SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 17 January 2017
Time: 3.00 pm
Place: Lesser Hall, Dukinfield Town Hall

Item No.	AGENDA	Page No
1.	**WELCOME AND APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from members of the Single Commissioning Board.	
3.	**MINUTES OF THE PREVIOUS MEETING** To receive the Minutes of the previous meeting held on 6 December 2016.	1 - 4
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance, Single Commission.	5 - 24
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the attached report of the Director of Public Health and Performance.	25 - 56
6.	**COMMISSIONING FOR REFORM**	
a)	**NEW CONTRACTUAL AND PARTNERSHIP RELATIONSHIP BETWEEN TAMESIDE AND GLOSSOP'S CARE TOGETHER SYSTEM AND PENNINE CARE IN RELATION TO THE DELIVERY OF MENTAL HEALTH SUPPORT** To consider the attached report of Clare Watson, Director of Commissioning.	57 - 62
b)	**PRIMARY CARE - PRIORITIES AND SCOPE 2017-2021** To consider the attached report of Clare Watson, Director of Commissioning.	63 - 74
c)	**NEIGHBOURHOOD PRIMARY CARE INNOVATION SCHEME** To consider the attached report of Clare Watson, Director of Commissioning.	75 - 82
d)	**PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF LIFTS AND HOISTS** To consider the attached report of Clare Watson, Director of Commissioning.	83 - 86

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

Item No.	AGENDA	Page No
e)	**TENDER FOR THE PROVISION OF AN ADVOCACY HUB**	87 - 90
	To consider the attached report of Clare Watson, Director of Commissioning.	
f)	**MENTAL HEALTH SUPPORTED ACCOMMODATION**	91 - 94
	To consider the attached report of Clare Watson, Director of Commissioning.	
g)	**DERMATOLOGY AND GUIDANCE AND INTERCEPTOR SERVICE**	95 - 104
	To consider the attached report of Clare Watson, Director of Commissioning.	
h)	**PROPOSAL FOR AN INTERCEPTOR FOR KEY EUR PROCEDURES**	105 - 118
	To consider the attached report of Clare Watson, Director of Commissioning.	
7.	**EVIDENCE BASED DECISION MAKING - AN APPROACH TO EQUALITY, QUALITY AND CONSULTATION**	119 - 172
	To consider the attached report of Sandra Stewart, Director of Governance, and Michelle Walsh, Interim Director of Nursing and Quality.	
8.	**URGENT ITEMS**	
	To consider any items which the Chair is of the opinion shall be considered as a matter of urgency in accordance with legal provisions as set out in the Local Government Act 1972 (as amended).	
9.	**DATE OF NEXT MEETING**	
	To note that the next meeting of the Single Commissioning Board will take place on Tuesday 14 February 2017.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Linda Walker on 0161 342 2798 or by emailing linda.walker@tameside.gov.uk, to whom any apologies for absence should be notified.

TAMESIDE AND GLOSSOP
SINGLE COMMISSIONING BOARD

6 December 2016

Commenced: 2.30 pm **Terminated: 3.30 pm**

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

IN ATTENDANCE: Sandra Stewart – Director of Governance
Stephanie Butterworth – Executive Director (People)
Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Ali Rehman – Public Health
Anna Moloney – Public Health
Debbie Watson – Public Health

APOLOGIES: Councillor Peter Robinson – Tameside MBC

99. WELCOME AND CHAIR'S OPENING REMARKS

In opening the meeting, the Chair welcomed Alison Lea, Commissioning Lead for Planned Care, who had joined the Board as the fourth GP member.

100. DECLARATIONS OF INTEREST

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

101. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 1 November 2016 were approved as a correct record.

102. 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 a 2016/17 financial year update on the month 7 financial position at 31 October 2017 and the projected outturn at 31 March 2017.

It also contained a summary of the Tameside Hospital NHS Foundation Trust financial position to ensure Board members had 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.

Board members noted that the overall financial position of the Care Together Economy had improved by £357,000 month on month reducing the projected year end deficit to £6.2m or 1.4% of the full year budget from the original commissioner financial gap of £21.5m. 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.

It was explained that the risks in the year end had been identified and planned mitigations would require rigorous monitoring to ensure delivery of the CCG QIPP schemes. In addition, the Winter Plan reflected an integrated approach across the economy which was essential in managing delayed transfers of care (DTOCs) with implementation of the Home First transformation project critical to managing the level of DTOCs.

It was further reported that the current financial gap across the health and social care economy in Tameside and Glossop would be £70.2m by 2020/21. In 2016/17 the gap was £45.7m made up of £13.5m Tameside and Glossop CCG, £8m Tameside MBC and £24.2m. The provider gap represented the underlying recurrent financial position at Tameside Hospital NHS Foundation Trust. However, the Trust was in receipt of £6.9m sustainability funding in 2016/17 resulting in a planned deficit of £17.3m. Reference was made to the initiatives / savings identified to close the financial gap.

RESOLVED

(i) That the 2016/17 financial year update on the month 7 financial position at 31 October 2016 and the projected outturn at 31 March 2017 be noted.

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

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

103. 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 September position was shown for elective care and a November 'snapshot' in time for urgent care. Also included was the CCG NHS Constitution scorecard showing CCG performance across indicators. The format also included elements on quality from the Nursing and Quality directorate. Particular reference was made to the following:

- Performance issues remained around waiting times in diagnostics and the A&E performance;
- The number of patients still waiting for planned treatment 18 weeks and over continued to decrease and the risk to delivery of the complete standard and zero 52 week waits was being reduced;
- Cancer standards were achieved in September and quarter 2 performance achieved apart from 62 day consultant upgrade;
- Endoscopy was no longer a challenge in diagnostics at Central Manchester;
- A&E standards were failed at Tameside Hospital NHS Foundation Trust; and
- The number of Delayed Transfers of Care recorded had increased recently.

It was explained that the work was progressing on a revised format for presenting assurance and performance data at future meetings. It was critical to raising standards whilst meeting budgetary requirements that a clear outcome framework was developed, that was properly monitored and meeting the statutory obligations and regulatory framework of all constituent parties.

Board members were aware that at a meeting on the 28 October 2016, the Greater Manchester Health and Social Care Partnership Board approved as Assurance Framework, including Performance Dashboard, attached at **Appendix 1** to the report, as the basis for undertaking

assurance on behalf of the Partnership. The dashboard comprised 30 key indicators encompassing the four elements of system performance, quality, finance and transformation. It was important that the performance dashboard was replicated going forward to ensure there was an understanding as to the locality was performing in a GM context in addition to any local indicators.

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

104. HOMESTART HOME VISITING AND BEFRIENDING SERVICE AND TWO YEAR OLD FREE EARLY EDUCATION ENTITLEMENT SUPPORT

Consideration was given to a report of the Director of Public Health and Performance advising that work on how best to commission support to families and maximising available budgets had been ongoing since the beginning of the year. Agreement in early September 2016 was reached to commission a single more holistic low level family support service. The new service would be designed with the existing provider to better target vulnerable families by using supervised peer supporter volunteers achieving a more sustained assed based approach.

The new service would support reducing demand in Early Help and Children's Social Care and complement the transformation programme in 2017/18, which would start the delivery of integrated services for Children and Families, requiring all agencies locally to understand and collaborate on arrangements for delivering a children and families offer. The work would be aligned to the Integrated Neighbourhoods agenda and build on the Integrated Care Organisation programme to date.

The Council had a productive partnership with Homestart since around 2008 delivering a home visiting and befriending service. Homestart was established for the benefit and well-being of vulnerable families in Tameside and its uniqueness was defined in their service model of using trained and supervised volunteers to deliver agreed support interventions to families. Homestart had worked with the Council to redesign its service offer over the years, responding to the changing profile of family needs being presented along with the tightening of financial resources available. The fundamental purpose of the service was to improve child outcomes through effective prevention, early intervention and quality family support. Trained and supported volunteers had offered support in the families' own homes and in children's centres including practical help, friendship in order to help prevent family breakdown and crisis and signposting to other services.

Approval was sought to extend the current grant arrangement by 18 months from 1 April 2017 to allow time to plan, design and implement a new model that would be phased in during this period of time. It was intended that the 18 month extension period would be used to pilot the new service model with Homestart as the supplier as this long standing provider of services had a desirable volunteer based delivery model that market intelligence suggested was unique to this supplier.

The new design model would ensure alignment with the Care Together vision for integrated children and families with a longer term intention to transfer the new service outcomes into the Integrated Care Organisation programme via a comprehensive review of the pilot. The pilot would also enable commissioners to ensure that the future budget was also correctly aligned with the supplier market and budget pressures.

