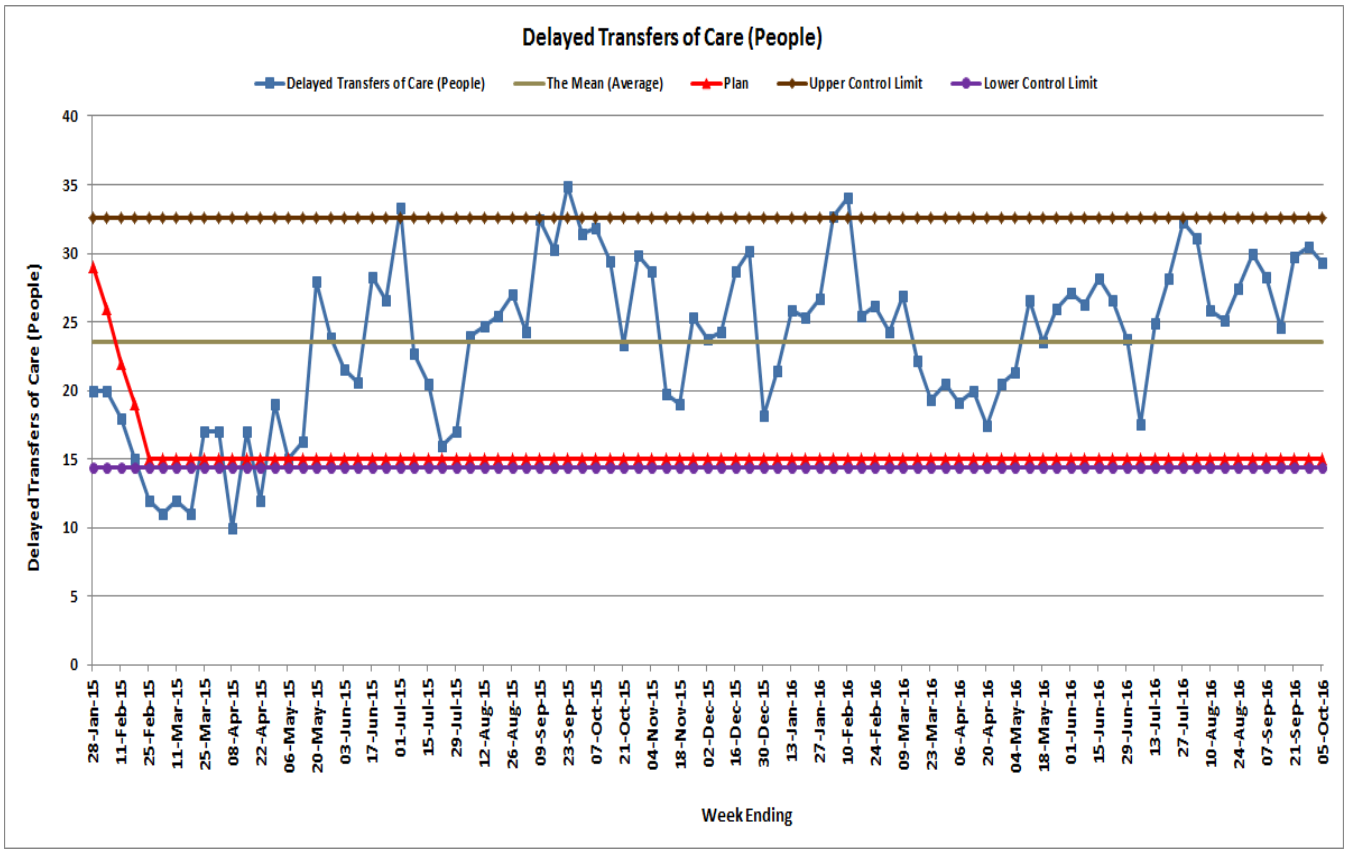
Week Ending	Actual Number of A&E Type 1 Attendances	Actual Number of 4 hour Type 1 breaches	Actual Performance	Number of Emergency Admissions via A&E	Number of Direct Emergency Admissions	Total Emergency Admissions
03 Jul	1686	166	90.2%	443	73	516
10 Jul	1701	310	81.8%	422	59	481
17 Jul	1785	335	81.2%	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
18 Sep	1702	364	78.6%	392	69	461
25 Sep	1691	230	86.4%	409	52	461
02 Oct	1637	307	81.2%	421	81	502
09 Oct	1692	381	77.5%	404	72	476

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

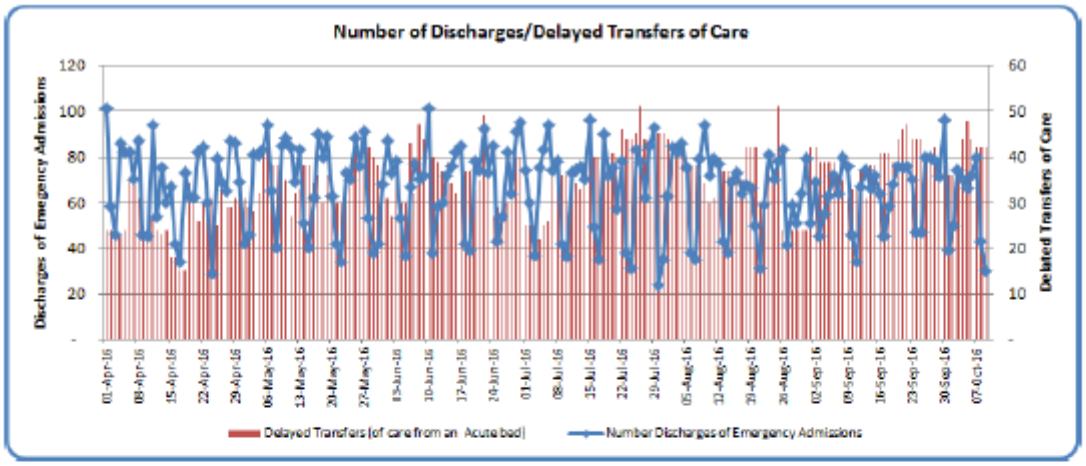
	April	May	June	July	August	September	October to 09th
Referrals	198	183	178	221	190	188	58
Accepted	196	183	177	220	190	188	58
Red Refusals to Hospital also seen	18	15	17	27	34	25	10
Deflected	139	142	132	162	138	141	44
Accepted %	99.0	100	99.4	99.5	100	100	100
% Deflected (of Referrals)	78.1	85	82.5	83.9	88.5	86.5	92
% Deflected (of Accepted)	**78.1**	**85**	**82.5**	**83.9**	**88.5**	**86.5**	**92**

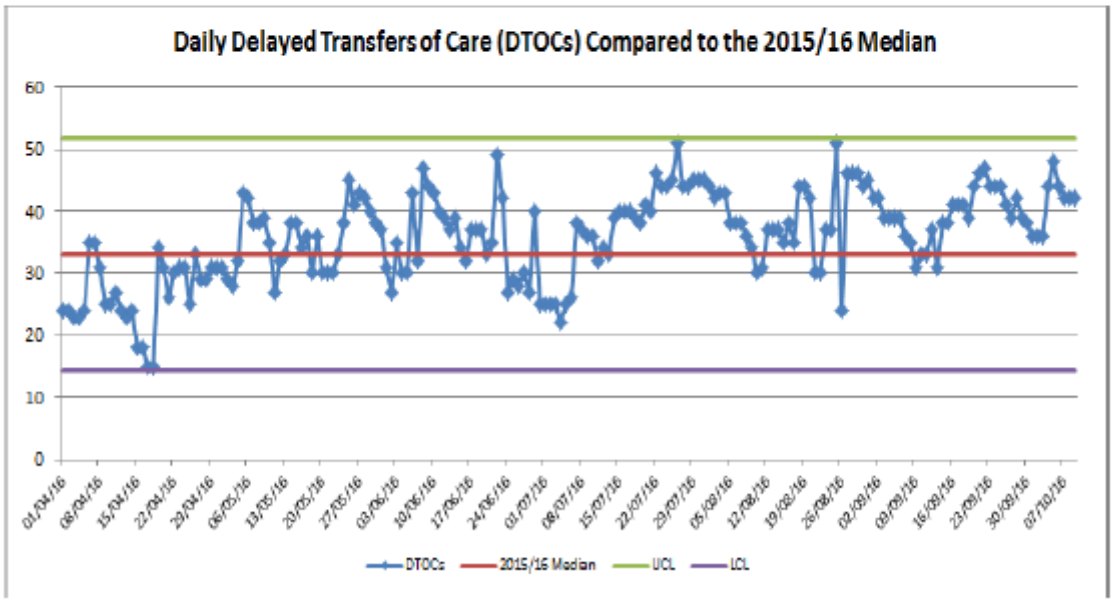


3.29 The number of Delayed Transfers of Care (DTOC) recorded has increased recently.



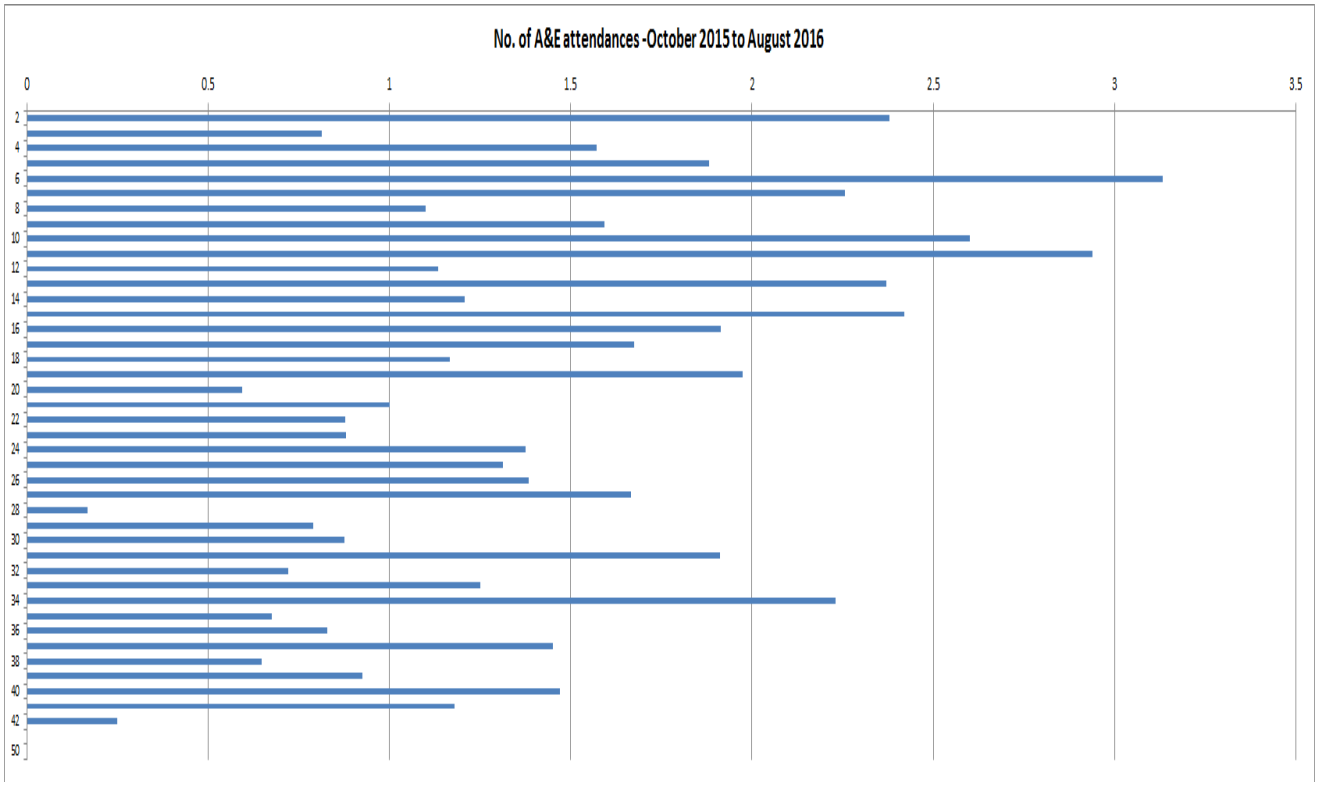
3.30 Reducing DTOC and the level of variation day by day is a key aspect of the improvement plan with Integrated Urgent Care Team designed to significantly impact on bed availability by improving patient flow out of the hospital and avoiding admissions. This should deliver a culture of' Discharge to 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 Emergency Admissions
Delated Transfers of Care
Delayed Transfers (of care from an Acute bed)
Number Discharges of Emergency Admissions

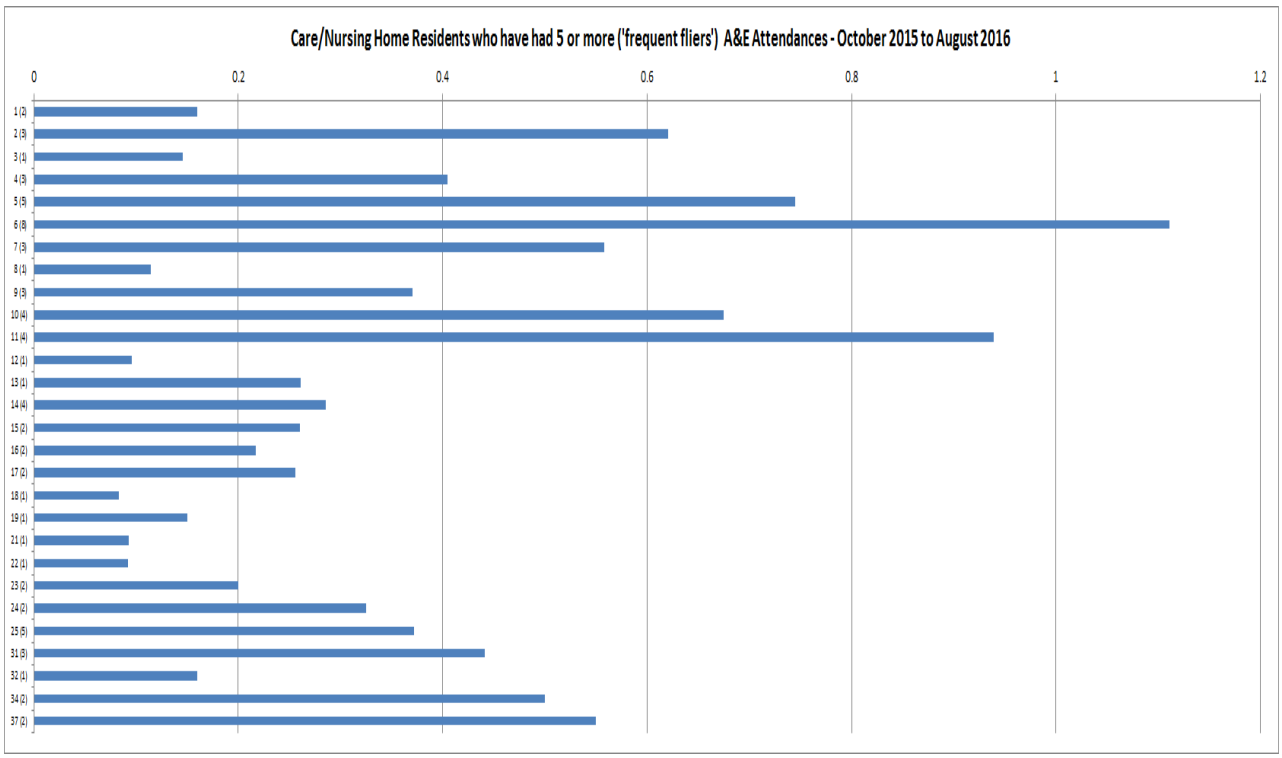

Daily Delayed Transfers of Care (DTOCs) Compared to the 2015/16 Median
DTOCs
2015/16 Median
UCL
LCL

Care Homes

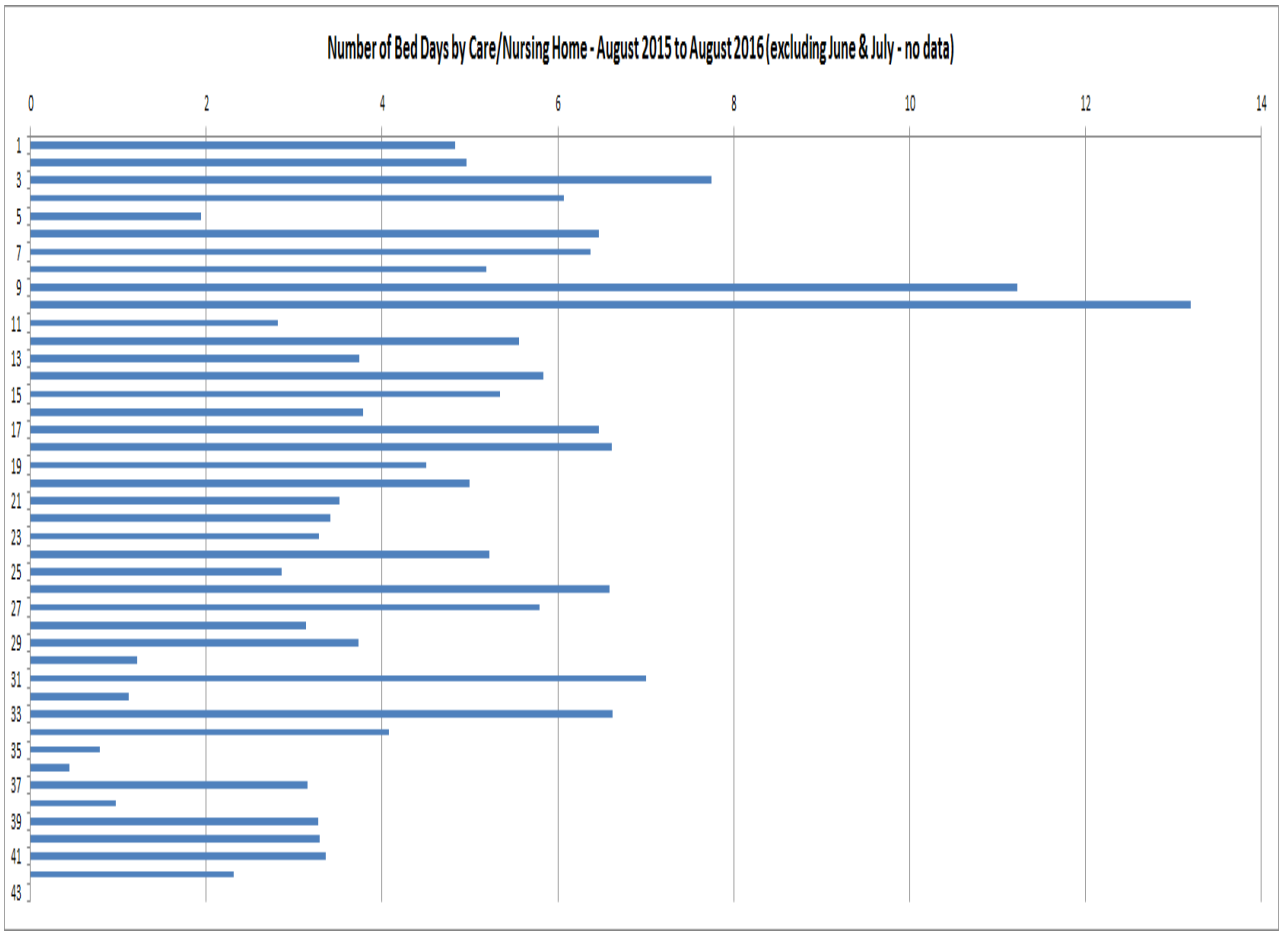
3.31 The decision was made to specifically look at the care homes use of our urgent care systems. This was to allow us to look to see if we can identify themes and trends regarding particular care home providers. In doing this it would allow us to focus support which will be individual to providers.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



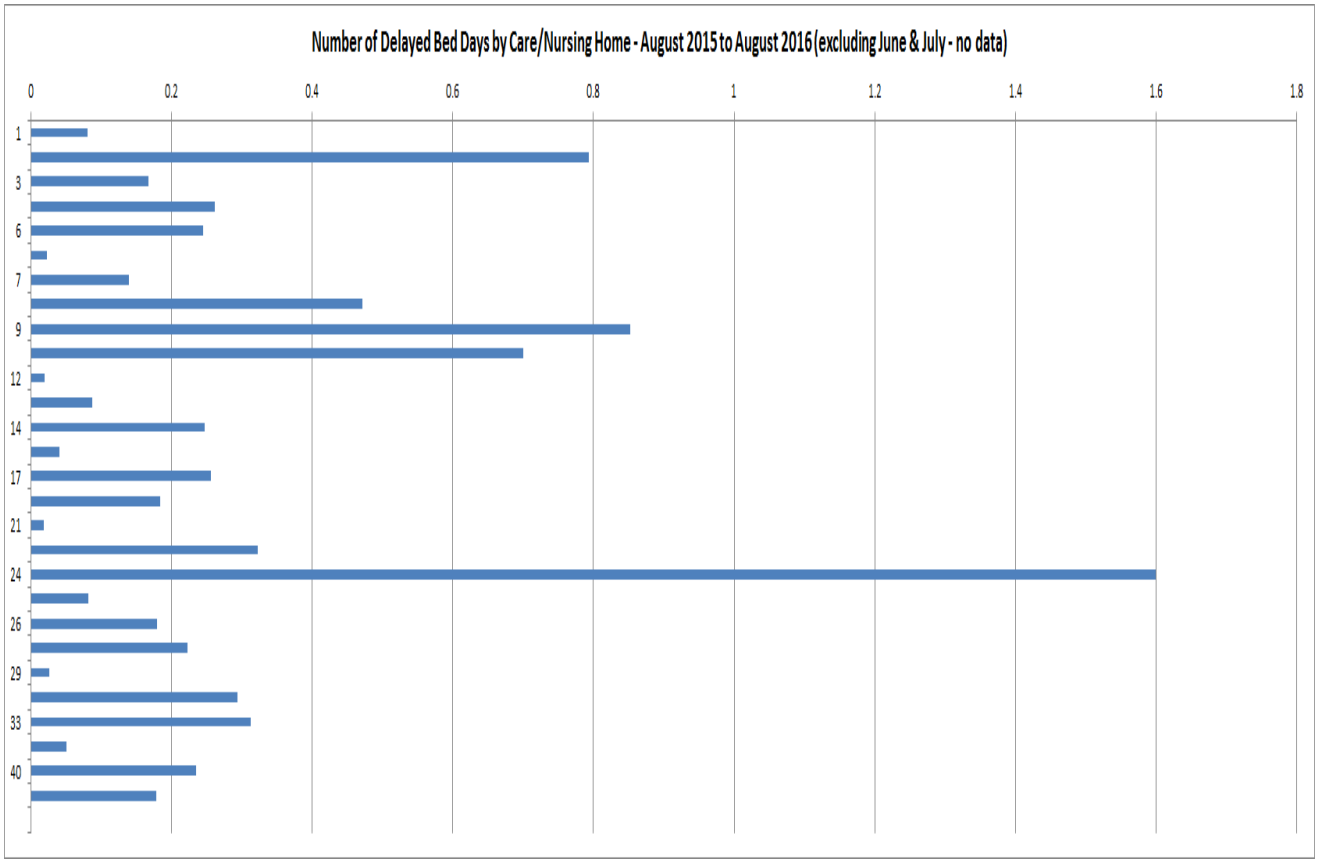
3.32 Work is currently being done to present this graph showing a month on month position. This will allow us to monitor attendances per care home per month giving us the ability to take action in a more timely manner.



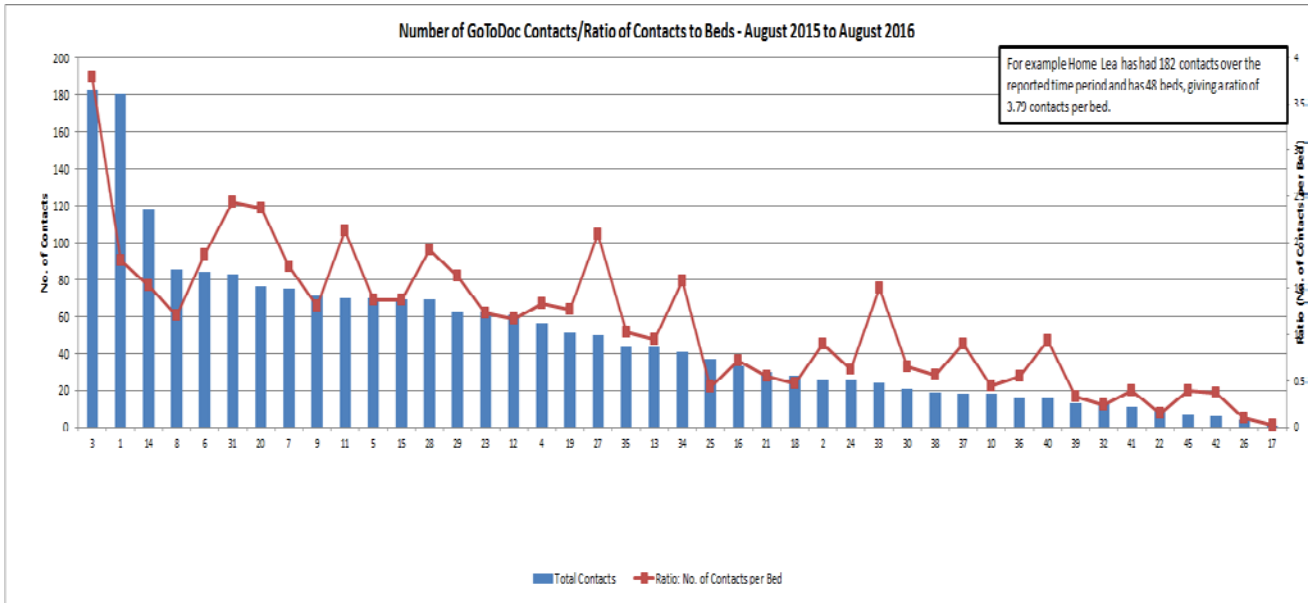
3.33 To enable an MDT to be wrapped around individuals who frequently attend A&E this data also needs to be as live as possible. Early work has already identified that a number of the clients in this category in the above graph had already passed away.



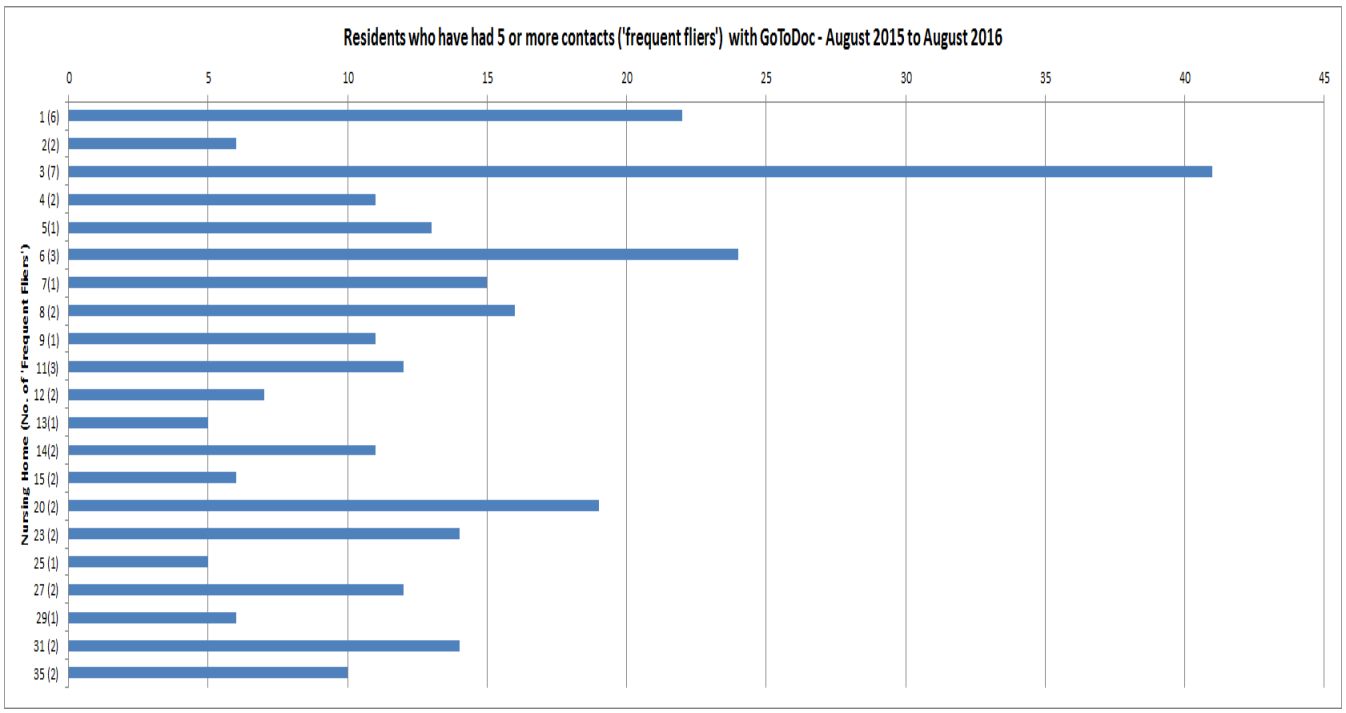
3.34 Once we are able to collate the above data on the number of inpatient bed days per care home on a monthly basis, we need to the correlate the above data with that of A&E attendances in the graph in section 4.1.



3.35 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.



3.36 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.

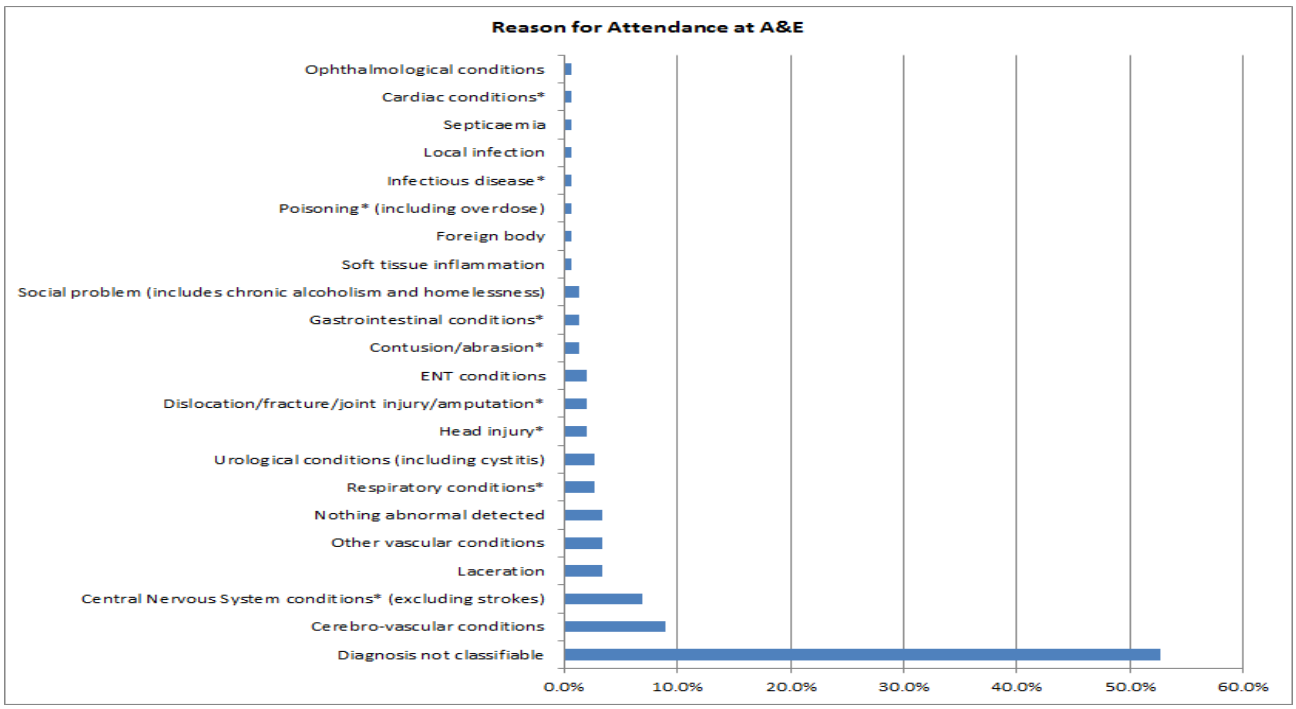


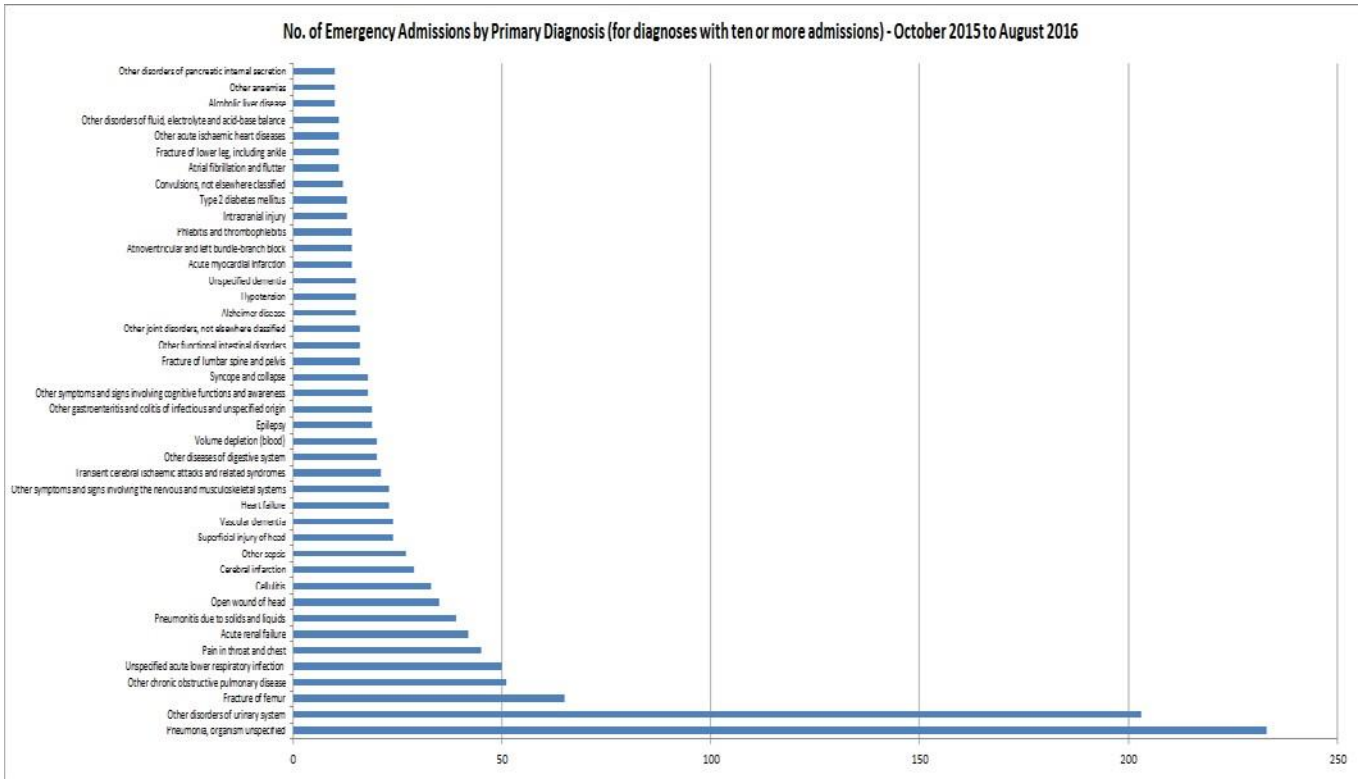
3.37 We need to move to a position where this data is reported monthly to allow us to mobilise an MDT in a more timely manner.

3.38 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.

3.39 The care home steering group is now looking at a piece of work to allow for consistency in early detection of urine infections. The IV therapy work is a part of the winter plan.

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.