Whilst the financial model had yet to be finalised, the likelihood was that the budget would be no more than the current total budget of £120,000. The contract provided early intervention and support and engaging families in this way was a much more cost effective way of providing support compared to supporting a child by other means, e.g. foster care. A full cost benefit analysis would be undertaken during development of the future delivery model.

RESOLVED
That approval be given to grant fund the core activity of Homestart from 1 April 2017 for a period of 18 months. The grant conditions to include a three month notice termination clause.

105. CONTRACT FOR THE PROVISION OF A BREASTFEEDING PEER SUPPORT SERVICE

Consideration was given to a report of the Director of Public Health and Performance outlining the current contractual arrangements for the provision of a breastfeeding peer support service and seeking to enter into a collaborative procurement with Oldham MBC to take effect once their contract with the same provider ended on 30 September 2017.

Homestart currently provided a breastfeeding peer support programme for Tameside and Oldham where parents could benefit from early, evidence-based information in order to enable them to make an informed infant feeding choice.

The proposed extension for six months at a cost of £57,000 would ensure continued compliance with the Greater Manchester Early Years Delivery Model and the Greater Manchester Early Years Starting Well Strategy. It would also ensure alignment with Oldham MBC's contract and would enable the service to be jointly commissioned from 1 October 2017. Commissioning a new contract jointly with Oldham MBC would provide scope for operational and financial efficiencies which would be quantified within the development of the revised contract specification. In addition, a meeting had been arranged with the commissioning lead at Derbyshire CCG to discuss financial arrangements going forward for Glossop parents accessing the service at Tameside Hospital which complemented Derbyshire CCGs referral programme.

RESOLVED
That approval be given:
(i) To extend the current contract from 1 April 2017 to 30 September 2017;
(ii) To recommission the service jointly with Oldham MBC.

106. URGENT ITEMS

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

107. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 17 January 2017 commencing at 3.00 pm at New Century House, Denton.

108. CHAIR'S CLOSING REMARKS

In closing the meeting the Chair advised that this would be Richard Bircher's last Board meeting. Members of the Board joined the Chair in extending their thanks to Richard for his contribution as one of the key visionaries of the Integrated Care Organisation and joint commissioning and wished him well for the future.

CHAIR

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
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 NOVEMBER 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 8 financial position (at 30 November 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 : To note the 2016/2017 financial year update on the month 8 financial position (at 30 November 2016) and the projected outturn (at 31 March 2017). Acknowledge the significant level of savings required during the period 2016/17 to 2020/21 to deliver a balanced recurrent economy budget. Acknowledge the significant amount of financial risk in relation to achieving an economy balanced budget across this period.
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 November 2016 (Month 8 – 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 this report will be required to be presented to the decision making body of each one to ensure good governance.
How do proposals align with Health & Wellbeing Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Health and Wellbeing Strategy
How do proposals align with Locality Plan?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Locality Plan
How do proposals align with the Commissioning Strategy?	The Integrated Commissioning Fund supports the delivery of the Tameside and Glossop Single Commissioning Strategy
Recommendations / views of the Professional Reference Group:	A summary of this report is presented to the Professional Reference Group for reference.
Public and Patient Implications:	Service reconfiguration and transformation has the patient at the forefront of any service re-design. The overarching objective of Care Together is to improve outcomes for all of our citizens whilst creating a high quality, clinically safe and financially sustainable health and social care system. The comments and views of our public and patients are incorporated into all services provided.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	The reconfiguration and reform of services within Health and Social Care of the Tameside and Glossop economy will be delivered within the available resource allocations. Improved outcomes for the public and patients should reduce health inequalities across the economy.
What are the Equality and Diversity implications?	Equality and Diversity considerations are included in the re-design and transformation of all services
What are the safeguarding implications?	Safeguarding considerations are included in the re-design and transformation of all services
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no information governance implications within this report and therefore a privacy impact assessment has not been carried out.

Risk Management: These are detailed on slide 10 of the presentation

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

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TAMESIDE AND GLOSSOP
Caretogether

Tameside and Glossop Integrated Financial Position: M8

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

15 December 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	250,941	251,641	(700)	377,978	380,495	(2,517)	(3,188)	671
Tameside MBC	46,043	48,290	(2,126)	69,272	72,643	(3,371)	(3,050)	(321)
Total Single Commissioner	**296,984**	**299,931**	**(2,826)**	**447,250**	**453,138**	**(5,888)**	**(6,238)**	**350**
ICFT Deficit	(11,356)	(11,476)	(120)	(17,300)	(17,300)	0	-	-
Total Whole Economy			**(2,946)**			**(5,888)**	**(6,238)**	**350**

The overall financial position of the Care Together Economy has improved by £350k month on month reducing the projected year end deficit to £5.89m or 1.3% of the full year budget. Key points to note are as follows:

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.

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 (i.e., reported as green in QIPP/recovery plans). Please note that accruals are included within the year end projections for the Council and not within the year to date totals. The CCG projections include accruals with in both year to date and year end projection total.

Original commissioner financial gap £21.5m. Still need to close £5.9m of this gap which is dependent on a proportion of amber and red schemes delivering in accordance with the optimism bias applied.

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.
- Continued work to deliver and identify further savings as part of the TMBC QIPP.
- Diligent efforts in striving to deliver the savings target in full. Significant risk attached to this.

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	132,749	132,003	746	197,643	197,522	121	(20)	141
Mental Health	19,350	19,384	(34)	29,098	29,153	(55)	(97)	42
Primary Care	54,709	55,192	(483)	81,655	82,736	(1,081)	(249)	(832)
Continuing Care	7,568	7,729	(161)	12,251	12,637	(386)	(376)	(10)
Community	18,322	18,296	26	27,559	27,520	39	47	(8)
Other	15,350	16,001	(651)	24,610	23,852	758	69	689
QIPP					2,517	(2,517)	(3,188)	671
CCG Running Costs	2,893	3,036	(143)	5,162	4,558	604	627	(23)
CCG Total	**250,941**	**251,641**	**(700)**	**377,978**	**380,495**	**(2,517)**	**(3,188)**	**671**

Page 12

Overall there has been an improvement to the CCG's projected year end financial position by just over £1m in the projected year end variance. It is important to note that the majority of this improvement is a result of non-recurrent means and includes:

- Green rated QIPP schemes have increased by £671k to £10,983
- Other changes in outturn position by directorate:
  - **Acute**: Detailed breakdown of movements in acute providers detailed separately
  - **Prescribing**: A full review of prescribing costs has now been completed. This has resulted in a pressure of £757k. The forecast includes an expectation around QIPP achievement and an adjustment relating to number of prescribing days. But the key driver of the underlying pressure is the fact that prescribing volumes in 16/17 have increased by 4.28% in T&G against a benchmark increase of 2.84% in GM and 2.08% nationally.
  - **Continuing Care**: Forecast in line with month 7 to account for overall economy pressure relating to FNC rate increase. Detailed work on value of 16/17 forecast and monitoring arrangements ongoing.
  - **Other:** QIPP findings as above.
  - **Running Costs**: The deterioration in the Running Costs is due to IT expenditure regarding the impending moves from NCH offset by reduction of the Hyperion licences which we no longer use.

- Significant improvement in the CCG QIPP position following submission of recovery plan.
- £10,983k of the £13,500k target is now fully achieved, leaving a residual gap of £2,517k.
- The CCG has a plan to close this residual gap and has reported a post mitigation risk of zero to NHSE at M8, but still work to do to implement this plan.
- Much of the gap is closed non recurrently therefore still work to close gap recurrently in future years.
- CCG planning to:
  - Deliver 1% surplus in 2016/17
  - Keep 1% of allocation uncommitted
  - Maintain Mental Health Investment Target (formerly parity of esteem)
  - Remain within running cost allocation

Recommendations

- Note the updated M8 YTD position and projected outturn
- 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 (i.e., reported as green in QIPP/recovery plans)