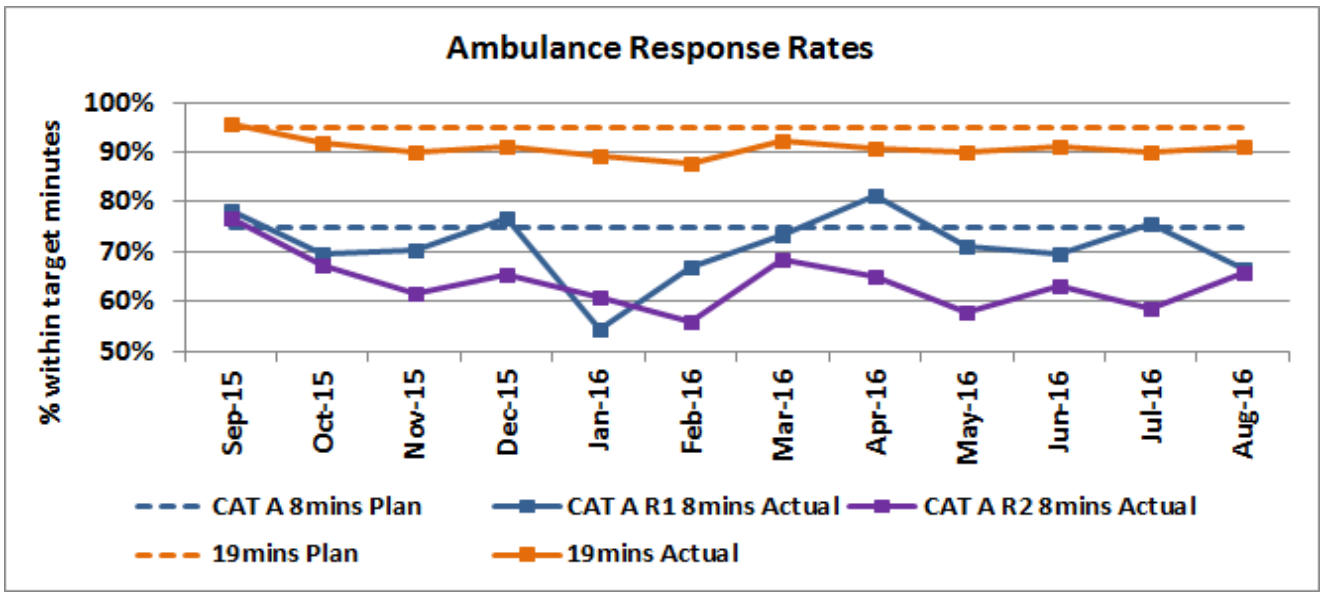


3.41 CQC Inspection published in September 2016.

Care Homes with Nursing	Outstanding	Good	Requires Improvement	Inadequate	Comments
none					
Care Homes	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**	**Comments**
Balmoral Care Home	0	0	1	0	Overall: Requires Improvement TMBC supporting home to improve.
Holme Lea	0	0	1	0	Overall: Requires Improvement On-going support being given by TMBC to assist with improvements and has inproved since July.

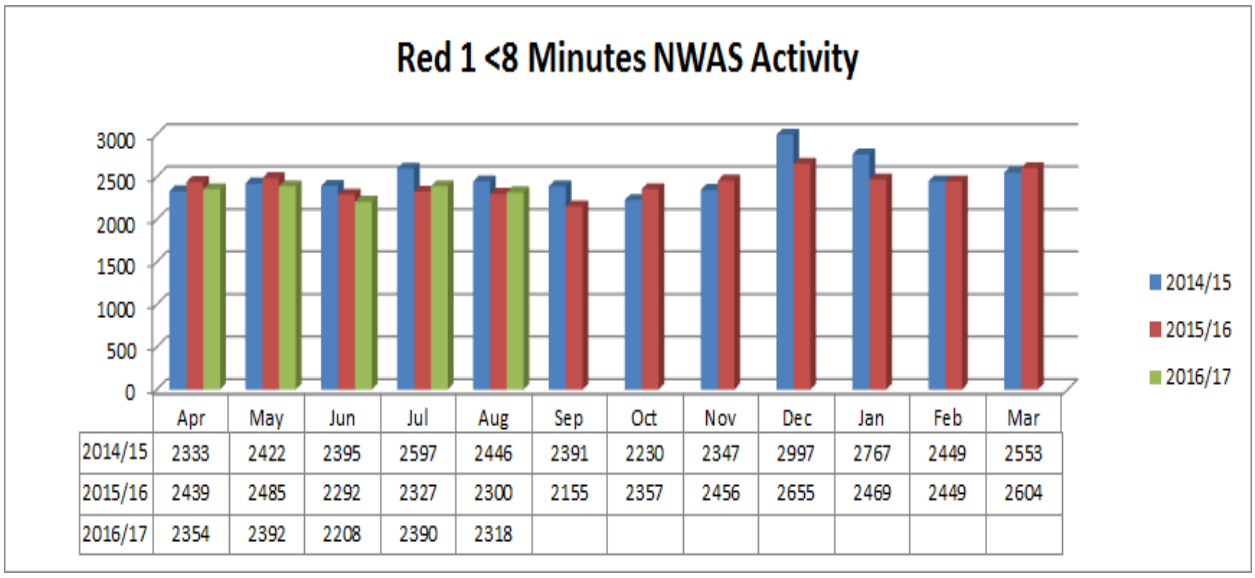
Ambulance – please note position reported iS August

3.42 In August 2016 the CCG failed to achieve the response rates locally with 66.67% for CAT A 8mins Red 1, 65.76% for CAT A 8mins Red 2 and 90.99% for CAT A 19mins Red 2.

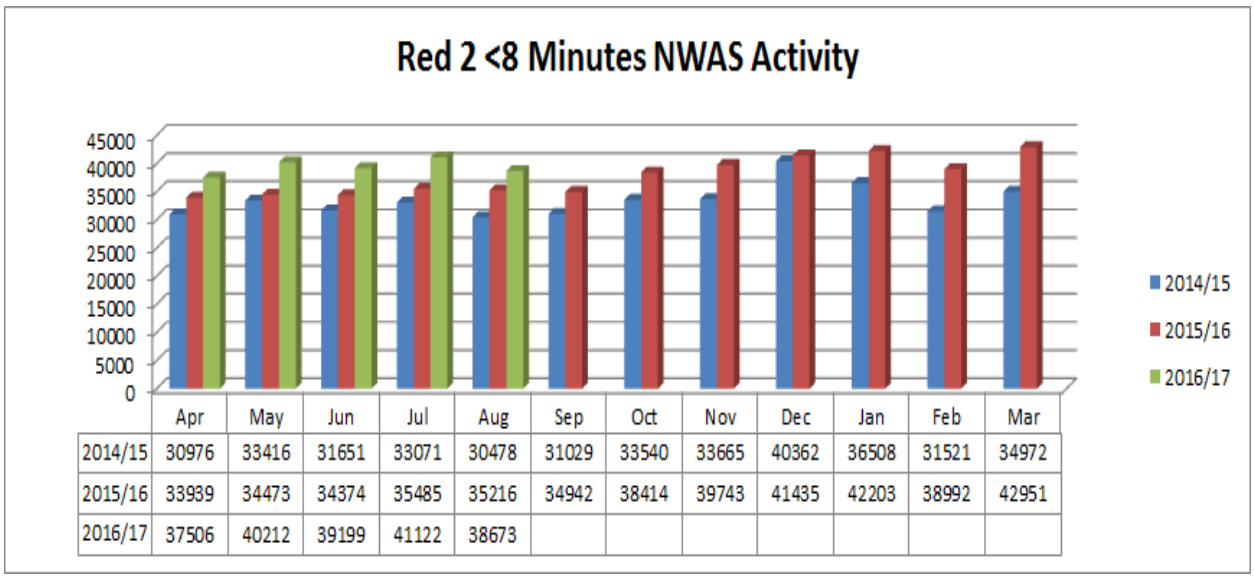


3.43 However, we are measured against the North West position which was 72.60% for CAT A 8mins Red 1; 65.25% for CAT A 8mins Red 2 and 91.09% for CAT A 19mins Red 2 which means none achieved this month.

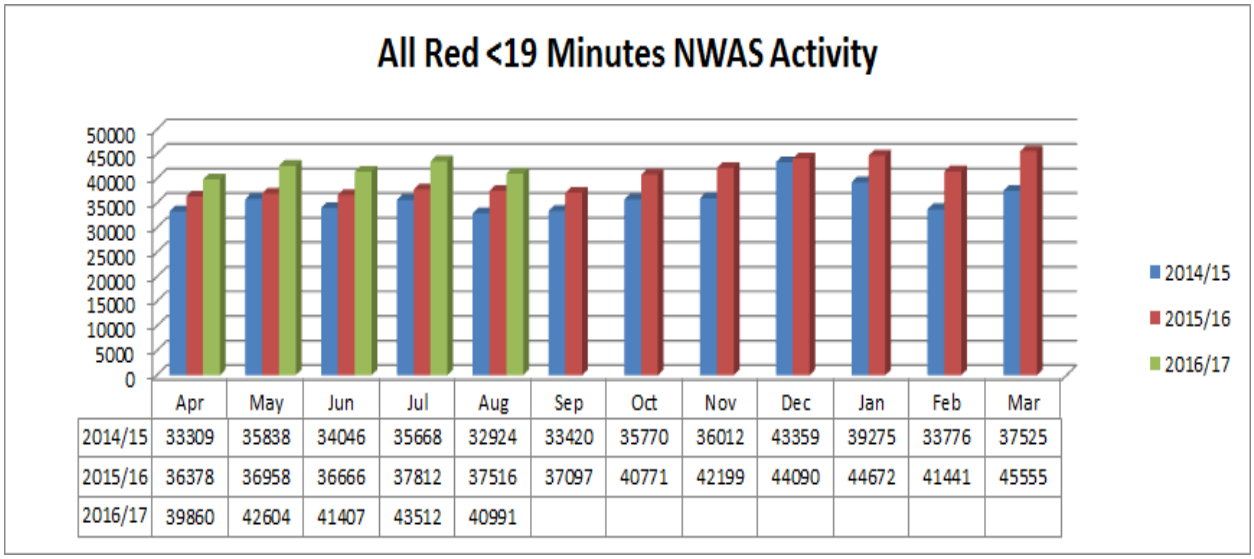
3.44 Increases in activity have placed a lot of pressure on NWAS which has not been planned for. This is impacting on its ability to achieve the standards.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	2333	2422	2395	2597	2446	2391	2230	2347	2997	2767	2449	2553
2015/16	2439	2485	2292	2327	2300	2155	2357	2456	2655	2469	2449	2604
2016/17	2354	2392	2208	2390	2318							

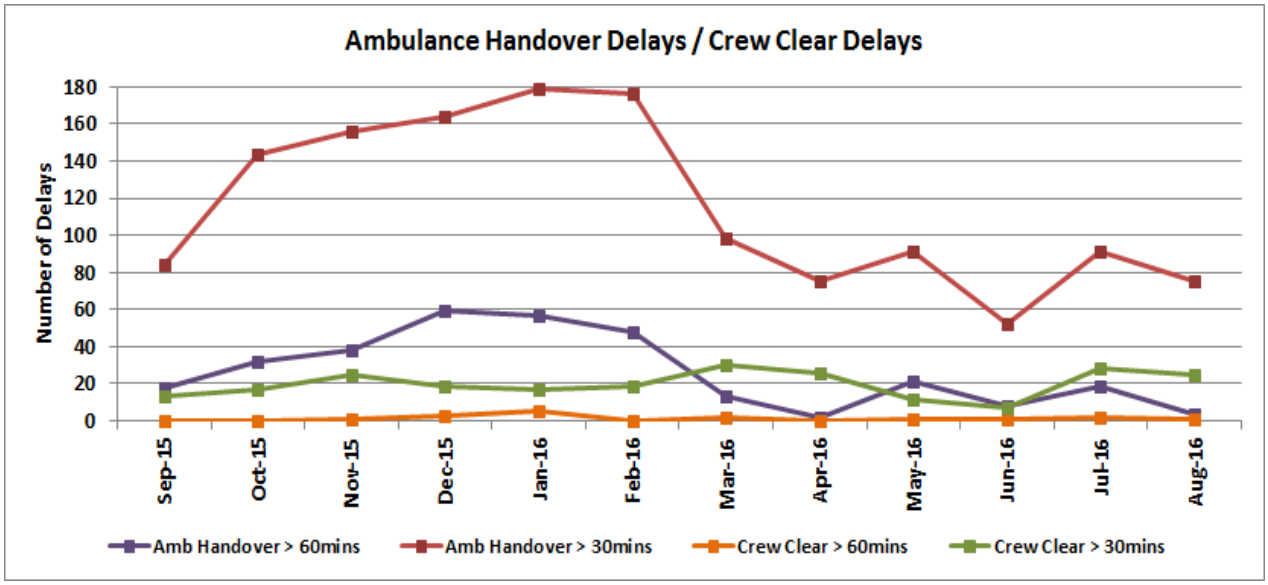


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	30976	33416	31651	33071	30478	31029	33540	33665	40362	36508	31521	34972
2015/16	33939	34473	34374	35485	35216	34942	38414	39743	41435	42203	38992	42951
2016/17	37506	40212	39199	41122	38673							

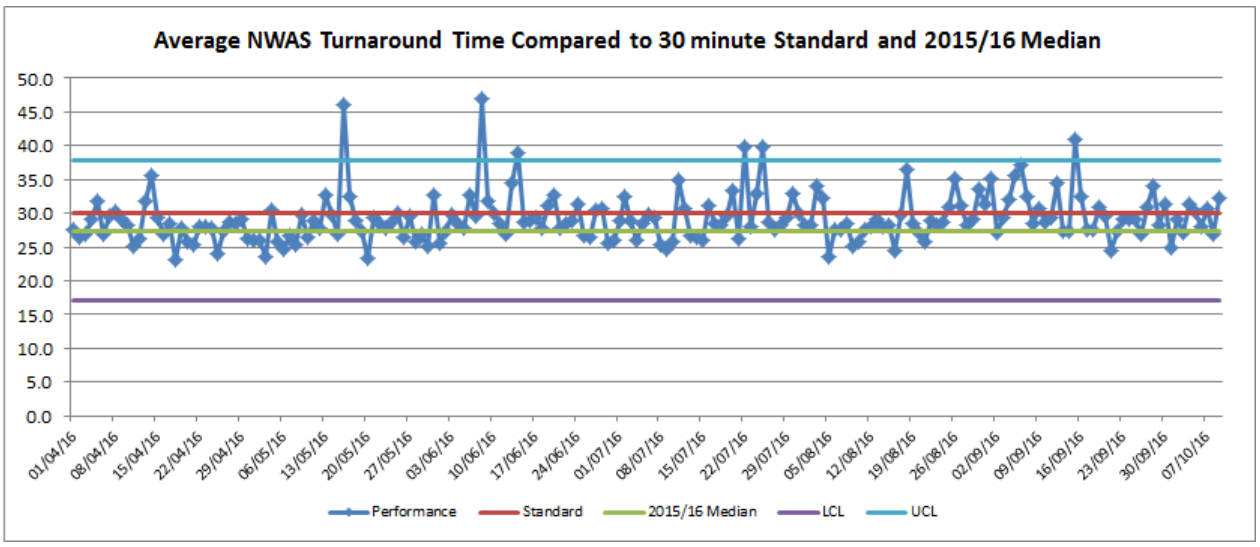


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	33309	35838	34046	35668	32924	33420	35770	36012	43359	39275	33776	37525
2015/16	36378	36958	36666	37812	37516	37097	40771	42199	44090	44672	41441	45555
2016/17	39860	42604	41407	43512	40991							

3.45 The number of ambulances with handover delays decreased in August.



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



111 – please note position reported is August

3.47 111 went live in GM 10 November so this is the ninth full month reported under the new arrangements.

3.48 Primary KPI performance

- The North West NHS 111 service was offered 148,268 calls in the month, answering 127,402.
- 114,711 (90.04%) of these calls were classified as being triaged

3.49 The NW NHS 111 service showed improved performance against all KPIs in August. They continue to review demand, staffing and subcontractor performance on a daily basis to ensure we sustain the improved performance seen in August. HPFs and complaints continue to decrease as they both improve performance and continue to take proactive steps to mitigate issues as we review the trends and themes raised.

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

	Target	Reported
•	Calls answered (95% in 60 seconds)	90.36%
•	Calls abandoned (<5%)	1.78%
•	Warm transfer (75%)	35.41%
•	Call back in 10 minutes (75%)	38.75%

3.51 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 August). 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.

3.52 Our use is in line with NW levels.

	15 and Under	16 to 65	65 and Over	Total
Callers Triaged by	667	1,861	713	3,241

Age				
% Breakdown	21%	57%	22%	100%
Total for NW Region	22,762	67,204	24,745	114,711
% Breakdown NW Region	20%	59%	22%	100%

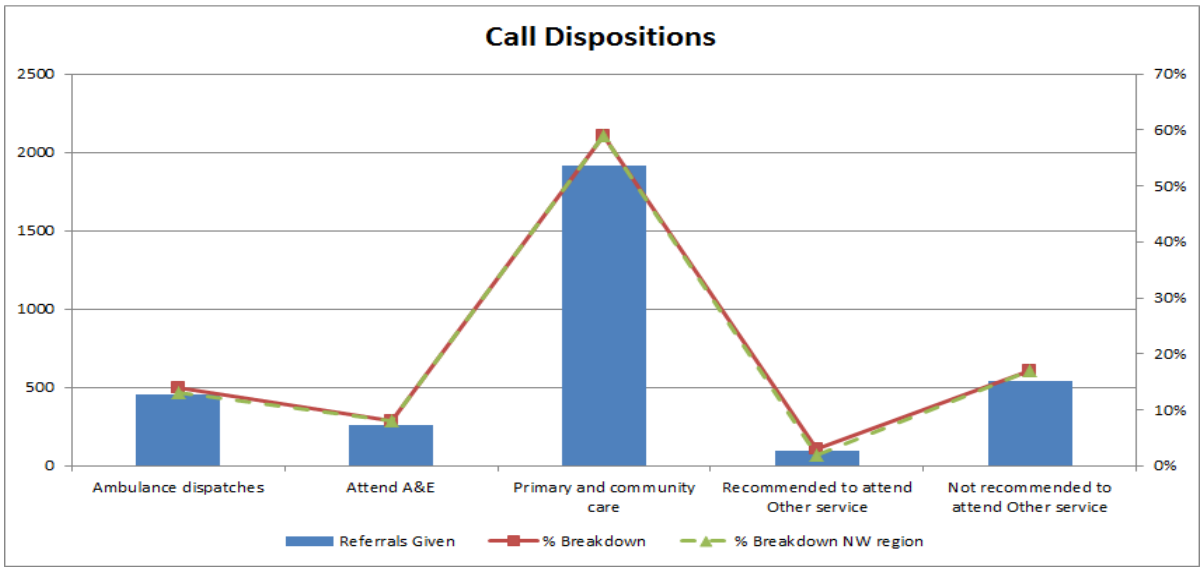
3.53 Our treatment is generally in line with NW levels. Though the number of call backs within 10 minutes was lower than the monthly average across GM by 12%.

	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	3,241	253	98	664	235	429	117
% Breakdown	100%	8%	3%	20%	35%	65%	27%
Total for NW Region	114,711	9,792	3,928	22,967	8,132	14,835	5,748
% Breakdown NW Region	100%	9%	3%	20%	35%	65%	39%

3.54 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	3,241	479	236	1,743	71	712
% Breakdown	100%	15%	7%	54%	2%	22%
Total for NW Region	114,711	16,217	9,971	63,272	2,838	22,413
% Breakdown NW Region	100%	14%	9%	55%	2%	20%

3.55 Our dispositions are in line with this.



4. HEALTH CARE ACQUIRED INFECTIONS (HCAIs)

Clostridium Difficile

4.1 The CCG seeks assurance about the arrangements providers have in place for infection prevention and control practice via various mechanisms including:

- Monthly submission of HCAI assurance framework;
- RCA investigation of all positive CDIF and MRSA cases which are monitored for themes and trends at the HCAI Quality Improvement Group;
- CCG Quality Visits include the monitoring and observation of compliance with infection prevention practice as a standard item.