CCG – Provider Performance

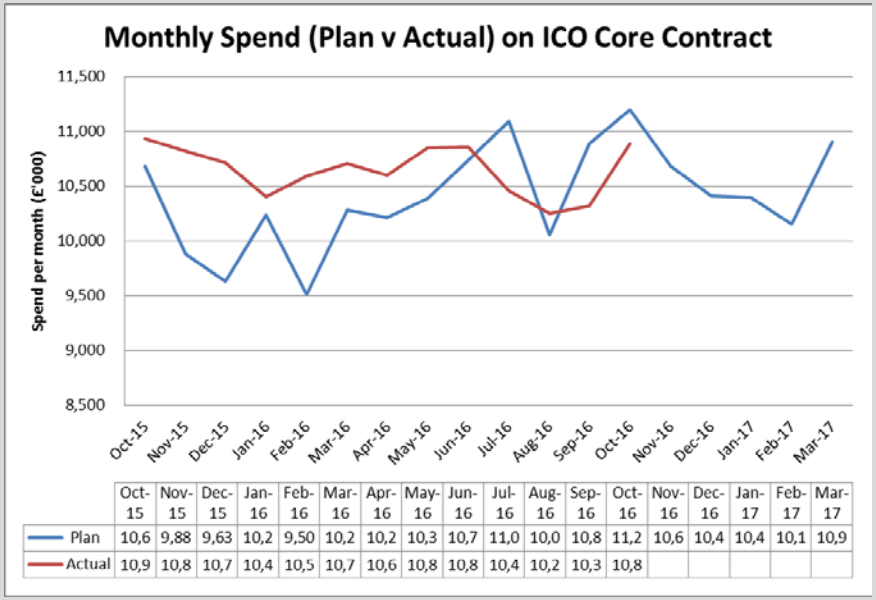
Acute Provider Drilldown

- **ICFT**: We are working towards agreeing a year end settlement with the ICFT which is anticipated to be an underspend against plan.
- Detailed below are the current areas underspending, however, these underspends should be considered in line with the budget profiling discussed under 'Acute TFT Movement' opposite:
  - **Non Elective:** General Surgery at £40k / T&O at £44k / General Medicine at £60k
  - **Critical Care:** £424k underspent YTD
  - **Drugs**: £191k underspent YTD
- **Central Manchester**: Adverse movement of full year forecast due to additional NEL activity - Cardiology (£35k), Nephrology (£44k), General Surgery (£35k) and Critical Care (£146k).
- **Pennine Acute:** Adverse movement of full year forecast due to one high cost patient incurring costs of (£43k) and Critical Care charges of (£12k).

Description	Year to Date			Year End Forecast		
	Budget £'000s	Actual £'000s	Variance £'000s	Budget £'000s	Actual £'000s	Variance £'000s
ICFT	85,193	84,442	751	126,575	126,575	0
Central Manchester	14,995	15,552	(557)	22,280	23,037	(757)
Stockport	7,985	7,396	589	11,969	11,114	855
South Manchester	4,344	4,570	(226)	6,568	6,830	(262)
Pennine Acute	2,697	2,623	74	4,029	3,871	158
Salford	2,159	2,259	(100)	3,226	3,478	(252)
WWL	929	798	131	1,409	1,259	150
Bolton	53	51	2	80	85	(5)
CCG Total	**118,355**	**117,691**	**664**	**176,136**	**176,249**	**(113)**

Acute TFT Movement

- The YTD position is underspent by £751k, of which £280k is non-recurrent and relates to cross year excess bed days.
- The graph below shows a spike in the profiling of the budget during July and September. Extending this to October, we have a further increase in budget contributing to the favourable YTD movement. It is expected that this will come back in line with plan over subsequent months so an element of forecast underspend as a year end settlement would seem a reasonable position.



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Plan	10,6	9,88	9,63	10,2	9,50	10,2	10,2	10,3	10,7	11,0	10,0	10,8	11,2	10,6	10,4	10,4	10,1	10,9
Actual	10,9	10,8	10,7	10,4	10,5	10,7	10,6	10,8	10,8	10,4	10,2	10,3	10,8					

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	28,052	28,943	(779)	41,995	43,331	(1,336)	(1,347)	11
Childrens Services, Strategy & Early Intervention	17,017	18,293	(1,276)	25,877	27,791	(1,914)	(1,582)	(332)
Public Health	973	1,054	(71)	1,400	1,521	(121)	(121)	-
TMBC Total	**46,043**	**48,290**	**(2,126)**	**69,272**	**72,643**	**(3,371)**	**(3,050)**	(321)

Overall the TMBC year end forecast position has deteriorated by £0.3m since period 7 increasing the projected year end variance to c.£3.4m, 7.3% on the current year's net budget. An explanation of the movements and other background is provided below:

Children's Social Care

- Additional temporary social workers recruited to address caseload capacity (£0.5m), additional external residential and foster care placements (£0.4m), planned savings initiatives yet to be realised (£0.9m), additional minor variations (£0.1m).

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. This is partial offset by underspends elsewhere within Public Health.

Adult Social Care

- Changes to the regulations associated with the Better Care Fund has created a pressure of £1.12m
- CCTV - The service has a projected deficit of £0.100m. A service review is underway in this area to reduce expenditure where appropriate. Updates will be provided in future reports.

Recommendations

- Note the updated M8 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position

Tameside & Glossop Integrated Care NHS Foundation Trust (ICFT)

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	135,590	137,443	1,853	202,785	205,184	2,399	205,137	(47)
Expenditure	140,688	143,184	(2,496)	210,707	213,803	(3,096)	213,749	(54)
Earnings before interest, taxes, depreciation and amortisation	(5,098)	(5,741)	(643)	(7,922)	(8,619)	(697)	(8,612)	7
Net Deficit after Exceptional Costs	**(11,356)**	**(11,476)**	**(120)**	**(17,300)**	**(17,300)**	-	**(17,300)**	-

Financial Position

- For the 8 months to November 2016, the ICFT is delivering a deficit of £11.5m, 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 contract
  - Small over performance on all associate PbR contracts
  - Financial and performance criteria for receipt of £6.5m Sustainability and Transformation funding (STF) is achieved.
  - £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.£1.8m of schemes are currently rag rated medium or high risk.
- Increased expenditure on agency staffing.
- Additional unplanned expenditure due to winter pressures.
- Savings relating to transformation schemes delayed.
- Performance targets requiring unplanned expenditure to use the independent sector.

Closing the Financial Gap

Establishing the Financial Gap

- Current financial gap across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 20/21.
- In 16/17 the opening gap was £45.7m. This is made of £13.5m CCG, £8m council and £24.2m ICO. Progress towards closing these gaps has been made throughout the year.
- 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.
- An updated position for 2017/18 and subsequent years will be presented after budget setting is completed in January 2017.

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

- CCG recovery plan submitted to NHS England which demonstrates initiatives which would allow the CCG to close the £13.5m 16/17 gap and deliver required surplus.

Summary of QIPP £'000s	2016/17 R	A	G	Total	2017/18 R	A	G	Total
PRIORITY 1 - Prescribing	1,449	0	0	**1,449**	1,123	1,393	0	**2,516**
PRIORITY 2 - Effective Use of Resources / Prior Approval	0	0	0	**0**	0	1,500	0	**1,500**
PRIORITY 3 - Demand Management	0	0	500	**500**	828	5,318	0	**6,146**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	120	543	**663**	0	486	523	**1,009**
PRIORITY 5 - Back Office Functions and Enabling Schemes	250	0	0	**250**	500	1,000	0	**1,500**
PRIORITY 6 - Governance	0	30	0	**30**	0	100	0	**100**
Other Schemes in progress/achieved:								
Neighbourhoods	0	0	460	**460**	0	525	230	**755**
Primary Care	0	0	698	**698**	0	312	1,000	**1,312**
Mental Health	0	0	232	**232**	500	0	232	**732**
Acute Services - Elective	0	110	500	**610**	500	59	500	**1,059**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,682	0	**1,682**
Technical Finance & Reserves	0	370	4,992	**5,362**	0	0	4,382	**4,382**
Other efficiencies	0	603	3,058	**3,661**	4,388	0	28	**4,416**
Grand Total:	1,699	1,233	10,983	**13,915**	7,839	12,374	6,895	**27,108**
Including adjustments for Optimum bias	170	617	10,983	**11,769**	784	6,187	6,895	**13,866**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								

- Savings identified exceed the target by £415k but after allowing for optimism bias, this becomes a shortfall of £1.731m.
- Analysis of recurrent vs. Non Recurrent savings:

Recurrent vs Non Recurrent	2016/17	2017/18
Recurrent Savings	**3,709**	**21,158**
Red	1,699	7,011
Amber	260	12,134
Green	1,750	2,013
Non Recurrent Savings	**10,206**	**5,950**
Red	0	828
Amber	973	240
Green	9,233	4,882
Total	**13,915**	**27,108**

Closing the Financial Gap - TMBC

Service	Savings Area	Detail	2016/17			
			R	A	G	Total
Public Health	Savings found	Planned Reduction to annual management fee payable to Active Tameside and other incidental savings			217	217
		Reduction in Community Services contract value - agreed with ICO			169	169
	Additional resource (projected cost pressures)				49	49
	Reduction in estimated capital financing repayments	Reduction in capital financing costs in 2016/17 due to rephasing of works to reconfigure Active Tameside estate			456	456
	Savings still to be found			490		490
	sub total Public Health		**-**	**490**	**891**	**1,381**
Adult Social Care	Additional resource (projected cost pressures)				3,908	3,908
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	997			997
	sub total Adult Social Care		**997**	**-**	**3,908**	**4,905**
Childrens Social Care	Savings found	Reduction to inflationary increases that were projected to materialise during 2016/17.			120	120
	Additional resource (projected cost pressures				1,215	1,215
	Savings still to be found	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.	379			379
	sub total Childrens Social Care		**379**	**-**	**1,335**	**1,714**
TOTAL			**1,376**	**490**	**6,134**	**8,000**
Including adjustment for Optimism Bias			138	245	6,134	**6,517**
	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						**8,000**
Savings still to be found after accounting for optimism bias						**1,483**

Commissioner 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.
- Key changes to the financial risks since last month:
  - The probability of failing to close the financial gap has reduced in the current financial year, so the RAG has been reduced from Red to Amber.
  - There is an increased probability that the GP prescribing budgets will overspend, so the RAG has been increased from Amber to Red.
  - Due to the progress made in the CCG's recovery plan, the risk of not maintaining expenditure within the revenue resource limit and not achieving the 1% surplus has significantly reduced. The risk status has therefore been amended to Green.
  - Due to increased dependency levels of those placed in care homes and the associated cost pressures, the risk has been changed from Amber to Red.
  - Significant demand and associated financial pressures in the care home market nationally is resulting in an increased probability of provider failure.

Extracts From the Corporate Risk Registers	Probability	Impact	Risk	RAG
The achievement of meeting the Financial Gap recurrently.	3	4	12	A
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	4	4	16	R
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.	1	4	4	G
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	4	4	16	R
Looked After Children placement costs are volatile and can fluctuate throughout the year	3	4	12	A
Unaccompanied Asylum Seekers	4	3	12	A
Care Home Provider Market Failure	3	5	15	R
Funded Nursing Care – impact of national changes to contribution rates	4	3	12	A

Other Significant Issues

Tameside 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 budgets (£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	1,974
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**	**-**	**412**
Carer Breaks (Adults)	412	-	412
Primary Care (£5 per head for over 75's)	**1,070**	**-**	**1,070**
Existing Grant - Disabled Facilities Grant	**-**	**1,978**	**1,978**
Impact of New Care Act Duties	**-**	**529**	**529**
Integration Pump Primimg	**982**	**-**	**982**
Maintaining Services	**-**	**4,801**	**4,801**
Mental health Services		2,450	2,450
Adult Social Care - Community based Services (Inc care Homes)		2,351	2,351
Contingency	**900**	**-**	**900**
Total	4,354	12,947	17,301
	Funded by (£000's)		
NHS Tameside & Glossop CCG			15,323
Central Funded Grants			1,978
Total BCF Fund			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.

Scheme name	Hosted by DCC/Other CCGs CCG	CCGs	Total
	£000's		
Community Home & Hospital Enhanced care team	**-**	**23,138**	**23,138**
Reablement Services / Community services		18,287	18,287
CDM & Discharge Ward		2,877	2,877
Mental Health		1,974	1,974
Primary Care	**164**	**1,529**	**1,693**
Intergration Pump priming		**8,051**	**8,051**
Maintaining Services	**284**	**24,801**	**25,085**
Maintaining Eligibilty Criteria			-
LCCTS	284		284
Adult Social care		24,801	24,801
Demographic pressures			-
Total	448	57,519	57,967
	Funded by (£000's)		
NHS Tameside & Glossop CCG			2,212
Other CCGs and Central			55,755
Total BCF Fund			57,967

Other Significant Issues

Funded Nursing Care

- 40% increase in health contribution toward FNC cases has been agreed nationally. The assessment of the impact to the whole economy has been completed and the additional cost is estimated to be £189k.
- This is 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 been developed and was signed on 16th December 2016. The year 1 funding of £5.2m has now been made available to the economy.

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	132,749	132,003	746	197,643	197,522	121	(20)	141
Mental Health	19,350	19,384	(34)	29,098	29,153	(55)	(97)	42
Primary Care	54,709	55,192	(483)	81,655	82,736	(1,081)	(249)	(832)
Continuing Care	7,568	7,729	(161)	12,251	12,637	(386)	(376)	(10)
Community	18,322	18,296	26	27,559	27,520	39	47	(8)
Other	15,350	16,001	(651)	24,610	23,852	758	69	689
QIPP	0	0		-	2,517	(2,517)	(3,188)	671
CCG Running Costs	2,893	3,036	(143)	5,162	4,558	604	627	(23)
CCG sub-total	**250,941**	**251,641**	**(700)**	**377,978**	**380,495**	**(2,517)**	**(3,188)**	**671**
Adult Social Care & Early Intervention	28,052	28,943	(891)	41,995	43,331	(1,336)	(1,347)	11
Childrens Services, Strategy & Early Intervention	17,017	18,293	(1,276)	25,877	27,791	(1,914)	(1,582)	(332)
Public Health	973	1,054	(81)	1,400	1,521	(121)	(121)	-
TMBC sub-total	**46,043**	**48,290**	**(2,247)**	**69,272**	**72,643**	**(3,371)**	**(3,050)**	**(321)**
Grand Total	**296,984**	**299,931**	**(2,947)**	**447,250**	**453,138**	**(5,888)**	**(6,238)**	**350**
A: Section 75 Services	**154,253**	**155,323**	**(1,069)**	**232,295**	**234,629**	**(2,334)**		
CCG	126,324	126,030	294	190,275	190,565	(290)		
TMBC	27,929	29,292	(1,363)	42,020	44,065	(2,045)		
B: Aligned Services	**121,767**	**123,440**	**(1,672)**	**183,380**	**186,500**	**(3,120)**		
CCG	103,654	104,442	(788)	156,128	157,922	(1,794)		
TMBC	18,113	18,998	(884)	27,252	28,578	(1,326)		
C: In Collaboration Services	**20,962**	**21,169**	**(207)**	**31,574**	**32,009**	**(434)**		
CCG	20,962	21,169	(207)	31,574	32,009	(434)		
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 8 £'000s	Projected Expenditure to 31 March 2017 £'000s	2016/2017 Projected Outturn Variation £'000s	Comments
Childrens Services - In Borough Residential Properties	912	912	618	750	162	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	3,174	4,064	1,139	Active Dukinfield - The scheme is on budget with an anticipated opening date of 9th January 2017. Active Longendale (Total Adrenaline) - The scheme is on budget and opened on 19th November 2016. Active Hyde – Work due to start on site on February/March 2017 with completion scheduled for November/ December 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	749	1,978	0	
Total	**23,158**	**8,093**	**4,541**	**6,792**	**1,301**	

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Reporting Member / Officer of Single Commissioning Board	Angela Hardman – Director of Public Health and Performance
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – PERFORMANCE UPDATE**

Report Summary:

This report provides the Single Commissioning Board with a draft quality and performance report for comment. Assurance is provided for the NHS Constitutional indicators. In addition CCG information on a range of other indicators are included to capture the local health economy position. This is based on the latest published data (at the time of preparing the report). This is as at the end of October 2016.

The format of this report will include elements on quality from the Nursing and Quality directorate. As this report evolves.

It is also anticipated that the format of the report will also include elements of the Single Outcomes Framework, and an update on the progress with the Framework is included with this report.

The following have been highlighted as exceptions:

- Cancer standards were achieved in October. Quarter 2 performance achieved apart from 62 day consultant upgrade.
- Diagnostic standard improving but still failing the standard. Endoscopy is no longer a challenge in diagnostics at Central Manchester.
- A&E Standards were failed at THFT.
- 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.
- Number of patients waiting over 52 weeks.
- Improving Access To Psychological Therapies (IAPT) performance for Aceess and Recovery remain a challenge.
- 111 Performance against KPIs.
- MRSA.

Attached for info is the Draft GM Partnership dashboard and the latest NHS England Improvement And Assessment Framework (IAF) Dashboard.

Recommendations:

The Single Commissioning Board are asked:

- To note the contents of the performance and quality report, and comment on the revised format.
- To note the update on the System Wide Outcomes Framework, endorse the structure, content and next steps.

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)**	The performance / assurance and quality data and its presentation needs to be kept under review to ensure that it provides the necessary information in a readable format to ensure that actions are taken expediently to deal with any concerns.
How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 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 The purpose of this report is to provide the Board with a draft quality and performance report for comment and an update on the System Wide Outcomes Framework. The new quality and performance report format aims to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report will align with the Systems Outcomes Framework, other Greater Manchester and National dashboard reports.