Tameside & Glossop CCG		Apr-16	May-16	Jun-16	Jul-16	Aug-16	16-17 YTD	16-17 Total
Whole Health Economy	No. of Cases	4	7	3	9	10	33	33
	Plan	8	10	8	10	6	42	97
	Variance Against Plan	-4	-3	-5	-1	4	-9	-64
	% Variance Against Plan	-50.0%	-30.0%	-62.5%	-10.0%	66.7%	-21.4%	-66.0%
Acute	No. of Cases	2	2	2	4	5	15	15
	Tameside Hospital FT	2	1	1	3	5	12	12
	South Manchester FT	0	0	0	0	0	0	0
	Central Manchester FT	0	1	0	0	0	1	1
	Christie Hospital FT	0	0	1	0	0	1	1
	Royal Orthopaedic Hospital NHS FT	0	0	0	1	0	1	1
	Stockport FT	0	0	0	0	0	0	0
	Plan	4	4	3	4	4	19	45
	Variance Against Plan	-2	-2	-1	0	1	-4	-30
	% Variance Against Plan	-50.0%	-50.0%	-33.3%	0.0%	25.0%	-21.1%	-66.7%
Non-Acute	No. of Cases	2	5	1	5	5	18	18
	Plan	4	6	5	6	2	23	52
	Variance Against Plan	-2	-1	-4	-1	3	-5	-34
	% Variance Against Plan	-50.0%	-16.7%	-80.0%	-16.7%	150.0%	-21.7%	-65.4%

2016-17 Clostridium Difficile: Tameside & Glossop CCG

4.2 For August 2016 Tameside & Glossop CCG had a total of 10 reported cases of clostridium difficile against a monthly plan of 6 cases. For the month of August this places Tameside and Glossop CCG 4 cases over plan. Of the 10 reported cases, 6 were apportioned to the acute (6 at Tameside Hospital FT) and 4 to the non-acute.

4.3 To date (April to August 2016) Tameside and Glossop CCG had a total of 33 cases of clostridium difficile against a year to date plan of 42 cases. This places Tameside and Glossop CCG 9 cases under plan. Of the 33 reported cases, 16 were apportioned to the acute (13 at THFT, 1 at Central Manchester FT, 1 at Christie Hospital FT, 1 at The Royal Orthopaedic Hospital FT) and 17 to the non-acute.

4.4 In regards to the 2016/17 financial year, Tameside and Glossop CCG have reported 33 cases of clostridium difficile against an annual plan of 97 cases. This currently places the CCG 64 cases under plan with 7 months of the financial year remaining.

4.5 MRSA

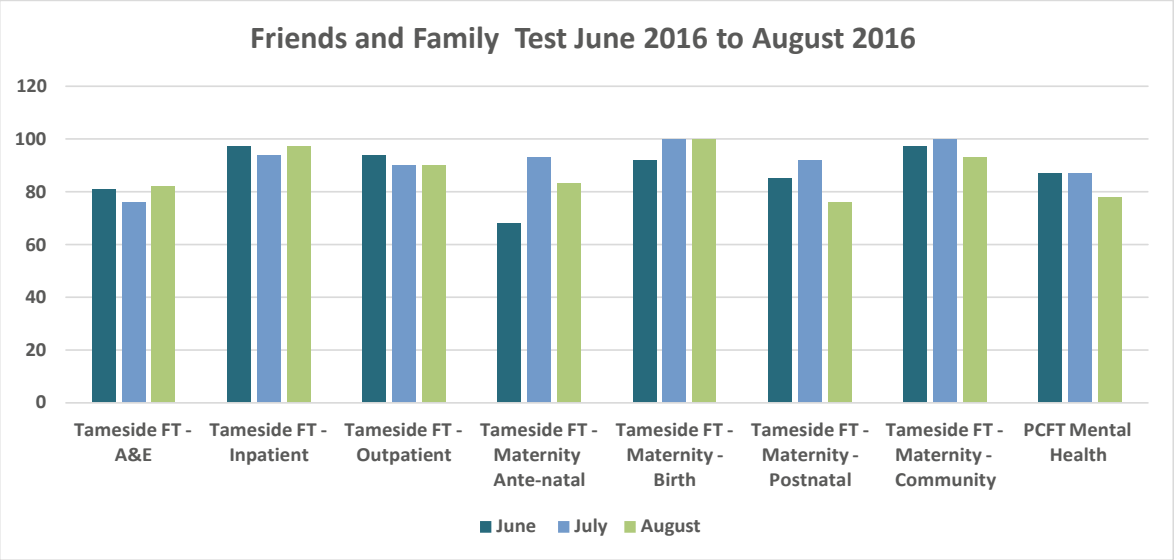
Tameside & Glossop CCG		Apr-16	May-16	Jun-16	Jul-16	Aug-16	16-17 YTD	16-17 Total
Whole Health Economy	No. of Cases	0	0	2	1	3	6	6
	Plan	0	0	0	0	0	0	0
	Variance Against Plan	0	0	2	1	3	6	6
	% Variance Against Plan	0.0%	0.0%	200.0%	100.0%	300.0%	600.0%	600.0%
Acute	No. of Cases	0	0	2	0	2	4	4
	Tameside Hospital FT	0	0	0	0	1	1	1
	Central Manchester FT	0	0	1	0	1	2	2
	University Hospital of South Manchester FT	0	0	1	0	0	1	1
	Plan	0	0	0	0	0	0	0
	Variance Against Plan	0	0	2	0	2	4	4
	% Variance Against Plan	0.0%	0.0%	200.0%	0.0%	200.0%	400.0%	400.0%
Non-Acute	No. of Cases	0	0	0	1	1	2	2
	Plan	0	0	0	0	0	0	0
	Variance Against Plan	0	0	0	1	1	2	2
	% Variance Against Plan	0.0%	0.0%	0.0%	100.0%	100.0%	200.0%	200.0%

2016-17 MRSA: Tameside & Glossop CCG

4.6 For August 2016 Tameside and Glossop CCG have reported 3 case of MRSA against a plan of zero tolerance. Of these 3 cases, 2 were apportioned to the acute (1 at Tameside Hospital FT, 1 at Central Manchester FT) and 1 to the non-acute.

4.7 To date (April 2016 to August 2016) Tameside and Glossop CCG have reported 6 cases of MRSA against a plan of zero tolerance. Breakdown includes 4 acute cases (1 at Tameside Hospital FT, 2 at Central Manchester, 1 at South Manchester FT) and 2 acute cases.

5. FRIENDS AND FAMILY TEST – PROVIDER SUMMARY JUNE 2016 TO AUGUST 2016



5.1 The graph shows performance across the FFT touch-points, for the majority of areas performance is in line with the national Benchmark (A&E = 87%, Inpatients and Maternity ante- natal = 95%, Outpatients and Maternity postnatal = 93%, Maternity Birth = 96%, Maternity community = 97% and Mental Health = 88%):

- A&E is still lower than the national benchmark although significant improvement has been seen since 2014; this data will continue to be monitored via the THFT Quality Monitoring meeting.
- The Ante-natal touch point for Maternity has seen a drop the percentage of patients who would recommend the service in the last two months and this will require monitoring.

6. RECOMMENDATION

6.1 Governing Body are asked to:

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

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

Description	Indicator	Level	Threshold	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Exceptions
18 Weeks RTT	Admitted patients to start treatment within a maximum of 18 weeks from referral (unadjusted)	T&G CCG	90%	89.0%	84.4%	85.8%	84.2%	83.9%	85.8%	86.0%	87.3%	89.1%	88.3%	88.8%	88.9%	86.8%	89.1%	87.9%	87.7%	87.1%	85.9%	CCG target not achieved. Failing specialties are; general surgery (85.64%), urology (65.31%), T&O (71.35%), ENT (89.81%), plastic surgery (85.71%), gynaecology (82.93%). CCG at THFT failing specialities are; T&O (72.49%), Gynaecology (79.03%).
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	T&G CCG	95%	88.7%	88.5%	87.2%	87.5%	80.3%	86.0%	83.5%	85.8%	85.1%	85.4%	84.9%	86.0%	85.7%	86.0%	88.4%	87.6%	88.2%	89.6%	CCG target not achieved. Failing specialities are; general surgery (84.69%), urology (69.78%), T&O (91.74%), ENT (93.58%), neurosurgery (80%), plastic surgery (81.4%), cardiothoracic surgery (92.86%), general medicine (89.47%), gastroenterology (87.42%), cardiology (82.44%) dermatology (94.36%), thoracic medicine (75.68%), rheumatology (83.70%), gynaecology (91.35%), other (92.53%). CCG at THFT failing specialties are; general surgery (85.71%), urology (68.09%), T&O (89.34%), ENT (89.87%), plastic surgery (84.62%), general medicine (90.05%), gastroenterology (79.22%), cardiology (83.43%), dermatology (94.35%), rheumatology (89.55%), gynaecology (89.63%), other (91.80%).
	Patients on incomplete non emergency pathways (yet to start treatment)	T&G CCG	92%	89.3%	90.7%	91.4%	91.8%	92.0%	92.2%	91.8%	92.2%	91.8%	91.8%	92.1%	91.9%	91.6%	92.4%	92.5%	92.4%	92.4%	92.1%	CCG failing specialties are; urology (85.69%), T&O (90.17%), oral surgery (66.67%), neuro surgery (81.82%), plastic surgery (87.50%), cardiothoracic surgery (73.85%), cardiology (89.86%), thoracic medicine (86.41%), geriatric medicine (86.67%), gynaecology (91.34%), othe (91.77%). CCG at THFT failing specialities are; urology (89.99%), T&O (87.52%), neurosurgery (88.89%), plastic surgery (84.38%), gynaecology (90.17%).
	Patients waiting 52+ weeks on an incomplete pathway	T&G CCG	Zero Tolerance	6	5	1	1	0	1	2	0	1	0	2	0	12	1	0	1	1	1	In Aug-16 there was 1 patient waiting over 52 weeks for treatment on an incomplete pathway. This patients is waiting under the speciality cardiology and has now been seen.
Diagnostics < 6 Weeks	Patients waiting for diagnostic tests should have been waiting less that 6 weeks from referral	T&G CCG	1%	1.2%	1.6%	1.7%	1.7%	2.1%	2.8%	2.8%	2.4%	2.5%	2.7%	1.8%	2.9%	2.2%	2.5%	1.6%	2.4%	1.7%	1.2%	CCG target not achieved, 56 breaches. Failing for CCG are Central Manchester with 11 breaches for echocardiography, flexi sigmoidoscopy, gastroscopy and MRI. PAHT with 5 breaches for colonoscopy and gastroscopy. Stockport with 1 breach for colonoscopy. THFT with 29 breaches,for audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS. Care UK with 8 breaches for audiology assessments and MRI. Pioneer Healthcare Limited with 2 breaches for neurophysiology.
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	THFT	95%	86.4%	93.6%	93.4%	91.8%	89.2%	87.7%	82.6%	77.2%	73.0%	73.4%	76.0%	93.1%	84.9%	92.5%	92.2%	86.5%	85.0%	90.5%	2015-16 performance shows that 12,737 patients waited more than 4 hours (denominator 84,303). Breached by 8,522 patients. June 2016 performance is 86.54% breached by 608 patients. July 2016 performance is 84.98% breached by 763 patients. August 2016 performance is 90.5% breached by 307 patients. September performance is 82.7% breached by 872 patients.
Cancer 2 Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	T&G CCG	93%	95.5%	93.9%	95.3%	94.1%	95.5%	98.1%	96.8%	97.7%	97.5%	97.4%	97.7%	96.3%	96.4%	95.8%	97.1%	96.1%	94.3%	94.6%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	T&G CCG	93%	94.2%	91.1%	70.7%	93.6%	98.4%	96.7%	94.6%	96.7%	98.4%	96.1%	98.2%	98.9%	93.0%	93.9%	98.0%	95.8%	94.0%	96.7%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definative treatment for all cancers	T&G CCG	96%	98.9%	97.7%	98.0%	99.0%	97.8%	98.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	99.1%	100.0%	98.9%	100.0%	100.0%	98.8%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	T&G CCG	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	T&G CCG	98%	100.0%	100.0%	100.0%	93.8%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	T&G CCG	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definative treatment for cancer	T&G CCG	85%	97.7%	87.2%	83.7%	91.7%	83.0%	86.0%	86.8%	93.0%	88.2%	96.1%	93.3%	93.8%	89.9%	89.7%	88.6%	91.5%	89.6%	91.3%	
	Maximum 62 day wait from referral from an NHS screening service to first definative treatment for all cancers	T&G CCG	90%	100.0%	100.0%	100.0%	83.3%		82.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.3%	100.0%	100.0%	60.0%	100.0%	100.0%	June 2016 performance is below the 90% target, however due to the low numbers the de minimis rule applies. 3 patients breached out of a total of 5 patients.
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	T&G CCG	85%	100.0%	81.8%	94.7%	78.6%	80.0%	81.8%	91.7%	80.0%	85.7%	100.0%	92.3%	88.2%	88.9%	83.3%	86.7%	94.4%	82.4%	100.0%	For July 2016 a total of 17 patients were receiving their first definitive treatment for cancer following an urgent referral from a consultant upgrade for suspected cancer, 14 of these patients were receiving their first definative treatment within 62 days. Breached the 85% target by 1 patient.
Ambulance	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	NWAS	75%	71.2%	81.6%	79.8%	79.3%	77.7%	78.4%	75.9%	73.4%	74.9%	69.3%	70.5%	67.3%	74.8%	76.5%	74.3%	73.1%	70.4%	72.6%	High levels of demand and lengthening turn around times.
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	NWAS	75%	72.1%	79.4%	78.2%	76.0%	75.4%	74.9%	72.5%	68.5%	69.5%	63.5%	61.1%	58.9%	70.4%	67.5%	66.3%	66.2%	62.7%	65.2%	High levels of demand and lengthening turn around times.
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes	NWAS	95%	93.3%	96.4%	95.9%	94.6%	95.1%	94.6%	94.1%	92.0%	92.7%	89.9%	88.1%	86.7%	92.6%	92.0%	91.5%	91.5%	89.8%	91.1%	High levels of demand and lengthening turn around times.
Mixed Sex Accommodation	MSA Breach Rate	T&G CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0.1	0.2	0	Total of 1 breach in June 2016 and 2 breaches in July 2016 for T&G CCG. This is an unjustified mixing in relation to sleeping accommodation. Data shows the breach rate per 1,000 finished consultant episodes.
Cancelled Operations (Elective)	The number of last minute cancelled elective operations in the quarter for non-clinical reasons where patients have not been treated within 28 days of last minute elective cancellation	THFT	0	6			0			4			2			12	2					Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85
Care Programme Approach (CPA)	The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	T&G CCG	95%	94.2%			100%			96.3%			100%			96.7%	94.5%					16-17 Q1 52 patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care out of a total of 55 patients = 94.5%

IAPT

Access		3.75%	4.00%	4.50%	4.30%	4.41%	4.3%	3.95%
Recovery		50%	38.20%	36.92%	44.00%	40.14%	40.0%	45.75%
Wating times less than 6 weeks		75%	57.83%	54.81%	52.60%	60.14%	56.3%	62.75%
Wating times less than 18 weeks		95%	90.50%	91.11%	89.61%	90.54%	90.4%	91.50%

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	1 November 2016
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**COMMISSIONING INTENTIONS 2017-19**
Report Summary:	This report outlines the approach taken to the development of the Tameside & Glossop Commissioning Intentions for 2017-19 and as an appendix the draft letter which, once approved, will be shared with all providers. These commissioning intentions have been developed in line with national NHS planning and contract guidance, including the requirement that we commission on a 2 year basis for 2017-19.
Recommendations:	(i) SCB are asked to endorse the approach taken with regard to the development of the commissioning intentions for 2017-19. (ii) SCB are asked to approve the letter attached to this paper at **appendix 1** and for the contracts team to share with providers in line with the NHS England contract timetable.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The commissioning intentions outlined in this paper comprise funding from budgets within the Section 75 and aligned budget elements of the Integrated Commissioning Fund. As outlined in the attached documents, it is imperative that all commissioning proposals are congruent to the Care Together commissioning strategy and vision of delivering clinically safe and financially sustainable services by 2020-21. The Economy Finance Service will only support and make recommendations for approval where there is a clear return on investment which demonstrates value for money and contributes to addressing and closing the economy financial gap within 5 years and on a recurrent basis thereafter. It is further recommended that more services become subject to prior approval to strengthen the impact of the Effective Use of Resources (EUR) policy. Whilst we have a joint approach with the ICO for EUR, it is important not to lose sight of EUR amongst other NHS and Independent Sector providers.
Legal Implications: (Authorised by the Borough Solicitor)	This report appears essentially to be a statement of intent for the commissioning of contracts during 2017 – 18 by the Tameside and Glossop CCG. This is acceptable provided it occurs within the framework of the joint governance arrangements of the Council and CCG. Adverse legal implications may arise where the commissioning of individual contracts take place outside this statement of intent, and so in those cases clear reasons should be given for deviating from the same.
How do proposals align with Health & Wellbeing Strategy?	The Commissioning Intentions are aligned with the Health & Well Being strategy.

How do proposals align with Locality Plan?	The Commissioning Intentions have been developed in line with the locality plan and proposed model of care. They are aligned with the recent transformation fund submission to Greater Manchester.
How do proposals align with the Commissioning Strategy?	The documents are aligned with the commissioning intentions in the Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	Proposals have been shared with PRG.
Public and Patient Implications:	Public and patient implications have been considered for each of the individual intentions included in the document.
Quality Implications:	The appropriate individual Quality Impact Assessments are being / have been undertaken. This document is a compilation of the commissioning activities of the single commission.
How do the proposals help to reduce health inequalities?	The commissioning intentions are in line with the single commission approach to reducing health inequalities
What are the Equality and Diversity implications?	Equality Impact Assessments have been / will be undertaken on commissioning activities as required. This document is a compilation of the commissioning activities of the single commission, all of which will receive the appropriate individual consideration in terms of equality and diversity implications.
What are the safeguarding implications?	Safeguarding implications of the proposals will be considered and addressed on an individual basis.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information Governance and Privacy Impact Assessments will be undertaken for individual projects rather than for this proposal, including requirements for Privacy Impact Assessments.
Risk Management:	Any risks will be reported and managed via the CCG risk register.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Commissioning Telephone: e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 The Single Commission are required to produce commissioning intentions for 2017-19 in line with the national guidance for NHS planning https://www.england.nhs.uk/wp-content/uploads/2015/12/tech-guid-17.pdf

1.2 The deadline for the contracts to be agreed is 23 December 2016

2 PROCESS FOR COMPLETION OF THE COMMISSIONING INTENTIONS

2.1 The contract team within the commissioning directorate of the Single Commission have collated the intentions from a wide range of Single Commission teams to ensure the attached report is inclusive of all intentions for 2017-19

2.2 The Single Commission's main provider – Tameside & Glossop Integrated Care NHS Foundation Trust – have been made aware through our contract meetings with them of the approach the Single Commission are taking with this process for 2017-19

2.3 As members of the Greater Manchester Contract Steering Group the Tameside & Glossop contracts team have ensured that any Greater Manchester wide commissioning intentions and Healthier Together intentions have been included in this document, and that the format used is consistent with the GM approach. More details on individual proposals within the outline intentions have been collated and will be shared with providers to inform individual contract activity and financial planning.

2.4 The commissioning intentions letter (attached at **Appendix 1**) is based on our Care Together intentions, the Single Commission's submission to Greater Manchester H&SC Partnership for Transformation Funding, our financial recovery plan, and the Locality Plan. Thus ensuring the commissioning intentions have a sound basis on the Tameside & Glossop plans for integrated care.

3 RECOMMENDATIONS

3.1 As set out on the front of the report.

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NHS
Tameside and Glossop
Clinical Commissioning Group

Appendix 1

Headquarters
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Progress Way
Windmill Lane
Denton
Manchester
M34 2GP

Tel: 0161 304 5300
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Dear

Tameside & Glossop Commissioning Intentions 2017-19

This letter sets out, in high level terms, how Tameside & Glossop Single Commission intends to commission services from providers in 2017-19. In line with the national contract guidance, these commissioning intentions cover 2 years (1/4/17 – 31/3/19). Details of specific commissioning intentions, in terms of activity and financial planning, will be shared with appropriate providers during contract negotiation.

Tameside & Glossop's Care Together programme is a transformational approach to significantly improving the health and wellbeing of the 250,000 residents of Tameside and Glossop. We aim to develop a sustainable economy by improving the healthy life expectancy (HLE) of our population. In doing this, our programme has three key ambitions which are wholly in line with both GM and national policy:

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

The programme comprises three key elements:

- Establishment of a Single Commissioning Function to ensure resources are aligned and distributed in a way which facilitates integration and most effectively meets need – in place since 1st April 2016;
- Development of an Integrated Care Organisation to eliminate traditional organisational silos and boundaries – formally established in September 2016 as Tameside & Glossop Integrated Care Organisation NHS Foundation Trust ;
- A new model of care to drive forwards at pace and scale the changes to achieve our ambitions in terms of improved outcomes for our population and a financially and clinically sustainable health and care system.

We have the economy wide leadership in place to deliver our integration agenda. We have a coherent and ambitious strategy, comprehensive governance arrangements and as stated above have already delivered a single commissioning function and shadow Integrated Care Organisation.

CCG Financial Plan and QIPP

As some providers will be aware, the CCG has a challenging financial position for 2017-18, which contributes to setting the context for these commissioning intentions. We will require providers to support the delivery of our Care Together Model of Care (as set out below), maximise productivity and deliver patient outcomes in the most cost effective way.

To this end, we have already notified NHS acute providers, where we are an associate to the contracts, that they should expect to see a reduction in demand which we anticipate will reduce 17/18 contracts by approximately 10%.

The CCG financial recovery strategy focuses on 6 priority programmes of work which must be delivered to ensure a financially viable system. We will expect providers to adhere to the details within these QIPP plans, which will yield benefits across the 2 year duration of the contracts to commence 1/4/17:

- Prescribing
- Effective Use of Resources / Prior Approval
- Demand Management (reduction in secondary care activity)
- Single Commission Function Responsibilities (including running costs review)
- Back office functions and enabling schemes (including IM&T and estates)
- Governance – streamlining / improving the efficiency of our governance and decision making processes

These priority programmes, along with a range of enabling / ongoing projects, are required to deliver a QIPP of circa £20m in 2017-18.

Care Together Model of Care

The Care Together Model of Care includes 3 key workstreams – Healthy Neighbourhoods (incorporating the Healthy Lives and Integrated Neighbourhoods initiatives), Planned Care and Urgent Care, each of which are responsible for leading the design and implementation of the structure of our integrated model of care. Implementation plans are being developed to move at pace to transform to our new model of care and start to deliver the transformation and significant financial savings required.

The economy has been successful in securing GM Transformation Funding to support the implementation of our model of care. We have a comprehensive economy transformation plan which will bring us back into financial balance by 20/21, which includes the investment of The GM Transformation Funding. Our investment plan with GM is in the final stages and will illustrate how the investment of £23.2m will deliver net savings of c£20.9m through preventing growth and reducing activity across elective and non-elective care. Details of the cost benefit analysis of our Care Together schemes will be shared with individual providers during contract negotiation to ensure all providers are aware of the impact on them. Six specific Care Together schemes have been developed for the economy to stem the growth in demand for all health and social care services and also to reduce acute activity. The schemes are:

Demand Reduction/Absorbing Growth

1) **Development of Integrated Neighbourhoods (INs) -** Building upon the introduction of place based public sector hubs in Tameside, we will develop health and social care teams to deliver a wide range of services that not only treat illness but promote wellness and behaviour change. This will involve a comprehensive response from community services, social and primary care, outreach from hospital specialists, mental health and support from public health and preventative services. Input from the voluntary and community sector will be central to the success of this approach. There will be five INs across the Tameside and Glossop CCG footprint.

Headquarters: NHS Tameside and Glossop Clinical Commissioning Group, New Century House, Progress Way, Windmill Lane, Denton, Manchester M34 2GP. **Tel:** 0161 304 5300 **Fax:** 0161 304 5400 www.tamesideandglossopccg.org

2) **A System Wide Approach to Self-Care -** One of the key approaches to creating a sustainable economy will be supporting the population to manage their health more effectively, adopt healthier behaviours and choose appropriately when accessing support from health and social care. We will adopt a system wide approach to self-care and supported self-management, where self-care becomes our default and something promoted by all parts of the health system. Underpinned by a proactive risk stratification approach and the use of the Patient Activation Measure, we will identify people who are at greatest risk of poor health and high levels of unplanned activity. We will focus on the development of social prescribing at scale and combine it with an asset based community development approach seeking to unlock the potential of communities and individuals.

3) **Help to support people at home service -** Using a holistic approach to service delivery, we will redesign the current homecare model to ensure it is focused on individual strengths and capabilities. The workforce and providers delivering this service will form an integral part of the INs. We will place an emphasis on moving away from time and task, to high quality contact with people that utilises a wide range of community assets, technology and the range of community and primary health available to remain safe, secure and independent at home. The new service will deliver a sustainable care home market with significant more capacity and which pays its staff at levels commensurate with the expected role.

Acute Activity Reduction

4) **Home First -** 'Home First' is the urgent care response to ensuring that wherever possible, people can receive care in their own home. Home First will ensure that people, over the age of 18, are supported in the environment most appropriate for them and most likely to achieve the best outcomes. The Integrated Urgent Care Team (IUCT) is the operational team that underpins the delivery of the model. The team will consist of a range of integrated health, social care and voluntary and community sector professionals to support people through their journey to recovery.

5) **Flexible Community Bed Base -** When people cannot be supported at home, the flexible community beds base will offer:
   - Step down capacity for discharge to assess (including complex assessments)
   - Step up capacity
   - Intermediate care capacity
   - Recuperation beds that offer an opportunity to re-stabilise prior to undertaking rehab
   - Specialist assessment and rehab for people who have dementia or delirium

6) **Digital Health -** Enhancing technology in care homes will offer the ability alongside a highly skilled workforce to deliver clinical consultations to occur in the person's place of residence without the need to transfer a resident to hospital. It will support both residents and care home professionals to engage in "skype" conversation with health and social care professionals leading to a personalised response with "home" as the default position.

Contracting for 2017-18

Whilst the Single Commission and wider economy focus initially on the implementation of the priority projects outlined above, and the delivery of the recovery plans which we have in place to support our financial position, it is the intention that other contracts for single commission services, including Primary Care/LCS contracts, will be rolled forward into 2017-18. Plans are being developed in line with our model of care to transform the wider planned care and urgent care

models, this will take place during 2017-18 working with the relevant providers on the design and implementation processes.

Mental Health Commissioning

The Single Commission will roll forward current commissioning plans for mental health services on a bi-lateral arrangement, with a focus on the Mental Health 5 Year Forward View implementation plan, but intends to take forward plans for reviewing how mental health services (including 3rd sector providers) are provided during the contract term.

Children & Families

By putting children first, excellent children's health and social care can transform the life chances and expectancy of all people growing-up and living in Tameside and Glossop. It can offer every child the promise of a brighter future, with every prospect of success. To deliver this vision an ambitious transformation programme in 20017/18 will start the delivery an integrated children's and family services. This will require all agencies locally to understand and collaborate on arrangements for delivering an integrated children's service. This work will be aligned to the Integrated Neighbourhoods agenda and build on the Integrated Care Organisation programme to date.

Healthier Together

It is the intention of the Greater Manchester CCGs to implement the first elements of the Healthier Together framework as soon as possible. In view of this it is our intention to implement the transfer of high risk elective general surgery patients to the 4 specialist sites (Salford Royal (see note below regarding NW variation), Royal Oldham, Manchester Royal Infirmary and Stepping Hill) from 1st April 2017. To facilitate this we would expect general surgeons from across the sector to have formed a single team across the sector with a single rota, single governance and leadership as well as the development of a single sector wide MDT. We would expect supporting infrastructure to be in place to allow transfer of these patients. These patients will be managed through specific agreed pathways identified in the local sector models of care as agreed in sectors by CCGs and providers and assured at GM level at Healthier Together Joint Committee. Alongside the transfer of these patients we would also expect to see progress on implementing the identified quality improvement projects (quick wins) e.g. ambulatory care, throughout the year. KPIs will be developed between the clinical alliance and heads of commissioning in preparation for contract sign off in December.

During contract negotiations there will be an expectation for some flexibility with the phasing of the transfer of high risk elective patients due to local circumstances and agreed processes that will need to be agreed across the sector and programme. We would expect preparations for implementation of the other elements of the Healthier Together model to continue.'

North West sector variation: It is recognised that it is not feasible to transfer high risk elective patients to the Salford Royal site until capital requirements are resolved. The intention is deferred until this is resolved. The sector is asked to continue assessing mitigating measures i.e. reciprocal shifts of activity to non-hub sites. All other aspects of intentions are valid including changes to the workforce arrangements.

I hope you find our commissioning intentions letter helpful, and we are willing to discuss this in more detail as required.

Regards

Clare Watson
Director of Commissioning

Report to: **SINGLE COMMISSIONING BOARD**

Date: 1 November 2016

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **PROCUREMENT OF WHEELCHAIR SERVICES**

Report Summary:

NHS Tameside & Glossop CCG (T&G CCG) currently commission wheelchair assessment and provision services from Stockport NHS Foundation Trust. This was formerly part of our community contract with Stockport NHS FT, but the service did not transfer to Tameside NHS FT on 1 April 2017 due to the joint commissioning and provision arrangements with 2 other CCGs. Oldham CCG is party to the T&G CCG contract for this service. Stockport CCG contract separately but for the same service. Prior to 31 March 2016 the funding arrangements were as follows:

- NHS Oldham CCG £466,572
- NHS Tameside & Glossop CCG £1,050,568
- NHS Stockport CCG £1,090,146

All 3 CCGs have comparable levels of activity despite the different level of investment.

The contract currently in place between T&G CCG (including Oldham CCG) is due to expire on 31 March 2017.

In light of the imbalance between the levels of investment by the 3 CCGs commissioning from Stockport NHS Foundation Trust, T&G CCG negotiated a reduction in the contract for 2016-17 from £1,050m to £821K, therefore achieving a recurrent Quality, Innovation, Productivity and Prevention (QIPP) saving of £229K. This report sets out proposals for the commissioning of a wheelchair service (assessment and provision).

Recommendations:

1. That the Single Commissioning Board endorses the service of notice on the Stockport NHS Foundation Trust wheelchair contract to take effect on 31 March 2017;
2. That the Single Commissioning Board agree that:
    i. the Single Commission will seek to negotiate additional savings for the economy whilst having due regard for the recovery, health and welfare of those in need of the service;
    ii. The Single Commission will continue to work with stakeholders on the finalisation of a service specification for wheelchair services. The specification will be in line with national guidance and will be subject to all necessary Impact Assessments;
    iii. The Single Commission will work with Tameside and Glossop Integrated Care Foundation Trust (T&GICFT) to ensure the service is used effectively;
    iv. The Single Commission will use the Shared Business

	Services framework to retender and procure the new wheelchair services (inc. assessment and provision) to take effect from 1 April 2017.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	The contract will be funded via the section 75 agreement as part of the Integrated Commissioning Fund. The Finance Group are supportive of this contract being retendered at as competitive a price as possible to deliver the service specification we require. It is recognised there is national benchmarking data that suggests a service should be deliverable within a £600k funding envelope. However, it is essential an evaluation of the impact on service provision continuation is facilitated in advance of the existing contract expiry date to mitigate any potential risk of tender prices exceeding this level. The Finance Group acknowledge and respect the legal and procurement advice in respect of the ICO providing this service but feel it is important that the ICO works collaboratively with commissioners in the procurement and management of this service as this is crucial to the delivery of the Care Together strategic vision with all appropriate contracts and services transferring to the ICO responsibility at the agreed date.
Legal Implications: **(Authorised by the Borough Solicitor)**	The current contract comes naturally to an end on 31 March 2017, but notice in any event has properly been given and acknowledged to ensure appropriate succession planning is put in place in a timely manner. The procurement of wheelchair services of the value stated in the report requires a procurement exercise consistent with the Public Contracts Regulations 2015. The framework referred to in paragraph 4.6 has been procured by using the open procedure (reference 2015/S 220-400660) under the Public Contracts Regulations 2015 and therefore it would not be unlawful to use this framework. Any contract let using the framework must be let in accordance with the terms of the framework. The procurement exercise must begin without delay in order to ensure the service continues without disruption on 1 April 2017. Whilst the views of the T&GICFT are important, in the unlikely event of them failing to agree any aspect of the procurement exercise this should not be allowed to delay the retendering process as ultimately it is the T&G CCG who are charged with this responsibility and who need to deliver a cost effective wheelchair service by 1 April 2017, so their judgment must ultimately take precedence. When the service is transferred to the T&GICFT any concerns which they may still have will be picked up through and subject to a due diligence exercise in the usual way for transferring contracts. .
How do proposals align with Health & Wellbeing Strategy?	The continued commissioning and future procurement of a wheelchair service will align with our H&WB strategy by: • Providing a joined up service to meet the local need • Ensuring the economy have a wheelchair service which aligns with our Care Together Model of Care (including discharge to assess / discharge planning models) • Providing targeted support to provide the correct equipment and provide regular reviews • Improve health and wellbeing and increase independence

How do proposals align with Locality Plan?	In line with the locality plan, the wheelchair service will provide a high quality, safe, clinically effective and local service which will deliver long term change. The wheelchair service will work across our integrated neighbourhood and integrated urgent care services.
How do proposals align with the Commissioning Strategy?	The wheelchair service will provide appropriate and cost effective equipment for people living with long term conditions, and will support our models for integrated neighbourhoods and integrated urgent care.
Views of the Professional Reference Group:	Reflected in the report.
Public and Patient Implications:	Public and Patient engagement will be undertaken in 2016/17 and 2017/18 to further refine the service model without any additional cost to the Single Commission and to support T&GICFT. Plans of how this will be done have been drafted and the commissioner will shortly be meeting the CCG Equality and Diversity Group to discuss further.
Quality Implications:	A draft specification has been developed and a Quality Impact Assessment has commenced. The content of the draft specification is in line with all relevant legislation.
How do the proposals help to reduce health inequalities?	Delivering a model of care around people's assessed needs will enable us to target the delivery of wheelchair equipment in a way that will reduce health inequalities and broaden the range of support available to people with these needs. We will ensure the delivery of this service is closely aligned with our wider ICFT model of care, in a hospital and neighbourhood setting. Refining the eligibility criteria will ensure we assess need for wheelchair equipment to reduce health inequalities.
What are the Equality and Diversity implications?	A draft specification has been developed, and an Equality Impact Assessment has commenced (See appendix B)
What are the safeguarding implications?	Any providers included in the delivery of this model will be bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	All partners involved in the delivery of this work will be bound by the necessary information governance guidelines. The single commission officers will ensure that an appropriate Privacy Impact Assessment is undertaken.
Risk Management:	Any risks will be identified and monitored through the single commission contract monitoring and performance management processes.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Commissioning Telephone: e-mail: clarewatson2@nhs.net

1. BACKGROUND & PURPOSE

1.1 Tameside & Glossop CCG (T&G CCG) currently commission wheelchair assessment and provision services from Stockport NHS Foundation Trust. This was formerly part of the CCG community contract with Stockport NHS Foundation Trust (SFT), but the service did not transfer to Tameside NHS Foundation Trust on 1 April 2017 due to the joint commissioning and provision arrangements with 2 other CCGs. Oldham CCG are party to the T&G CCG contract for this service. Stockport CCG contract separately but receive a similar service. Prior to 31 March 2016 the funding arrangements were as follows:

- NHS Oldham CCG £466,572
- NHS Tameside & Glossop CCG £1,050,568
- NHS Stockport CCG £1,090,146

1.2 When taking into account the eligibility criteria of all 3 CCGs, there is a comparable level of activity despite the different level of investment.

1.3 The contract currently in place between T&G CCG (including Oldham CCG) is due to expire on 31 March 2017.

1.4 This report sets out proposals for the commissioning of a wheelchair service (assessment and provision) including the procurement of a new service to start from April 2017.

2. NEGOTIATIONS FOR 2016-17 CONTRACT

2.1 The funding was a historical arrangement and there are no details of how this value was initially calculated. After a review by the commissioner, it became clear in 2015 that the level of activity between T&G CCG and Oldham CCG was equivalent and discussions with T&G CCG, Oldham CCG and Stockport FT commenced.

2.2 In light of the imbalance between the levels of investment, T&G CCG negotiated a reduction in the contract for 2016-17 from £1,050m to £821k, therefore achieving a recurrent QIPP of £229K. This has been included in the financial recovery plan submitted to NHSE on 9 September as a recurrent saving.