1.2 The format of this report will include further elements on quality from the Nursing and Quality Directorate as this report evolves.

1.3 It is also anticipated that the format of the report will also include elements of the Single Outcomes Framework, and an update on the progress with the Framework is included with this report.

1.4 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. UPDATE ON THE SYSTEM WIDE OUTCOMES FRAMEWORK

2.1 Attached to this report as Appendix 1 is the conclusion of a piece of work that has taken place over the past months to develop a system wide outcome framework. The framework is split into three themes:

- Population Health – Describing the shift we need to make to realise ambitions around life expectancy and healthy life expectancy, including wider determinants of health;
- Empowering People and Communities – Describing the paradigm shift that needs to take place between the system and the public, the public and their own health and the role communities play in the health and wellbeing of the population;
- System Performance and Sustainability – Describing the changes that need to take place within the health and care system in order to have a clinically and financially sustainable health economy. This section of the framework will also create space to encapsulate indicators linked to both the Greater Manchester emerging Frameworks and Investment Agreement, National 'must dos' and the Quality and Performance Report.

2.2 Under each theme, the framework identifies a set of outcomes and 'baskets' of metrics that create a picture of progress against achieving the outcome.

2.3 In developing the framework we have cross referenced with emerging wider Greater Manchester work and other frameworks and approaches that we should be cognisant of as a health and care economy in order to seek to ensure that our approach is as all-encompassing as possible.

2.4 The framework should first and foremost be viewed as a transformational approach. In order to deliver the sort of changes in health and care required to meet the challenges we face we need to think differently about the way services are designed, commissioned and provided. In having a single commissioner and an integrated provider we have the organisational structures to support this transition and it is now important that we challenge our entire system to move towards an outcomes orientated approach.

2.5 If adopted and fully implemented the framework will:

- Provide an economy wide view of a successful health and care economy, providing insight and intelligence to inform our strategies and approaches. Significantly it will

traverse all organisations with data being drawn from a variety of sources. The reports arising from the framework will be applied to key governance points throughout the system, including the Health and Wellbeing Board, Single Commissioning Board (SCB) and governance of the Tameside and Glossop Integrated Care Foundation Trust (T&GICFT).

- Change commissioning behaviour. The framework shouldn't be viewed as a blunt contracting instrument (although elements of it may be included in contracts). The framework should provide context to commissioners and affect the way we work. For example, when commissioning services for people with a learning disability a learning disability outcomes framework should be developed with service users and stakeholders using the overarching framework as context;

- Change practice amongst providers. We need to ensure that an outcomes focused approach permeates at every level of the system. Practitioners need to understand the impact of their intervention on the lives of the people they are working with and in the context of what is important to them;

2.6 The Leadership and development of the outcomes framework sits with the Collaborative Intelligence Function which draws on expertise and capacity from across the Single Commissioner and T&GICFT. Operationally an Outcomes Framework Management Group has been established sitting as a sub-group of the Collaborative Intelligence Group. The health and wellbeing outcomes within the framework apply across all integrated health and social care services. There is an opportunity to report on the outcomes framework at the Health and Wellbeing Board to promote shared priorities by bringing together responsibility and accountability for their delivery.

2.7 Following SCB endorsement of the approach, structure and content of the framework the following is planned:

- Brief phase of engagement with key staff and stakeholders to comment on the framework, its content and to identify any omissions (Jan/Feb 2017);
- Development of reporting approach and dashboards to provide effective reporting of the framework. This development should be aligned with other reporting approaches to avoid duplication; (Feb 2017);
- Formal publication of the framework along with accompanying narrative for the workforce across the SCF, T&GICFT and Local Authority (April 2017);
- Series of briefing sessions for staff (April/May 2017).

3. CONTENTS – QUALITY AND PERFORMANCE REPORT

3.1 NHS Tameside & Glossop CCG: NHS Constitution Indicators (October 2016).

3.2 Exception Report - the following have been highlighted as exceptions:

- Cancer standards were achieved in October. Quarter 2 performance achieved apart from 62 day consultant upgrade.
- Diagnostic standard improving but still failing the standard. Endoscopy is no longer a challenge in diagnostics at Central Manchester.
- A&E Standards were failed at THFT.
- 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.
- Number of patients waiting over 52 weeks.
- Improving Access To Psychological Therapies (IAPT) performance for Access and Recovery remain a challenge.
- 111 Performance against KPIs.
- MRSA.

3.3 Greater Manchester Combined Authority (GMCA)/NHS Greater Manchester (NHSGM) Performance Report:

- Better Health;
- Better Care;
- Sustainability;
- Well Led.

3.4 NHS England Improvement and Assessment Framework (IAF) dashboard.

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

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

Description	Indicator	Level	Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Exceptions	England	Trend
18 Weeks RTT	Admitted patients to start treatment within a maximum of 18 weeks from referral (unadjusted)	T&G CCG	90%	86.0%	87.3%	89.1%	88.3%	88.8%	88.9%	86.8%	89.1%	87.9%	87.7%	87.1%	85.9%	87.0%	84.8%	CCG target not achieved. Failing specialities are; urology (51.09%), T&O (76.38%), plastic surgery (83.67%), cardiology (57.58%) gynaecology (82.80%). CCG at THFT failing specialities are; T&O (76.25%), Gynaecology (85.71%) , Cardiology (88.46).	77.10%	
	Non-Admitted patients to start treatment within a maximum of 18 weeks from referral	T&G CCG	95%	83.5%	85.8%	85.1%	85.4%	84.9%	86.0%	85.7%	86.0%	88.4%	87.6%	88.2%	89.6%	88.6%	86.8%	CCG target not achieved. Failing specialities are; general surgery (86.82%), urology (66.51%), plastic surgery (72.73%), cardiothoracic surgery (81.82%), general medicine (89.32%), gastroenterology (81.71%), cardiology (80.82%), dermatology (89.34%), thoracic medicine (77.33%), rheumatology (84.62%),rheumatology (84.62%), geriatric medicine (80.00%), other (89.92%). CCG at THFT failing specialities are; general surgery (87.04%), urology (64.93%), T&O (88.42%), ENT (88.01%), plastic surgery (83.33%), general medicine (89.55%), gastroenterology (72.82%), cardiology (81.28%), dermatology(89.30%), rheumatology (85.92%).	89.70%	
	Patients on incomplete non emergency pathways (yet to start treatment)	T&G CCG	92%	91.8%	92.2%	91.8%	91.8%	92.1%	91.9%	91.6%	92.4%	92.5%	92.4%	92.4%	92.1%	92.1%	92.1%	CCG failing specialties are; urology 87.76%, T&O 90.06%, neurology 87.88%, plastic surgery 86.92%, cardiology 90.33%, thoracic medicine 88.51%, geriatric medicine 84.62%, cardiothoracic surgery 87.93%, general medicine 90.07%.	90.40%	
	Patients waiting 52+ weeks on an incomplete pathway	T&G CCG	Zero Tolerance	2	0	1	0	2	0	12	1	0	1	1	1	0	1	In Oct-16 there was 1 patient waiting over 52 weeks for treatment on an incomplete pathway. This patients is waiting under the speciality plastic surgery 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%	2.8%	2.4%	2.5%	2.7%	1.8%	2.9%	2.2%	2.5%	1.6%	2.4%	1.7%	1.2%	1.2%	1.3%	CCG target not achieved, 62 breaches. Failing for CCG are Central Manchester with 21 breaches for echocardiography, flexi sigmoidoscopy, gastroscopy and MRI. PAHT with 1 breach for gastroscopy. Stockport with 1 breach for colonoscopy. THFT with 31 breaches,for audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS. Care UK with 8 breaches for audiology assessments and MRI.	1.10%	
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%	82.6%	77.2%	73.0%	73.4%	76.0%	93.1%	84.9%	92.5%	92.2%	86.5%	85.0%	90.5%	82.7%	84.1%	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 967 patients. July 2016 performance is 84.98% breached by 1143 patients. August 2016 performance is 90.5% breached by 646 patients. September performance is 82.7% breached by 1224 patients. October performance is 84.1% breached by 1,176 patients. November performance is 86.6% breached by 943 patients.	89.00%	
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%	96.8%	97.7%	97.5%	97.4%	97.7%	96.3%	96.4%	95.8%	97.1%	96.1%	94.3%	94.6%	95.4%	96.5%		94.84%	
	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%	94.6%	96.7%	98.4%	96.1%	98.2%	98.9%	93.0%	93.9%	98.0%	95.8%	94.0%	96.7%	97.3%	100.0%		96.11%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	T&G CCG	96%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	99.1%	100.0%	98.9%	100.0%	100.0%	98.8%	98.9%	98.0%		97.31%	
	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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%		95.74%	
	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%	96.2%	100.0%	100%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Breach due to deferred treatment in Jan-16.	99.33%	
	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%		97.28%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	T&G CCG	85%	86.8%	93.0%	88.2%	96.1%	93.3%	93.8%	89.9%	89.7%	88.6%	91.5%	89.6%	91.3%	74.4%	91.1%	There were 10 breaches out of a total of 39 seen in Sept 16.	80.93%	
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	T&G CCG	90%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.3%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%		91.35%	
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	T&G CCG	85%	91.7%	80.0%	85.7%	100.0%	92.3%	88.2%	88.9%	83.3%	86.7%	94.4%	82.4%	100.0%	53.8%	78.3%	For Sept 16 there were 13 patients treated with 6 being treated over the target	87.97%	
Mixed Sex Accommodation	MSA Breach Rate	T&G CCG	0	0	0	0	0	0	0	0	0	0	0.1	0.2	0	0	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.	0.5	
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	4			2			12	2			0				Number of last minute cancellations at THFT; 15-16 Q1 = 63, Q2 = 54, Q3 = 86, Q4 = 96 16-17 Q1 = 85	1229	
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%	96.3%			100%			96.7%	94.5%			96.7%				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%	96.80%	
Maternity	Number of women Smoking at Delivery.	T&G CCG	England	14.4%			16.1%			15.8%	13.6%			16.9%					10.40%	