3. CURRENT CONTRACTUAL POSITION

3.1 The CCG contract with Stockport NHS Foundation Trust expires on 31 March 2017. The contract has already been extended by one year, in line with the permissions set in the standard NHS contract and through CCG governance, but cannot be extended again.

3.2 A letter has been sent advising Stockport NHS FT that the contract will end on 31 March 2016, which included the requirement for a succession plan to be put in place Stockport FT have acknowledged receipt of the letter.

3.3 Stockport NHS FT has also confirmed that there will be no financial impact or ‘stranded costs’ for the CCG as a result of this action

4. PROPOSALS FOR FUTURE COMMISSIONING ARRANGEMENTS - COMMISSIONING OF SERVICE FROM 1 APRIL 2017 – 31 MARCH 2020

4.1 With regard to the financial envelope for the new service NHS England will be publishing a wheelchair report imminently. This will include currencies for use, but will not include a

specific tariff, as NHS England need to improve their reference costs and will change their guidance when this data is available. Therefore there is no national tariff on which the cost of / budget for a wheelchair service can be based.

4.2 In the absence of a national tariff, benchmarking of the cost of wheelchair services has been undertaken by the commissioning and finance staff in the Single Commission. Information used includes:

- NHS Benchmarking (Community Services Dashboard Report, 2015) quote a figure of £238,086 per 100,000 population
- Existing provider activity and finance data
- Figures from other CCGs across GM

Commissioners have determined that a new service which meets the national standards and requirements for the population of Tameside & Glossop can be commissioned with a budget of £600,000 per year.

4.3 The current investment stands at £821K for 2016/17. The proposal is that the single commission establish commissioning arrangements for 2017-2020 which deliver a service to a maximum of £600K per annum. This could deliver a further recurrent saving for the system of £221K whilst maintaining a service for the population of Tameside & Glossop which meets national standard requirements. Through the procurement / commissioning process, additional financial savings will be sought for the economy. This may require reductions in the level of provision and engagement with stakeholders would be required.

4.4 With regard to potential co-commissioning with Oldham CCG Oldham CCG have provisionally confirmed their initial intention to continue to be a party to the contract for wheelchair services going forward. However, as an equitable budget cannot be agreed it is anticipated that T&G CCG will undertake the procurement solely for the population of Tameside and Glossop. It will be a matter for Oldham as to how they then proceed.

4.5 A framework exists for the procurement of wheelchair services. The framework is the NHS Shared Business Services Community Equipment, Products and Services Framework (Ref: SBS/15/RC/GWB/8730). Due to the length of time available to undertake procurement and mobilise a service, the framework option is the most appropriate way to procure the service. Shared Business Services have already been informed of this potentially pending piece of work and have provisionally added it to their work plan pending SCB decision. The current service provider (Stockport NHS FT) is not included in this framework and has been made aware of the potential that the CCG may use this option for the service from April 2017 (See **Appendix A**). There will be a cost of £1,000 per annum for the Single Commission to access the Framework.

4.6 A draft service specification has been produced and consultation commenced (including an Equality Impact Assessment and Quality Impact Assessment) with a view to using this specification as the basis for the re-procurement. Partners in existing provider organisations have been involved in the development of the specification, including representatives from T&GICFT (see **appendix B, C and D**).

5. PROFESSIONAL REFERENCE GROUP COMMENTS AND RECOMMENDATIONS

5.1 PRG considered proposals for wheelchair services at meetings in May and August 2016.

5.2 In May 2016 PRG recommended that the CCG serve notice on the current contract and proceed with a procurement exercise for a replacement service to be operational from April 2017.

5.3 In August 2016 a draft service specification was presented to PRG as a basis for the CCG to procure a new service from April 2017 onwards. The presentation of this service specification led to further discussions, and PRG recommended that the current wheelchair contract (2016/17) should be transferred to Tameside & Glossop ICFT in-year. PRG also recommended that T&GICFT should be asked to lead the commissioning / procurement of a replacement service to be operational from 1 April 2017, therefore transferring a budget from the CCG to the ICFT (at a reduced level from the current £821k – see section 4.3 of this report) and finalising a service specification (inclusive of eligibility criteria).

5.4 The suggestions from PRG have been explored and in the current circumstances it is not feasible to engage with the T&GICT in the way described at 5.3 above. Whilst T&GICFT are willing to provide support for the procurement process to ensure the service will fit in with the aims and objectives of T&GICFT, this will not be permitted to delay the re-tendering of this service given the financial and operational imperatives for the service to be in place .by 1 April 2017.

6. WHEELCHAIRS AND THE INTERGRATED COMMUNITY EQUIPMENT SERVICE

6.1 The contract for the wheelchair service is due to expire on 31 March 2017. The contract for the Integrated Community equipment Service (ICES) is due to expire on the 30 September 2017. There would be no option to tender for both services at the same time due to the timescales and complexities of both services.

7. RECOMMENDATIONS

7.1 As set out at the front of the report.

APPENDIX A

Proposed Procurement Timeline

The Provision of a Wheelchair Service on behalf of NHS Tameside & Glossop Clinical Commissioning Group Draft High Level Procurement Timeline Milestones

DRAFT MINI COMPETITION TIMELINE MILESTONES (Framework)

Evaluation Requirements	Dates
Develop Invitation to Tender (ITT) document Pack	**11 November 2016**
Governance Approval Process to approve Pack	**18 November 2016**
Mini Competition issued to Framework Suppliers	**22 November 2016**
ITT Closes	**16 December 2016**
ITT Evaluation Period (extended as falls over Xmas period)	**4 January 2017**
Moderation Meeting	**12 January 2017**
Bidder Interviews (if required) and selection of Recommended Bidder	**20 January 2017**
CCG Governance Approval	**January 2017**
Issue Standstill and Outcome Letters including de-brief information	**February 2017**
Closure of Standstill period (subject to no challenges during Standstill)	**February 2017**
Contract Finalisation	**February 2017**
Service Mobilisation	**February 2017**
Service Commencement	**April 2017**

APPENDIX B

Equality Impact Assessment

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

Subject / Title	Wheelchair Services - Procurement

Team	**Department**	**Directorate**
Transformation	Commissioning	Single Commission

Start Date	**Completion Date**
April 2017	

Project Lead Officer	Samantha Hogg
Contract / Commissioning Manager	Samantha Hogg
Assistant Director/ Director	Alison Lewin

EIA Group (lead contact first)	**Job title**	**Service**
Samantha Hogg	Commissioning Development Manager	Single Commission
Nicola Kirkham	Senior Management Accountant	Single Commission
Patient Rep	tbc	tbc

PART 1 – INITIAL SCREENING

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

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

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

1a.	**What is the project, proposal or service / contract change?**	Tameside & Glossop CCG currently commission wheelchair assessment and provision services from Stockport NHS Foundation Trust. This was formerly part of our community contract with Stockport NHS FT, but the service did not transfer to Tameside NHS FT on 1 April 2017 due to the joint commissioning and provision arrangements with 2 other CCGs. Oldham CCG is party to the T&G CCG contract for this service. The contract currently in place between T&G CCG (including Oldham CCG) is due to expire on 31 March 2017. A new service will need to be procured ready to start on the 1st April 2017. The wheelchair service specification has been updated with input from stakeholders. There will be no change to the eligibly criteria or the type of service offered, however, there will be: 1. a reduction in the cost of the service 2. a change in provider
1b.	**What are the main aims of the project, proposal or service / contract change?**	1. Following a review of the finances, eligibility criteria and activity levels, it has been realised that there will need to be a reduction in the annual wheelchair budget. This is due to overpayment in previous years and not due to a change in the eligibility criteria/access to wheelchairs and postural support. 2. If SCB agree to use the SBS Wheelchair framework, there will be a change in the current provider as Stockport Foundation Trust would not be able to bid for the contract. Ideally, the framework would be utilised as it will reduce the length of time required for procurement and would ensure a service is in place for 1st April 2017, thereby avoiding a gap in provision.

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

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age			**X**	The service is currently based in Hyde. The new service may be based in a different location within Tameside and Glossop. This will be taken into account during the procurement process to ensure that there is no negative impact on access. Home/school/hospital visits will remain part of the service offer to ensure that the service is as flexible as possible.
Disability			**X**	The service is currently based in Hyde. The new service may be based in a

				different location within Tameside and Glossop. This will be taken into account during the procurement process to ensure that there is no negative impact on access. Home/school/hospital visits will remain part of the service offer to ensure that the service is as flexible as possible.
Ethnicity			**X**	
Sex / Gender			**X**	
Religion or Belief			**X**	
Sexual Orientation			**X**	
Gender Reassignment			**x**	
Pregnancy & Maternity			**X**	
Marriage & Civil Partnership			**X**	
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health			**X**	
Carers			**X**	The service is currently based in Hyde. The new service may be based in a different location within Tameside and Glossop. This will be taken into account during the procurement process to ensure that there is no negative impact on access. Home/school/hospital visits will remain part of the service offer to ensure that the service is as flexible as possible.
Military Veterans			**X**	
Breast Feeding			**X**	
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

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

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The service offer will remain the same therefore it is not anticipated that there would be any noticeable difference for people who would access the service. The main change is to the provider of the contract and the cost envelope of the service.	

APPENDIX B

Quality Impact Assessment

Title of scheme: Wheelchair Service - Procurement
Project Lead for scheme: Samantha Hogg
Brief description of scheme:

Tameside & Glossop CCG currently commission wheelchair assessment and provision services from Stockport NHS Foundation Trust. This was formerly part of our community contract with Stockport NHS FT, but the service did not transfer to Tameside NHS FT on 1 April 2017 due to the joint commissioning and provision arrangements with 2 other CCGs. Oldham CCG is party to the T&G CCG contract for this service.

The contract currently in place between T&G CCG (including Oldham CCG) is due to expire on 31 March 2017.
It is anticipated that there will be an overall reduction in the cost of the service; however this is due to overpayment in previous years and not due to a change in the eligibility criteria/access to wheelchairs and postural support.

There may also be a new provider in place if SCB agree to use the SBS Wheelchair framework. By using the framework, Stockport Foundation Trust would not be able to bid for the contract, however, the framework allows for a reduced period of time for procurement and would ensure a service is in place for 1st April 2017, thereby avoiding a gap in provision.

It is not anticipated that there would be any risk related to quality or patient safety, however, with the delays that have occurred, there is a moderate risk around ensuring a contract is awarded and a service is mobilised by the 1st April 2017.

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.						**What is the likelihood of risk occurring ?**	**What is the overall risk score (impact x likelihood)**			
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**	**1-5**	**Low 1-5**	**Moderate 6-12**	**High 15-25**	**Comments**
Patient Safety	x					1	1			It is not anticipated that the new service would lead to any risk in relation to public safety

Clinical effectiveness	x					2	4			This depends on who is awarded the contract; New staff may need to put new processes in place which may have a minor impact on clinical effectiveness. The CCG would require a mobilisation plan to be put in place by the new provider
Patient experience	x					2	2			It is not anticipated that there would be any significant change to patient experience
Safeguarding children or adults	x					2	2			It is not anticipated that the newly procured service would lead to any safeguarding incidents and the specification explicitly requests safeguarding processes are in place

Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented. **NB please see appendix 1 for examples of impact on additional areas.**						**What is the likelihood of risk occurring ?**	**What is the overall risk score (impact x likelihood)**			**Comments**
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**	**1-5**	**Low 1-5**	**Moderate 6-12**	**High 15-25**	
Human resources/ organisational development/ staffing/ competence			x			3		9		There will be no staff to TUPE over if a new provider is awarded the contract. Therefore, new staff may need to be hired so there may be some impact on the service. The contract would only be awarded to a provider who can confirm staff would be in post on the 1st April 2017. It may also be possible to extend the transition period with Stockport

										Foundation Trust and conversations are underway.
Statutory duty/ inspections		x				3		9		Due to the short timescales for mobilisation, there may need to be an extension of the SFT contract to accommodate this.
Adverse publicity/ reputation		x				2	4			There may be some negativity if the service is not automatically able to meet the public's expectations although this is anticipated to be unlikely.
Finance	x					1	1			It is not anticipated that the new service would have any negative impact on finances due to the reduction in annual budget.
Service/business interruption			x			3		9		Due to the tight timescales for mobilisation, there may be a delay in the service offer. Conversations are underway with SFT to look at options for extending the handover period.
Environmental impact	x					1	1			It is not anticipated that there would be any effect on the environment.
Compliance with NHS Constitution		x				3		6		There is a requirement to for CCGs to provide a wheelchair service. There may be a temporary reduction is service depending on how quickly mobilisation can start. However, conversations are underway with SFT to look at the option of extending the handover period.
Partnerships	x					1	1			It is anticipated that there would be no negative impact on partnerships.
Public Choice	x					1	1			The wheelchair service will follow national guidelines therefore it is not anticipated that there would be an effect on public choice.

Public Access			x			3		9		There may be a delay in accessing the service if mobilisation is not started early enough.

Has an equality analysis assessment been completed?	YES	As the service offer will not change, it is not anticipated that there would be an effect on access to wheelchairs and postural support.
Is there evidence of appropriate public engagement / consultation?	Yes	The service specification has been updated but there has not been any change to the eligibility criteria. The Equality and diversity Group have been contacted for view on the performance criteria.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	1 November 2016
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**INTEGRATED COMMUNITY EQUIPMENT SERVICE (ICES)**

Report Summary:

The Integrated Community Equipment Service (ICES) supplies equipment to Tameside and Glossop residents prescribed by occupational therapists, physiotherapists and community nurses. The service operates a store of equipment that is supplied directly to service user's homes and to peripheral stores for use by prescribers. The service also collects and recycles equipment no longer required.

The ICES is provided under contract by Ross Auto Engineering Limited trading as Rosscare (Rosscare) and the current contract will conclude on 30 September 2017 necessitating a procurement exercise to ensure a new service is in place from this date.

Rochdale and Oldham Boroughs, who currently use the same provider as us, have expressed an interest in a joint procurement exercise.

A minor adaptations service, providing grab rails, stair rails and key safes, will conclude on 31 December 2016. The service could easily be integrated into the ICES service as it is provided for the same client group and specified by the same practitioners. To integrate the service permission is sought to extend the contract for up to 3 months to facilitate consultation under TUPE and to make a direct award to Rosscare for the minor adaptations service, co-terminus with the ICES contract and for the service to be incorporated within the ICES when reprocured.

Recommendations:

The Single Commissioning Board are asked to:-

(1) review the report and approve -

  a. Continued allocation of finance of £1.7 million for the combined ICES and minor adaptations service;

  b. Approve a joint procurement with other local commissioners for a contract of 3+2 years;

  c. The required waivers and authorisation to proceed with the proposals as detailed;

(2) Note that further discussions are to be held with commissioners and Tameside and Glossop Integrated Care NHS FT to propose the transfer of the future contract (2017-20) to TGICFT (to include transfer of the remaining budget and all contract / performance management responsibilities).

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

Finance group believe that the current £1.7m allocation should be reviewed to assess if any efficiencies or savings can be applied. That said we also recognise that investment in community and community equipment is an important part of the out of hospital strategy and could help enable savings in the acute sector,

	therefore are supportive of the procurement in general terms. We recommend the service specification needs to be reviewed to ensure consistency with the aims and objectives of the neighbourhoods. An alternative approach to the one outlined in the paper might be to consider merging the ICES and the wheelchair services into a single procurement exercise to drive economies of scale. Involving partner organisation in neighbouring localities might also align to this strategy.
Legal Implications: (Authorised by the Borough Solicitor)	The Council is obliged to follow its own procurement standing orders which include provision to both extend a contract and to make a direct award where it can be demonstrated that to do so will achieve Best Value and is in accordance with the Procurement Rules. The report details that to integrate the adaptations service within the wider ICES specification will result in a better service to service users. It would not be unreasonable or unlawful to approve the recommendations.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well, Ageing Well and Dying Well programmes for action Provision of equipment and minor adaptations (grab rails) facilitates hospital discharge, prevents admission into hospital, and enables the maintaining of independence for adults and children.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention) • Enabling self-care • Locality-based services • Urgent Integrated Care Services • Planned care services
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities • Commission for the 'whole person' • Create a proactive and holistic population health system • Take a 'place-based' commissioning approach to improving health, wealth and wellbeing • Target commissioning resources effectively
Recommendations / views of the Professional Reference Group:	The report was presented to the Professional Reference Group on 12 October 2016 who agreed with the report. .
Public and Patient Implications:	There is a statutory duty to provide equipment where there is an assessed need.
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. Any procurement exercise will be awarded on the basis of the most economically advantageous tender that balances the cost and quality advantages of tender submissions.
How do the proposals help to reduce health inequalities?	The proposal to continue commissioning an Integrated Community Equipment service including minor adaptations will target resources to those in need of equipment to enable them to live independently at home.
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 Children and Adults with an assessed need 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?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	If collaborative arrangements are entered into to jointly procure a service n agreement will be entered into by all participating Local Authorities detailing their responsibilities including the lead Authority to use a fully compliant OJEU process to procure any contracts.
Access to Information :	The background papers relating to this report can be inspected by contacting Richard Scarborough, Planning and Commissioning Officer  Telephone: 0161 342 2807  e-mail: Richard.scarborough@tameside.gov.uk

1. BACKGROUND

1.1 This report sets out the following proposals:

- To procure a new contract for the Integrated Community Equipment Service (ICES);
- To include minor adaptations within the current ICES service;
- To allocate an ongoing budget of £1.5m for ICES plus £200k for minor adaptations;
- To enter into collaborative procurement arrangements with Oldham and Rochdale;
- To enter into a joint procurement for 3 +2 years;
- To sign off required waivers and authority to proceed;
- To investigate the transfer of future commissioning of ICES (including management, delivery and provision) from 1 October 2017 – 30 September 2020 to the ICO.

Integrated Community Equipment Service

1.2 Tameside Metropolitan Borough Council (TMBC) are the lead commissioner for the Integrated Community Equipment Service (ICES) in a joint funding arrangement between Tameside MBC, NHS Tameside and Glossop CCG (TG CCG) and Derbyshire County Council (DCC) utilising a pooled budget under a Section 75 Partnership Agreement using Health Act Flexibilities.

1.3 The ICES service is currently provided by Rosscare under a contract that commenced on 1 October 2010 following a competitive tender. The contract had an initial five year duration with an allowable extension of two years which has been utilised. The contract will end on 30 September 2017.

1.4 The ICES service supplies equipment prescribed by occupational therapists, physiotherapists, community nurses and other authorised prescribers. The service operates a store of equipment that is supplied directly to service user's homes and to peripheral stores for use by prescribers. The service also collects and recycles equipment no longer required. Appendix two summarises contract activity.

1.5 The provision of community equipment supports children and adults who require assistance to perform essential activities of daily living. The provision supports hospital avoidance and discharge, and can reduce the need for social care support by enabling individuals and their carers to better manage their conditions and maintain their independence within the community.

1.6 Community equipment provision includes items such as adjustable electric beds and pressure care mattresses, hoists, commodes etc. The equipment is provided free to the service user and is prescribed by a health or social care professional. There is a statutory entitlement to community equipment.

1.7 The ICES pooled budget arrangements include the provision of an ICES coordinator, employed by TMBC, to oversee the day to day management of the contract and service, ensure all orders are authorised, set up the specials panel and arrange mandatory and essential training. The cost of this post is £41,710.

1.8 The current partnership funding arrangements for ICES are based on historic use of the service:

- TMBC - 30.5%
- TG CCG - 65.5%
- DCC - 4%

1.9 ICES Contract spend for 2015/16 was £1,487,000 and activity and spend levels for 2016/17 are at similar levels. The Council and CCG funding for this activity now sits within the Single Commissioning joint/aligned budget. The partnership budget for 2016/17, including contributions from all three commissioning organisations is £1.6m.

1.10 DCC will shortly confirm their intentions around whether they will continue to co-commission the ICES service.

Minor Adaptations Service

1.11 Tameside MBC commission a minor adaptations service that provides and fits –

- External grab rails
- Internal grab rails
- Stair rails (single and multi-part)
- Key safes
- Drop-down rails

1.12 The minor adaptations service was originally part of a wider Handyperson service commissioned from Age UK Tameside who subcontracted this element to New Charter Building Company (NCBC). With reductions in funding the wider Handyperson service was ceased and the contract for the minor adaptations element was novated to NCBC. The current contractual arrangements come to an end on 31 December 2016. Under the Care Act 2014 there is a statutory entitlement to minor adaptations where there is an assessed need and so there will still be a need to supply and fit rails and keysafes particularly to facilitate hospital discharge. The GM Fire service will also supply and fit grab rails as part of their Safe and Well service.

1.13 The contract price for the 9 month period 1 April to 31 December 2016 for the minor adaptations service is £162,000.

2 CO-COMMISSIONING WITH OTHER LOCAL COMMISSIONERS

2.1 Community Equipment services are commissioned under similar pooled budget arrangements led by other Local Authorities. Oldham has similar arrangements to Tameside using the same provider, Rosscare, with the same end date. Rochdale procured their service more recently and also have the same provider, Rosscare, with an end of the initial contract term of 30 June 2017 which they are seeking to align with our end date.

2.2 Oldham and Rochdale Local Authorities and CCGs are keen to work together with Tameside to jointly procure a new ICES service. The other commissioners are also taking the proposal through their governance processes. An indicative timetable is given at appendix one.

2.3 Approval is sought to enter into collaborative arrangements to co-commission the service with Oldham and Rochdale to procure a single service across the three Boroughs for a period of three years with an option to extend for a further two years. The contract to be based upon a similar tariff cost model to current arrangements with each party paying for the activity that it uses. The proposal will not necessitate any pooling arrangements between the Boroughs included.

2.4 Currently all local Community Equipment contracts sit within Local Authorities rather than within NHS organisations. There are concerns that if the contract sat within an NHS organisation then VAT rules for NHS organisations could mean that VAT could not be reclaimed, effectively increasing service costs by 20%. Whilst VAT can be reclaimed for services it cannot be reclaimed for purchase of equipment by NHS organisations. If the intention is to hold the contract within the ICO other commissioners may be reticent to enter into collaborative arrangements led by Tameside unless it can be determined that this arrangement won't impact upon their ability to reclaim VAT. It is therefore likely that Oldham or Rochdale will propose to lead the procurement and award of contract.

2.5 Agreement is sought to enter into joint commissioning arrangements with other Greater Manchester Local Authority and CCG partners and to enter into an agreement for one of the

participating authorities to lead the procurement and hold the contract. A formal agreement will be entered into to agree the responsibilities of each party.

2.6 If agreement cannot be reached on participation of Oldham and Rochdale then Tameside & Glossop will continue the procurement for the population of Tameside & Glossop only. The other areas will take forward a separate procurement exercise.

2.7 A joint commissioning arrangement with a single specification is likely to result in a lower cost for each party involved.

3 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

3.1 It is proposed that the minor adaptations service is included in the ICES specification. This has a number of advantages –

- Minor adaptations are prescribed by the same practitioners as the equipment provided within the ICES service so they can be incorporated into the same online ordering system reducing practitioner workload;
- ICES services already procure and supply grab rails;
- The proposal reduces the number of services etc. that need to visit a client;
- The ICES service can include a trusted assessor role so that technicians delivering and installing equipment can assess for additional equipment, including grab rails, and supply / fit them during a visit;
- The ICES service includes recycling of equipment and should increase the number of keysafes that are removed and recycled. Keysafes cost approximately £90 and traditionally recycling rates have been low.

3.2 It is proposed to move the responsibility for minor adaptations to Rosscare to incorporate it within the ICES service prior to the procurement of the new ICES service. Authorisation is therefore sought pursuant to Procurement Standing Order F1.4 to make a direct award to Rosscare for the minor adaptations contract at a cost of £108,000 and for the service to be incorporated within the ICES specification to achieve the advantages detailed in paragraph 3.1.

3.3 The Council could seek to extend the current contract with NCBC however this would fail to achieve efficiencies in the service provision due to the reduction of visits. We could retender the service however given the intention to incorporate the service within the ICES contract when reprocured, there is unlikely to be interest in a short term contract.

3.4 Authorisation is also sought pursuant to Procurement Standing Order F1.2 to extend the NCBC minor adaptations contract for 3 month contract at a value of £54,000 from 1 January 2017 to 31 March 2017 where there is no provision to do so in order.

3.5 An extension of this contract is required to enable an orderly transfer of the service into the ICES service and to enable TUPE due diligence to be taken.

3.6 Authorisation is sought to proceed with collaborative arrangements with Oldham and Rochdale Boroughs either as lead commissioner or with one of the other Authorities as lead commissioner.

4 FINANCIAL ENVELOPE FOR NEW SERVICE

4.1 There is no national tariff for equipment services and there are a range of budgets and equipment service models across England. ICES services are usually operated under a tariff

based cost model which incentives the cost effective management of the service. Ultimately overall spend is managed by controlling eligibility and prescribing behaviour of practitioners ordering equipment from the service which are beyond the control of the service provider.

4.2 The cost of the ICES services has increased over previous years and currently stands at circa £1.5 million. There has been an increase in the number of items provided, an increase in specialist/bespoke items and an increase in the number of people who have never received equipment before. Ultimately the ICES service has been integral to the discharge process and has helped to ensure people are able to live in the community. Therefore the service leads to cost avoidance in other parts of the system.

4.3 The proposal is to procure a service with a budget of £1.7 million (£1.5m for ICES and £200,000 for handyperson services) per annum.

5 PROPOSALS FOR FUTURE COMMISSIONING ARRANGEMENTS

5.1 Board are asked to agree to further discussions with TGICFT to propose the transfer of the budget and contract responsibilities for community equipment (2017-20) to TGICFT once a contract has been awarded to a provider to provide the service from October 2017.

5.2 This would include transfer of the remaining budget and all contract / performance management responsibilities.

5.3 The management of the service would need to be transferred across to the ICO along with the partnership budget including the funding from DCC and funding for the ICES Coordinator.

5.4 Once procured, TGICFT will be asked to lead the mobilisation of the replacement service which will be operational from 1st October 2017. This will require a transfer of the budget from TMBC to TGICFT (at a level of £1.7million) with a complete service specification (inclusive of eligibility criteria).

5.5 ICES would need to become integrated and part of the ICO from October 2017. This approach will ensure that TGICFT are involved in the design of the service to ensure that there is support to shift care from the hospital to the community and alignment with the wider Tameside & Glossop Model of Care.

5.6 There needs to be agreement from all parties (shadow ICO, TMBC, DCC, TG CCG) before the contract could be novated. There will also be TUPE implications for the existing management role. As the role involves manging the authorisation process to ensure that the appropriate products are supplied, this role would best fit within the ICO and would help support the performance management of the service.

6 RECOMMENDATIONS

6.1 As stated at the front of this report.

APPENDIX 1

PROCUREMENT TIMESCALES

A full OJEU compliant procurement will be required. In order to complete the procurement the following timeline has been proposed.

Consultation / EIA / draft spec	September – November 2016
Authority to proceed (PRG/SCB)	January 2017
Legal agreement between participating authorities	January 2017
All tender documentation completed	February 2017
Place advert on OJEU Commence ITT	March 2017
ITT closes	April 2017
Evaluate ITT	May 2017
Governance	June 2017
Standstill and Contract Award	June 2017
Handover/mobilisation period	July 2017
Contract Start Date	1 October 2017

APPENDIX 2

ICES DATA

In 2015/16 the ICES service –

- Provided 27,522 pieces of equipment
    - 14,958 direct to customers
    - 12,564 to peripheral stores
- Collected 16,880 pieces of equipment for recycling
- Serviced 2047 pieces of equipment in the community
- In a typical month delivered to 541 customers of which 191 were new
- Made 7349 deliveries
- Made 5804 collections

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	1 November 2016
Officer of Single Commissioning Board	Angela Hardman, Director of Public Health
Subject:	**HIV PREVENTION AND SUPPORT SERVICES**

Report Summary:

The purpose of this report is to seek agreement to continue the financial commitment to HIV Prevention and Support services until 31 March 2019. Current services are commissioned under joint arrangements for Greater Manchester Authorities by Manchester City Council. This request relates to the services delivered by the following providers:

- Lesbian Gay Bisexual and Transgender Foundation (LGBTF)
- George House Trust (GHT)
- BHA Equalities (BHA)

The report also details the proposed future commissioning intentions for HIV Prevention and Support services and continued collaborative commissioning arrangements with the other areas in Greater Manchester (GM). The proposal is to consolidate the existing provision across Greater Manchester into a more streamlined service(s) that is responsive to the needs of the most at risk of HIV. Salford City Council is proposing to be the lead commissioner of these services on behalf of Greater Manchester Authorities with support from the Greater Manchester Sexual Health Network (GMSHN).

The economy currently invests £22,560 per annum in Sexual Health HIV prevention across these three voluntary sector providers. This is the smallest amount invested by any Local Authority across Greater Manchester. Protecting this funding is important as it both funds the delivery of services to some of our most vulnerable and high risk population in terms of sexual health needs and gives us access to the wider Manchester City region investment in these services. The continued commitment to this level of funding will maintain the economies of scale we receive by collaboratively commissioning across GM

The current lead commissioner, Manchester City Council, has authority to extend current contracts until 31 March 2019 with contracts due to expire on 31 March 2017. They are seeking agreement from Greater Manchester partners to continue the current arrangements until a procurement exercise can be conducted to implement a new service. It is proposed to extend current services by up to six months until 30 September 2017 or until a new service is in place if sooner.

Salford (as the proposed new lead commissioner) intend to manage the tender process and award a new service within the first three months of this extension (by 1 July 2017). The six month extension will offer some degree of flexibility in the timescales which may be necessary when agreeing the service model, financial investments and ensuring the outcomes of public consultation and impacts to protected groups are carefully

considered across GM.

This continued commitment and proposed new service will align these services with the commissioning cycle of core clinical sexual and reproductive health services across Greater Manchester and the Greater Manchester Chlamydia screening service. It is envisaged all sexual health services could be re-tendered collectively with a new Greater Manchester service offer implemented from 1 April 2019.

Recommendations:

The Single Commissioning Board are recommended to :

1. Approve the extension of the existing contractual arrangements for a maximum period of 6 months to 30 September 2017 from the current contract expiry date of 31 March 2017 whilst a new Greater Manchester collaborative service offer is commissioned.
2. Approve the continued investment of £22,560 per annum (£11,280 for the 6 month maximum period as detailed in recommendation 1) towards the existing Greater Manchester collaborative service offer. The investment will be financed via the Public Health directorate revenue budget which is within the Integrated Commissioning Fund Section 75 allocation.
3. Approve in principle the continued participation within the new Greater Manchester collaborative service contract which will then be commissioned by Salford to the period ending 31 March 2019 at a continued annual investment of £22,560. The investment will continue to be financed via the Public Health directorate revenue budget which is within the Integrated Commissioning Fund Section 75 allocation. A further report will be presented to the Single Commissioning Board during 2017 in advance of the commencement of the new Greater Manchester service contract.
4. Note that the continued participation in principle to the Greater Manchester collaborative arrangements (to 31 March 2019) is approved subject to a further detailed review of commissioning intentions beyond this date.
5. Note that participation within a Greater Manchester combined sexual health service offer from 1 April 2019 including the level of associated investment, will be subject to a separate decision by Single Commissioning Board members at a later date.

Financial Implications:

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

The existing annual contribution of £22,560 towards HIV prevention and support services is financed via the Public Health directorate revenue budget, which is within the Integrated Commissioning Fund Section 75 allocation.

The report recommends continuation of this investment for a six month (maximum) extension to the existing contractual arrangements during 2017/2018 whilst a new Greater Manchester service offer is implemented by Salford. Appendix two provides supplementary financial considerations including the related estimated avoidance cost to the economy of having an effective

	HIV prevention and support service in place. It should be noted that the annual investment is not expected to increase once the new Greater Manchester service is implemented via Salford to the period ending 31 March 2019. Continued participation within a new sexual health service offer from 1 April 2019 including the level of annual investment will be subject to a separate decision by the Single Commissioning Board at a later date.
Legal Implications: ***(Authorised by the Borough Solicitor)***	Should the Board agree to the recommendations the Chief Finance Officer/Executive Director of Governance, Resources and Pensions agree to the waiver of In compliance with the Council's Procurement Standing Orders to enable the contract extension.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Living Well and Ageing Well programmes for action
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention) • Enabling self-care
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 • Target commissioning resources effectively
Recommendations / views of the Professional Reference Group:	As this report does not require a clinical view it has not been reviewed by PRG.
Public and Patient Implications:	The report requests commitment to continue existing funding for these services. As part of the procurement exercise for replacement services there will be a GM wide consultation and assessment of any disproportionate impact to the protected groups under the Equality Act 2010
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. Any procurement exercise will be awarded on the basis of the most economically advantageous tender that balances the cost and quality advantages of tender submissions.
How do the proposals help to reduce health inequalities?	The HIV prevention support services target our most vulnerable and high risk population in terms of sexual health needs. Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. The Public Health Outcomes Framework (POHOF) includes indicator 3.04 HIV Late Diagnosis to assess progress in achieving earlier HIV diagnoses. The latest

	available data from 2012-2014 Tameside had a rate of 40% compared to a regional value of 45.8% and a national value of 42.2%.
What are the Equality and Diversity implications?	As part of the procurement exercise for replacement services the lead commissioner, Salford, assisted by the Greater Manchester Sexual Health Network will conduct a GM wide consultation and assessment of any disproportionate impact to the protected groups under the Equality Act 2010
What are the safeguarding implications?	None
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of all contracts. The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	The proposed procurement exercise will be conducted by Salford Council using a fully compliant OJEU process to procure any contracts. Salford propos to undertake a GM wide consultation and equality impact assessment.
Access to Information :	The background papers relating to this report can be inspected by contacting Richard Scarborough, Planning and Commissioning officer Telephone: 0161 342 2807 e-mail: Richard.Scarborough@tameside.gov.uk

1 SUMMARY

1.1 The purpose of this report is to seek agreement to continue our commitment to existing contracts for HIV Prevention and Support services, commissioned under joint arrangements for Greater Manchester Authorities by Manchester City Council, for an additional six months until 30 September 2017. This request relates to the services delivered by the following providers which are discussed in more detail within the paper:

- Lesbian Gay Bisexual and Transgender Foundation (LGBTF)
- George House Trust (GHT)
- BHA Equalities (BHA)

1.2 The paper also details the proposed future commissioning intentions for HIV Prevention and Support services and continued collaborative commissioning arrangements with the other areas in Greater Manchester. The proposal is to consolidate the existing provision across Greater Manchester into a more streamlined service(s) that is responsive to the needs of the most at risk of HIV. Salford City Council is proposing to be the lead commissioner of these services on behalf of Greater Manchester Authorities with support from the Greater Manchester Sexual Health Network (GMSHN).

1.3 Tameside Local Authority invests a total of £22,560 per annum in Sexual Health HIV prevention split between these three voluntary sector providers. This is the smallest amount invested by any Local Authority across Greater Manchester. Protecting this funding is important as it both funds the delivery of services to some of our most vulnerable and high risk population in terms of sexual health needs and gives us access to the wider Manchester City region investment in these services. By participating we are able to influence and benefit from GM initiatives such as the Public Health England funded pilot of HIV Point of Care Testing being delivered by LGBTF and BHA in Manchester and Salford.

1.4 The current lead commissioner, Manchester City Council, has authority to extend these contracts until 31 March 2019 with contracts currently due to expire on 31 March 2017. They are seeking agreement from Greater Manchester partners to continue the current arrangements until 30 September 2017. This extension request will maintain the economies of scale we receive by collaboratively commissioning across GM whilst also ensuring time for an effective procurement process for these services, which will include finalising and agreeing the following across the city region:

- a new service specification,
- the allocation of resources from each GM authority,
- to undertake a GM-wide consultation on the re-tendering of these services,
- the assessment of disproportionate impact (if any) to the protected groups under the Equality Act 2010.

1.5 It is Salford's intention to manage the tender process and award a new service within the first three months of this extension (by 1 July 2017). The six month extension will offer some degree of flexibility in the timescales which may be necessary when agreeing the service model, financial investments and ensuring the outcomes of public consultation and impacts to protected groups are carefully considered across GM.

1.6 This continued commitment and proposed new service will align these services with the commissioning cycle of core clinical sexual and reproductive health services across Greater Manchester and the Greater Manchester Chlamydia screening service. This means all sexual health services could be re-tendered collectively and commence across Greater Manchester in 2019.

2 HIV PREVENTION AND SUPPORT SERVICES

2.1 Following the Health and Social Care Act 2012 and the transfer of Public Health functions, the Local Authority adopted responsibility for the commissioning of some of the sexual health services for their residents. Prior to the transfer of these sexual health commissioning responsibilities there had been an established tradition of collaborative arrangements for some of these services across Greater Manchester.

2.2 Manchester Primary Care NHS Trust held several collaborative contracts on behalf of the other areas of Greater Manchester which included some sexual health contracts. Following the transfer of responsibilities, these collaborative contracts were transferred to Manchester City Council (MCC) as agreed by the Directors of Public Health in the 10 local authority areas.