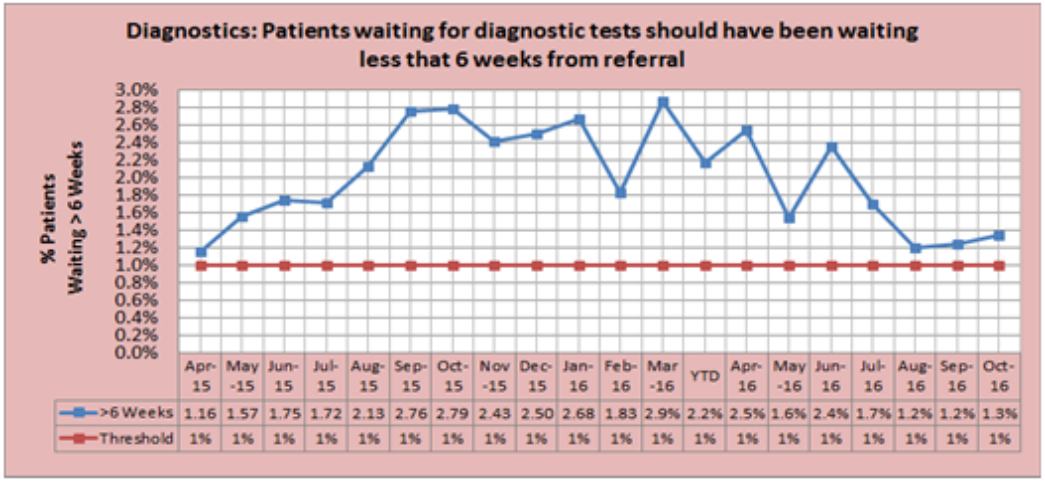
Description	Indicator	Level	Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Exceptions	England	Trend
	IAPT																			
IAPT-Improving Access to psychological services	Access	CCG	3.75%	4.30%			4.41%			4.3%	3.95%			3.92%					4.00%	
	Recovery	CCG	50%	44.00%			40.14%			40.0%	45.75%			46.00%					48.89%	
	Waiting times less than 6 weeks	CCG	75%	52.60%			60.14%			56.3%	62.75%			73.40%					84.82%	
	Waiting times less than 18 weeks	CCG	95%	89.61%			90.54%			90.4%	91.50%			98.60%					97.47%	
	Dementia																			
Dementia	Estimated diagnosis rate for people aged 65+	CCG	66.70%								69.60%	69.80%	70.50%	70.3%	71.3%	72.8%	75.3%		67.70%	
	Other Indicators																			
Other Indicators	Avoidable admissions- People	CCG		18.80%	5.58%	-14.25%	14.22%	14.95%	29.21%											
	Avoidable admissions-Cost	CCG		15.01%	39.92%	41.00%	12.51%	15.90%	-2.92%											
	Re admissions	CCG																		
	Average LOS	CCG										5.38	5.22	5.00	4.20					
	DTOCS (Patients)	LA		34	39	19	43	42	37		38	49	37	47	42	47				
	DTOCS (Patients)	Trust		36	33	16	43	36	25		26	38	25	32	29	38				
	Other Indicators-Referrals																			
Referrals	GP Referrals-Total	CCG		5894	5532	5116	5180	5723	5636	67180	6018	5494	5724	5359	5142	5310	5086	Variance from Monthly plan		
	Other referrals- Total	CCG		2929	2715	2694	2670	2871	2837	34656	2904	2748	2730	2751	2853	2786	3060	Variance from Monthly plan		
	GP referrals- T&G ICFT	CCG		4258	4088	3804	3817	4242	4129	48782	4088	3971	4053	3766	3452	3611	3566	Variance from previous year		
	Other referrals - T&G ICFT	CCG		1520	1375	1418	1419	1639	1540	19274	1640	1428	1521	1637	1670	1612	1836	Variance from previous year		
	Other Indicators-Activity																			
Activity	Outpatient Fist Attend	CCG	Plan	6719	7169	6561	6591	6698	6554	80783	6852	7137	7441	6755	6903	7205	7265	Variance from Monthly plan		
	Elective Inpatients	CCG	Plan	3033	2986	2642	2799	2898	2717	34015	2799	2890	3022	2871	2876	2915	2956	Variance from Monthly Plan		
	Non-Elective Admissions	CCG	Plan	2543	2462	2562	2407	2372	2636	28906	2361	2409	2314	2267	2336	2244	2337	Variance from Monthly Plan		

Description	Indicator	Level	Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Exceptions	England	Trend
	Other Indicators-111																			
111 KPIs	Calls answered (60 Seconds)	NW	95.00%			55.00%	56.00%	58.00%	49.00%		80.00%	85.00%	90.00%	83.0%	90.0%	89.0%	71.4%		88.50%	
	Calls abandoned	NW	<5%			15.00%	16.00%	15.00%	23.00%		6.00%	4.00%	2.00%	4.0%	2.0%	2.0%	6.4%		2.40%	
	Warm Transfer	NW	75%			38.0%	39.0%	38.0%	31.0%		35.0%	33.0%	32.0%	33.0%	35.0%	36.0%	33.2%		36.10%	
	Call back in 20 mins	NW	75%			36.00%	32.00%	34.00%	32.00%		39.00%	41.00%	40.00%	38.0%	39.0%	34.0%	34.7%		38.20%	
	Ambulance																			
Ambulance	Red 1 < 8 Minutes (75% Target)	CCG	75.00%	69.50%	70.40%	76.60%	54.50%	67.00%	73.20%		81.50%	71.10%	69.50%	75.6%	66.7%	65.9%	68.3%	High levels of demand and lengthening turn around times.	67.30%	
	Red 2 < 8 Minutes (75% Target)	CCG	75%	67.30%	61.60%	65.30%	60.90%	55.80%	68.30%		64.90%	58.00%	63.10%	58.60%	65.80%	60.00%	60.48%	High levels of demand and lengthening turn around times.	62.90%	
	All Reds <19 Minutes (95% Target)	CCG	95%	91.90%	90.20%	91.2%	89.1%	87.9%	92.3%		90.7%	89.9%	91.1%	89.9%	91.0%	89.1%	86.4%	High levels of demand and lengthening turn around times.	90.40%	
	Red 1 < 8 Minutes (75% Target)	NWAS	75%	75.90%	70.40%	78.5%	69.3%	70.5%	74.8%		76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%	High levels of demand and lengthening turn around times.	67.30%	
	Red 2 < 8 Minutes (75% Target)	NWAS	75%	72.50%	68.50%	69.5%	63.5%	61.1%	70.4%		67.5%	66.3%	66.2%	62.7%	65.3%	61.8%	63.0%	High levels of demand and lengthening turn around times.	62.90%	
	All Reds <19 Minutes (95% Target)	NWAS	95%	94.10%	92.00%	92.70%	89.90%	88.10%	92.60%		92.00%	91.50%	91.50%	89.8%	91.1%	89.0%	88.2%	High levels of demand and lengthening turn around times.	90.40%	
	Quality																			
Quality	Clostridium Difficile-Whole Health Economy		Plan	7	4	1	4	5	3	71	4	7	3	9	10	5	13		1120	
	Clostridium Difficile-Acute		Plan	6	1	0	1	4	0	29	2	2	2	4	5	2	8		399	
	Clostridium Difficile-Non-Acute		Plan	1	3	1	3	1	3	42	2	5	1	5	5	3	5		718	
	MRSA-Whole Health Economy		0	0	1	2	0	0	1	8	0	0	2	1	3	0	0		66	
	MRSA-Acute		0	0	0	1	0	0	0	3	0	0	2	0	2	0	0		29	
	MRSA-Non Acute		0	0	1	1	0	0	1	5	0	0	0	1	1	0	0		37	