2.3 These contracts include provision of several sexual health promotion and HIV prevention and support services aimed at specific at risk groups. The details of the individual contracts are discussed below in Section 3.

2.4 In 2015, Manchester City Council agreed an exception to their Contractual Standing Orders for these sexual health contracts so they could be extended up to 2019 if desired, which has previously allowed for these services to be extended annually. Contracts currently have an end date of 31 March 2017.

2.5 The GM sexual health commissioners, coordinated through the Greater Manchester Sexual Health Network, are proposing to redesign these services and procure a new service(s) in a joint commissioning arrangement led by Salford city council.

2.6 Discussions across GM commissioners are still ongoing and there is still no agreement from all authorities on the indicative budget for this tender. As such this has delayed the start of any formal procurement process as we are collectively unable to guarantee the budget for this service and therefore what service model could be offered to the market. Commitment is therefore sought to continue the current level of funding (£22,560 per annum). The funding for this service is within the Public Health directorate of the Integrated Commissioning Fund Section 75 allocation.

2.7 Tameside contributes minimal funding to these city region services compared to Manchester and Salford. Our continued investment will ensure we continue to benefit from the wider investment of other GM Authorities and economies of scale we receive by collaboratively commissioning across GM whilst also ensuring a thorough and effective tender process for future services.

2.8 The GM commissioners are mindful of the impact of redesigning these services may have on the populations it serves; the most at risk populations for acquiring or transmitting HIV such as gay and bisexual men, black African men and women and sex workers. This would require a careful and considered consultation with the public and the stakeholder and providers for these groups. This may also include an Equality/Community Impact Assessment to consider if there is any disproportionate impact to the protected groups within the Equality Act 2010. Any thorough consultation and impact assessment requires a clear understanding of the service model which is currently hindered by the finalising of resources from all GM authorities. This process will be supported by the Greater Manchester Sexual Health Network and Greater Manchester commissioners.

2.9 To allow sufficient time to finalise GM budgets and ensure an effective consultation and Equality/Community Impact Assessment is completed, Manchester City Council (as the host

authority of this contract) has requested the other GM partners extend their commitment to the existing contracts for an additional six months until 30 September 2017.

2.10 This report therefore seeks approval to support Manchester City Council's proposal to extend the HIV Prevention and Support services for an additional six months. This request for an extension specifically relates to the services delivered by the following providers, which are discussed in more detail in Section 3 of this paper:

- The Lesbian Gay Bisexual and Transgender Foundation
- The George House Trust
- BHA Equalities

2.11 Local data on HIV is given in **Appendix one**.

3 CURRENT SERVICES

3.1 The HIV prevention services which this paper refers to are summarised below.

Lesbian, Gay, Bisexual and Transgender Foundation (LGBTF)

3.2 LGBTF provide a sexual health promotion and HIV prevention service, specifically targeting a key at risk group for sexual ill health, men who have sex with men (MSM). This is a collaborative service with all the Greater Manchester Local Authorities including Tameside.

3.3 Most of the activity delivered is either Manchester centric or delivered though social media where geography is less of an issue. There is some targeted activity delivered in Tameside such as a bus tour and outreach within New Charter sessions and support for local pride events.

3.4 LGBTF also offer

- Distribution of safe sex packs
- Attendance at community events
- In reach into saunas, and other sex on premises venues
- College based promotion of sexual health messages
- Provision of training
- Outreach rapid HIV testing
- Support to age UK
- Support to planning pride events

3.5 The contract is held by Manchester City Council (MCC) and currently ends 31st March 2017. MCC are able to extend the contact until 31 March 2019.

3.6 Annual Contribution from Tameside is £9560

George House Trust (GHT)

3.7 George House Trust (GHT) provide a sexual health promotion and HIV prevention service, specifically aiming to reduce onward transmission of HIV by working with those already living with HIV. This is a collaborative service with other Greater Manchester Local Authorities including Tameside.

3.8 GHT is commissioned to deliver HIV support services across Greater Manchester. There are 69 Tameside residents accessing support from the GHT (24 female, 45 male), with the majority aged 36 to 50 although the service is used across the age range. The majority of

individuals accessing the service in Tameside are white British (38), with the second largest group being black African (22).

3.9 GHT offer a range of support from relationship advice, disclosure, emotional wellbeing, use of medication and treatment. Tameside service users accessed a range of advice, with the most common topic being financial advice.

3.10 The majority of work delivered to Tameside residents is delivered outside of Tameside mainly at their base in central Manchester.

3.11 The contract is held by Manchester City Council (MCC) and currently ends 31st March 2017. MCC are able to extend the contact until 31 March 2019.

3.12 Annual Contribution from Tameside is £7000

BHA Equalities

3.13 BHA Equalities work with women and men at high risk of sexual ill-health to reduce the incidence of sexually transmitted infections including HIV among women and men from black African communities, black Caribbean communities and Eastern European countries living in Greater Manchester. The programme also contributes to raising awareness of sexual health issues among the general population and promoting good sexual health and wellbeing.

3.14 BHA provide sexual health information, HIV prevention and support to individuals, families and communities across Greater Manchester, working within communities to encourage individuals to protect themselves from infection.

3.15 Recently community engagement in Tameside has centred around Ashton Market, with a particular focus on delivery on a Sunday to engage with individuals who would not otherwise engage in community events. There is also ongoing work developing a social media presence through Twitter and Facebook.

3.16 BHA records ethnicity, sexual orientation and age of clients engaging in one to one contact. The majority of Tameside contacts reported are with individuals describing themselves as black African, the most common sexuality reported was heterosexual and most people in contact with the service were aged over 30.

3.17 BHA report that they have found engaging with some BME groups in Tameside challenging and this is an area of work they will continue to focus on.

3.18 The contract is held by Manchester City Council (MCC) and currently ends 31st March 2017. MCC are able to extend the contact until 31 March 2019.

3.19 Annual Contribution from Tameside is £6,000

4 PROPOSAL FOR FUTRE COLLABORATIVE COMMISSIONING

4.1 The GM sexual health commissioners, coordinated through the Greater Manchester Sexual Health Network, are proposing to procure a new HIV prevention service with a lead provider model in a joint commissioning arrangement led by Salford city council.

4.2 As a key member of the Greater Manchester Sexual Health Network and an area with high prevalence of HIV (the third highest in the England outside of Greater London), Salford City Council is offering to be the lead commissioner and to manage the procurement process on behalf of Greater Manchester. This lead commissioner role will be supported by the Greater Manchester Sexual Health Network and Greater Manchester commissioners who have been working collaboratively on Public Health sexual health services for over 10 years.

4.3 An open tender exercise will be undertaken with expressions of interest invited through the Official Journal of the European Union and advertised on The Chest.

4.4 These collaborative Greater Manchester services deliver economies of scale benefits for all Greater Manchester authorities with a specific focus on working with key at risk groups. This Greater Manchester solution also recognises that people do not necessarily choose their sexual partners or to access services within the boundaries of their own area of residence.

4.5 This collaborative procurement also supports the Devolution Manchester agenda by demonstrating the effective joint commissioning arrangements that are possible across the city region.

4.6 All areas of Greater Manchester have carried out tender exercises for their core clinical sexual and reproductive health services in the last 12 months which includes the specialist genitourinary medicine, contraceptive and sexual health services along with psychosexual counselling. All these core services across Greater Manchester are now commissioned up to 2019. The continued commitment and proposed joint commissioning of new HIV prevention services will align these services with the commissioning cycle of core clinical sexual and reproductive health services across Greater Manchester and the Greater Manchester Chlamydia screening service. The alignment of all sexual health service commissioning cycles will allow for a future GM wide re-tendering of all sexual health services (both clinical and non-clinical) in one exercise in 2019.

5 PROCUREMENT STANDING ORDER SEEKING TO WAIVE / AUTHORISATION TO PROCEED

5.1 Authorisation is sought to proceed with collaborative arrangements led by Salford as lead commissioner

6 FINANCIAL ENVELOPE FOR NEW SERVICE

6.1 Tameside's contribution to current expenditure on HIV prevention services in Greater Manchester is £22,560 per annum. The major funders of these services in Greater Manchester are Manchester and Salford which reflects their much higher diagnosed HIV rates and specific at risk group issues. Contributions from the remaining 8 authorities are considerably lower with Tameside's being the lowest currently. The proposed levels of funding of other local authorities are currently unknown as they are all undergoing governance to approve budget allocations.

6.2 The funding for this service is within the Public Health directorate revenue budget of the Integrated Commissioning Fund Section 75 allocation.

6.3 **Appendix two** provides supplementary financial considerations including the related estimated avoidance cost to the economy of having an effective HIV prevention and support service in place.

7 RECOMMENDATIONS

7.1 As stated at the front of this report.

APPENDIX ONE

1 LOCAL HIV INFORMATION

1.1 Much of the following information comes from the Sexual and Reproductive Health profiles produced by Public Health England and the Tameside Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2014 produced by Public Health England in November 2015. This information is supplemented with data from local services for the 12 month period to 30 June 2016.

1.2 Late diagnosis is the most important predictor of HIV-related morbidity and short-term mortality. The Public Health Outcomes Framework (PHOF) includes indicator 3.04 HIV Late Diagnosis to assess progress in achieving earlier HIV diagnoses. The latest available data from 2012-2014 Tameside had a rate of 40% compared to a regional value of 45.8% and a national value of 42.2%.

1.3 Tameside's diagnosed HIV prevalence rate per 1000 age 15-59 is 1.49% (194 cases). In local authorities with a diagnosed HIV prevalence greater than 2 per 1,000, implementation of routine HIV testing for all general medical admissions and for all new registrants in primary care is recommended.

1.4 In 2014, among genitourinary medicine (GUM) clinic patients from Tameside who were eligible to be tested for HIV, 41.8% were tested (compared to 68.9% in England) and an HIV test was offered at 83.8% of eligible attendances at GUM clinics among residents of Tameside and, where offered, an HIV test was done in 38.6% of these attendances. More recent data from the local service shows that of the patients identified as high risk 81% of those offered a test accepted it.

1.5 In 2014, nationally, an HIV test was offered at 80.1% of eligible attendances at GUM clinics and, where offered, an HIV test was done in 77.5% of these attendances. In 2014, among GUM clinic patients from Tameside who were eligible to be tested for HIV, 41.8% were tested. Nationally, 68.9% of GUM clinic patients who were eligible to be tested for HIV were tested.

1.6 A quarter of people estimated to be living with HIV are unaware of their infection in the UK and remain at risk of passing it on if having sex without condoms. Reductions in undiagnosed infection can be achieved through increasing testing coverage in STI clinics, the introduction and consolidation of HIV testing in a variety of different medical services, in addition to further development of community testing, including self-sampling/self-testing.

1.7 The number of people living with diagnosed HIV infection has continued to increase in England, while the number of new HIV diagnosis remains stable at around 6,000 per year in recent years. People diagnosed with HIV late have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed promptly.

1.8 Once diagnosed, the quality of HIV care provided by clinical services in England is high with limited variations by sex, ethnicity and exposure groups. Consequently, people living with HIV can expect a near-normal life span if they are diagnosed and treated promptly. Early treatment has been recommended by national and international treatment guidelines, not only for the benefits of diagnosed people but also for the prevention of onward transmission.

1.9 In 2014, 212 adult residents (aged 15 years and older) in Tameside received HIV-related care: 150 (number rounded up to nearest 5) men and 65 (number rounded up to nearest 5) women. Among these, 60.9% were white, 28.3% black African and 2.2% black Caribbean.

With regards to exposure, 50.0% probably acquired their infection through sex between men and 43.2% through sex between men and women

1.10 Service data shows that currently 91 people are receiving HIV treatment and Care in the local Tameside service. This compares to 67 in the same period in 2014. HIV Treatment and care is commissioned by NHS England but delivered across Greater Manchester with many patients electing to receive care from Manchester services.

1.11 Where residence information was available in 2014, 13 adult residents of Tameside were newly diagnosed with HIV. The rate of new HIV diagnosis per 100,000 of population among people aged 15 or above in Tameside was 7.22, compared to 12.34 in England.

APPENDIX TWO

2 FINANCIAL CONSIDERATIONS

2.1 The main aims of the HIV Prevention Support Services are to -

- support people living with HIV
- prevent onward transmission of HIV
- to improve testing rates so that we detect earlier and
- to improve testing rates so that we detect more

2.2 Supporting people with HIV to manage their HIV infection as a long-term condition, avoid onward transmission and improving detection rates and early detection will result in cost avoidance.

2.3 Poor sexual and reproductive health and ongoing transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing, and result in significant costs for health and social care budgets.

2.4 There is a strong association between poor sexual and reproductive health and other risk behaviours. Sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities, and improving sexual and reproductive health and HIV outcomes will address these major health inequalities.

2.5 People living with HIV who are diagnosed late have a tenfold increased risk of death in the year following diagnosis compared to those diagnosed promptly.

2.6 NHS's expenditure on infectious diseases has an average annual spend of £13,900 for each person accessing HIV services[1]

2.7 Each new case of HIV infection is estimated to incur between £280,000 and £360,000 in lifetime treatment costs.[2]

2.8 Those diagnosed late incur twice the direct medical costs for HIV care in the first year after diagnosis compared with those diagnosed early.[3]

2.9 This is largely due to increased inpatient hospital care costs, which are 15 times higher for those diagnosed late. Subsequent HIV care costs, for those diagnosed late, remain 50% higher in the years following diagnosis due to increased rates of hospital admission and increased costs of providing treatment.[4]

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[1] 1 - HC Deb 16 June 2014 200862W http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2014-06-16/200862/

[2] 2 - Health Protection Agency. HIV in the United Kingdom: 2012 Report. London: Health Protection Services, Colindale. November 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/335452/HIV_annual_report_2012.pdf

[3] Beck EJ, Mandalia S, Sangha R, Sharott P, Youle M, Baily G, et al. The cost-effectiveness of early access to HIV services and starting cART in the UK 1996-2008. PLoS One. 2011;6(12):1–9.

[4] 4 Krentz, H.B. & Gill, M.J. The Direct Medical Costs of Late Presentation (<350/mm 3) of HIV Infection over a 15-Year Period. AIDS Research and Treatment. AIDS Res Treat. 2012; 2012:757135.

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	1 November 2016
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**ASHTON IN-HOUSE PHARMACISTS**
Report Summary:	To present the case for continuing funding of in-house pharmacists in the Ashton neighbourhood, using the Better Care Fund monies.
Recommendations:	That the five Ashton practices – Ashton GP Service, Bedford House, HT Practice, Tame Valley and Waterloo – receive funding from the Better Care Fund to cover the costs of in-house pharmacists for 2016/17.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	There is no evidence attached to the report, which supports the case for in house pharmacists, only assertions, accepting that the finance group who agree with the report consider that going down this route will achieve savings. The Finance Group are supportive of this proposal and in line with the recommendations for other proposals of this nature, it is recommended the CCG fund this to the 30 September 2016 but from the 1 October 2016 this should be funded from the Neighbourhood funds. During the period October – March 2017, the Neighbourhoods will determine whether this is a scheme they would wish to support beyond March 2017. This scheme will be subject to on-going performance monitoring to ensure value for money in line with the other pharmacist schemes in operation. Funding for this proposal would be from the Section 75 element of the Integrated Commissioning Fund.
Legal Implications: **(Authorised by the Borough Solicitor)**	In the absence of evidence, as highlighted by the section 151 officer above, it is not possible to form a view as to whether this approach represents value for money and therefore a better solution for the public purse. It is clearly in the public interest, however, for pharmacy services to be available according to need, ensuring that the sick and vulnerable are able to properly access them in a timely way and in accordance with their health and welfare requirements. Accordingly, this approach should be reviewed in light of some measurable deliverables.
How do proposals align with Health & Wellbeing Strategy?	To develop cost effective solutions and innovative services, through improved efficiency and delivering more joined up services that meet local need.
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 care delivered in primary care and support cost reductions by reducing prescribing costs.
Recommendations / views of the Professional Reference Group:	The recommendations were accepted by PRG.

Public and Patient Implications:	The general practice offer to patients will be improved by in-house pharmacists.
Quality Implications:	In-house pharmacists can improve the quality of care patients received from general practice.
How do the proposals help to reduce health inequalities?	In-house pharmacists improve the management of patient medication to ensure patients are receiving the most appropriate medication to manage their health, which may reduce inequalities.
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 IG responsibilities. N/A
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 Christopher Martin, Primary Care Development and Quality Manager  Telephone:  e-mail: Christopher.martin4@nhs.net

1. INTRODUCTION

1.1 In-house pharmacists were introduced in the Ashton Neighbourhood in the 2015/16 financial year funded from the Better Care Fund or the Commissioning Improvement Scheme.

1.2 The five Ashton practices who funded their schemes under the Commissioning Improvement Scheme (CIS) did not have a mechanism for the Clinical Commissioning Group to disburse funds to them as the CIS funding stream was paid to practices in two lump sums, which the practices then used to pay for the in-house pharmacists.

2. CONTEXT

2.1 There are five practices in Ashton who funded their pharmacist by the CIS scheme – Ashton GP Service, Bedford House, HT Practice, Tame Valley and Waterloo.

2.2 The table below shows the 2016/17 costs for each of these practices alongside the funds available under the Better Care Fund

Practice	Payments From	Time	Monthly Payment	16/17 Total Payment	16/17 Budget (£5 per weighted patient)
Ashton GP Service	Apr-16	2 x 3hr sessions a week	712.8	8553.6	15730
Bedford House	Apr-16	4 x 3 hour sessions a week	1425.6	17107.2	35640
HT Practice	Apr-16	2 x 4hr sessions a week	950.4	11404.8	39320
Tame Valley	Apr-16	32hrs per month	950.4	11404.8	33695
Waterloo	Apr-16	2 x 3hr sessions a week	712.8	8553.6	13150
Total				57024	137535

2.3 It is accepted that in-house pharmacists provide financial savings to practice prescribing as well as reducing the workload on GPs.

2.4 Bedford House, one of the practices above has since February 2016, in conjunction with restricted pharmacy ordering of patient prescriptions, reduced the number of items prescribed by 5.9% against a CCG wide reduction in items prescribed by a 1.51% average. Bedford House has reduced its cost by 9.1% against a CCG wide average reduction in cost of 3.4%.

2.5 If Bedford House had not put these measures in place it is estimated that it would have spent approximately £40,000 more on prescribing since February 2016.

2.6 The medicines management team believes that if these five Ashton practices retain the services of an in-house pharmacist throughout 2016/17 this will be a major contributory factor in making significant savings on the Ashton prescribing budget,

3. RECOMMENDATIONS

3.1 That the five Ashton practices named above receive funding from the Better Care Fund to cover the costs of in-house pharmacists for 2016/17.

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