Exception Report

Tameside & Glossop CCG- November

Diagnostics- Patients Waiting for Diagnostic test. **Lead Officer:** Elaine Richardson **Governance:** Contracts



	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	Sep-16	Oct-16
>6 Weeks	1.16	1.57	1.75	1.72	2.13	2.76	2.79	2.43	2.50	2.68	1.83	2.9%	2.2%	2.5%	1.6%	2.4%	1.7%	1.2%	1.2%	1.3%
Threshold	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%

Key Risks and Issues:

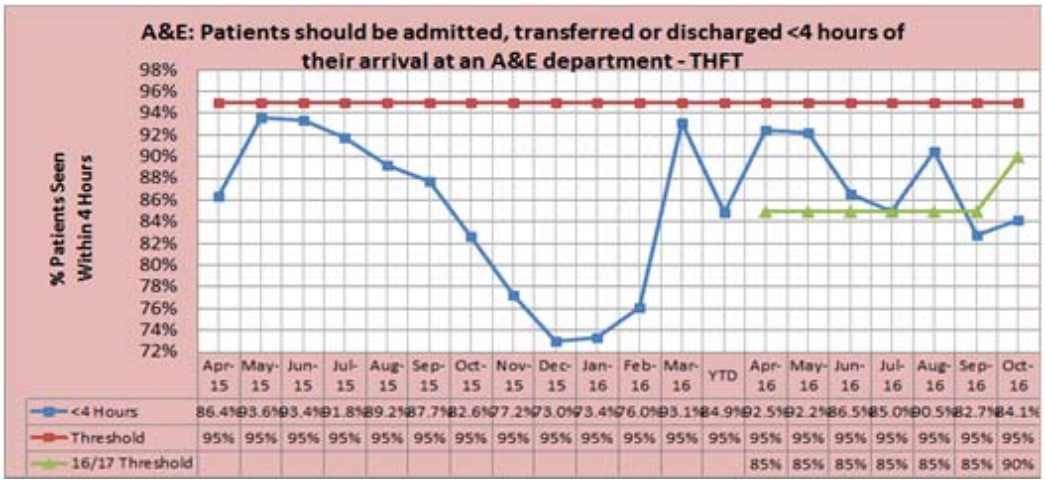
This month the main providers that have failed to meet the 1% standard are Tameside Trust, Central Manchester Trust, and Care UK. There were 62 patients in total waiting over 6 weeks. The main tests where there seam to be particular issues are Audiology at Tameside Trust, Colonoscopy at Central Manchester Trust, and Computed Tomography at Care UK.

Actions:

We continue to receive updates from the Lead commissioner for CMFT. We have contacted T&G ICFT to understand the issues with Audiology and understand the main issue seams to be capacity to deal with the demand.

FORECAST

A&E: Patients waiting < 4 hours **Lead Officer:** Elaine Richardson **Governance:** A&E Delivery board



	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	Sep-16	Oct-16
<4 Hours	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%	82.7%	84.1%
Threshold	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
16/17 Threshold														85%	85%	85%	85%	85%	85%	90%

Key Risks and Issues:

The A&E performance for October was 84.1% which is below the target of 95%. Performance for Qtr 2 was 86.0% which met the Quarterly trajectory and Year to Date is 87.6%. Issues that are impacting on performance include Medical cover, bed capacity resulting in late first assessments, specialty delays when teams are in theatres and IAU remaining a bedded area.

Actions:

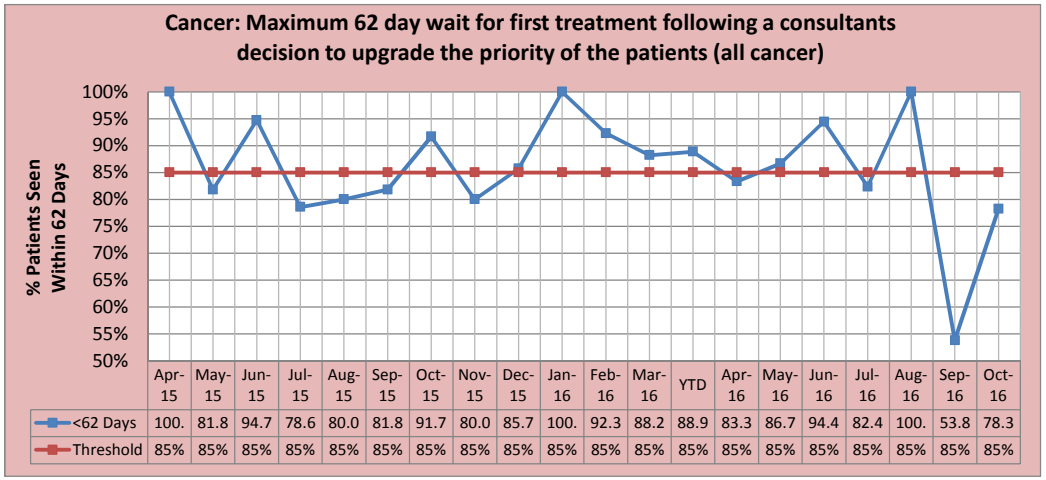
Several actions are being taken as part of a Service Improvement Project include:

- New bed declaration tool devised to map the times of discharges and declaration (go live Nov 2016)
- Opening of 16 additional beds on Stamford Unit to assist in the de-escalation of IAU.
- AMB score tool devised currently awaiting approval. This will support the Ambulatory Care Model.

FORECAST

* Please note that Tameside Trust local trajectory for 16/17 is Q1 85%, Q2 85% Q3 90% And Q4 95%.

Cancer 62 Days Upgrade- **Lead Officer: Alison Lewin** **Governance: Contracts meeting**



	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	Sep-16	Oct-16
<62 Days	100.	81.8	94.7	78.6	80.0	81.8	91.7	80.0	85.7	100.	92.3	88.2	88.9	83.3	86.7	94.4	82.4	100.	53.8	78.3
Threshold	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Key Risks and Issues:
The 62 day upgrade standard was not met in Oct with performance at 78.3% against the 85% threshold. 5 breaches mostly due to late referrals and patient cancellation.

Actions:
Tameside & Glossop ICNHSFT have introduced an internal policy to manage the 'consultant upgrade' process. To date there have been issues with consultants upgrading patients to 2ww pathways when referring them for further diagnostics, thus putting additional pressure on the radiology and endoscopy departments. Due to the recognised challenges created by the national lack of diagnostic resources, the ICFT recognise that both the Radiology and Endoscopy departments must be able to manage the priority demand for this cohort of patients. Both departments have in place a system that identifies the patients as those with a suspected or confirmed cancer. To allow this identification to take place it is the responsibility of the clinical team referring the patient for the test to appropriately mark the request as a Suspected Cancer Patient (SCP) or Cancer Patient (CP). This allows for the patient identified to be prioritised effectively. The revised Standard Operating Procedure was approved at the Cancer Board meeting on 30th November 2016.

FORECAST

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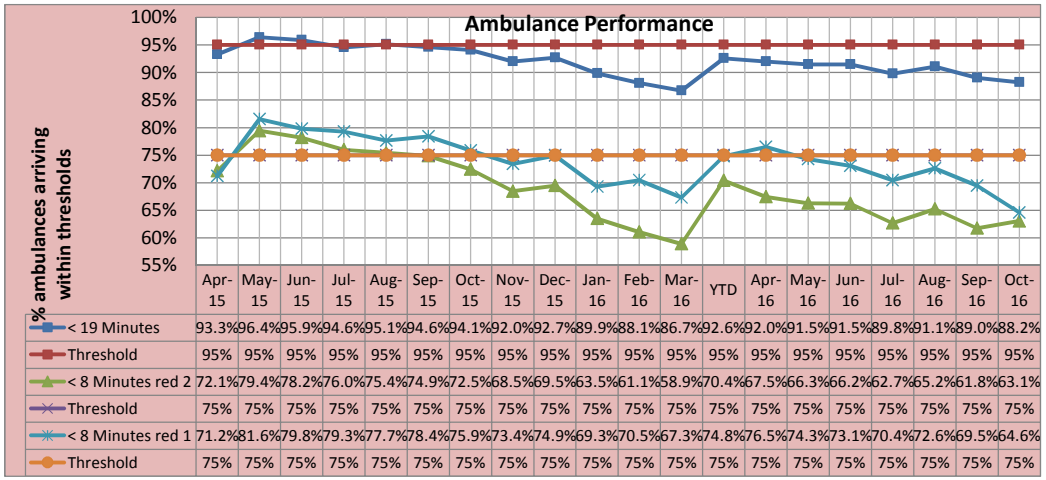
Ambulance performance- **Lead Officer: Elaine Richardson** **Governance: A&E Delivery Board**



	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	Sep-16	Oct-16
< 19 Minutes	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%	89.0%	88.2%
Threshold	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
< 8 Minutes red 2	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%	61.8%	63.1%
Threshold	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
< 8 Minutes red 1	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%	69.5%	64.6%
Threshold	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

Key Risks and Issues:

In October the CCG failed to achieve the response rates locally with 64.6% for CAT A 8 mins Red 1, 63.1% for CAT A 8 mins Red 2 and 88.2% for CAT A 19 mins Red 2. However, we are measured against the North West position which was 63.1% for CAT A 8 mins Red 1, 63.1% for CAT A 8 mins Red 2 and 88.2% for CAT A 19 mins Red 2. 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.

Actions:

Awaiting info.

FORECAST

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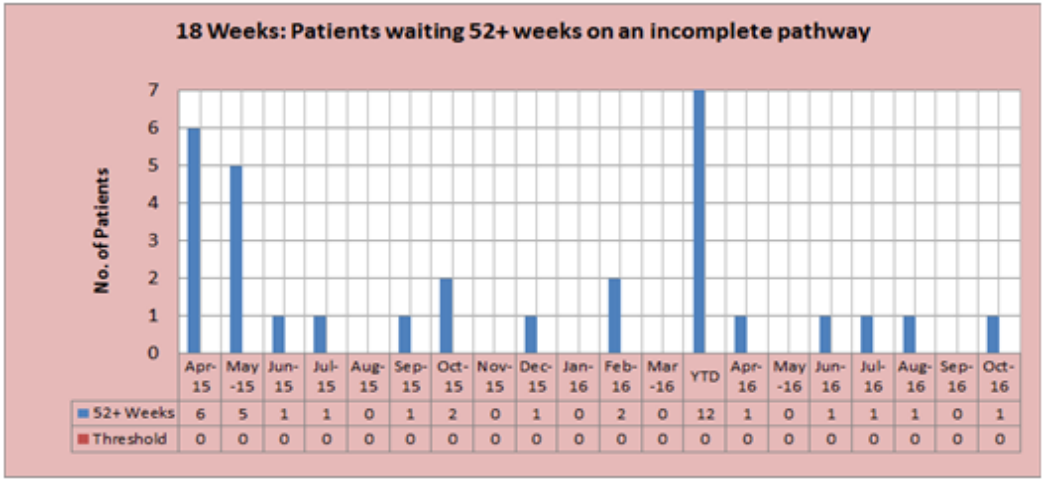
Patients waiting 52+ weeks on an incomplete pathway-

Lead Officer: Elaine Richardson

Governance: Contracts



	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	Sep-16	Oct-16
52+ Weeks	6	5	1	1	0	1	2	0	1	0	2	0	12	1	0	1	1	1	0	1
Threshold	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Key Risks and Issues:

There was 1 patient waiting over 52 weeks on an incomplete pathway. This patient was waiting at UHSM and has now been treated. There continues to be a risk with 13 patients waiting 43 to 47 weeks. 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. As at the 06th of December 2016, Eight patients had been waiting longer than 52 weeks when treated. Zero patients still waiting to be treated.

Actions:
Close monitoring of waiting lists at 36 weeks. Regular updates received from UHSM around the issues with validation of waiting lists and >52 week waiters.

FORECAST

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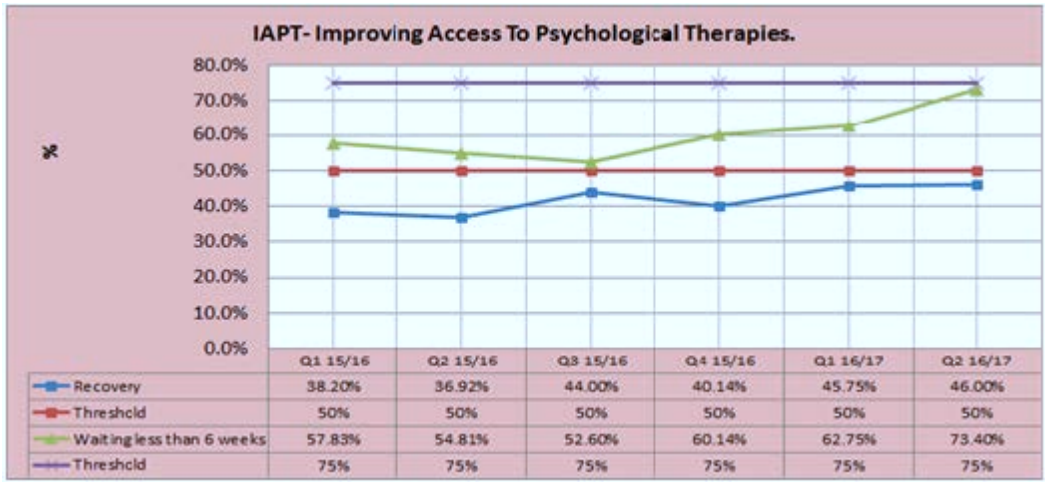
Improving Access To Psychological Therapies (IAPT)- **Lead Officer: Pat McKelvey** **Governance: Contracts**



	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17
Recovery	38.20%	36.92%	44.00%	40.14%	45.75%	46.00%
Threshold	50%	50%	50%	50%	50%	50%
Waiting less than 6 weeks	57.83%	54.81%	52.60%	60.14%	62.75%	73.40%
Threshold	75%	75%	75%	75%	75%	75%

Key Risks and Issues:
Recovery.
Higher than expected waiting times compounded by high complexity levels. Poor outcomes relating to depression and Post Traumatic Stress Disorder (PTSD).

Access.
Ongoing clearance of backlog from high referral rates. Currently in line with trajectory

Actions:
Recovery.
In line with action plan 1) increasing use of anxiety disorder measures to 100% of relevant cases 2) Review of PTSD pathway and clinical interventions 3) Review of interventions for depression

Access
In line with current action plan 1) Promoting accurate data reporting 2)

FORECAST

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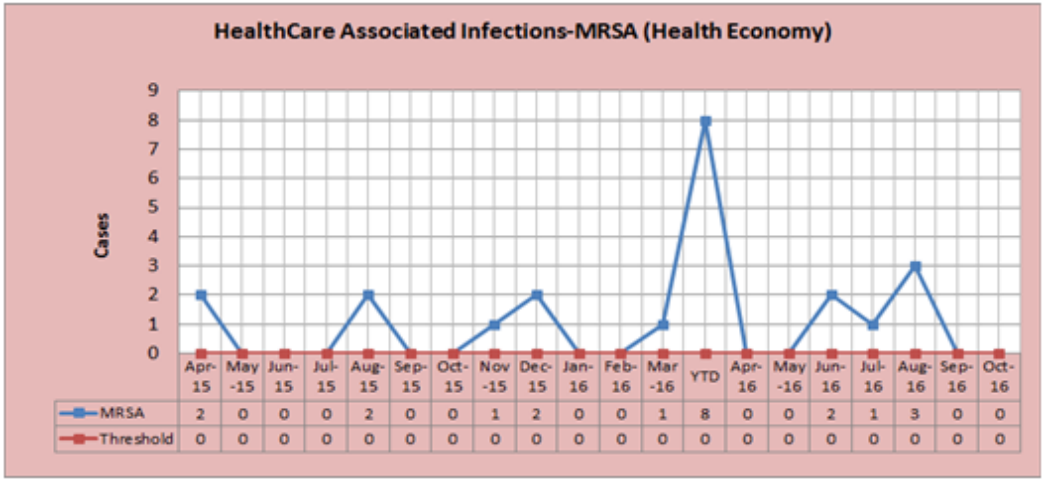
MRSA- **Lead Officer: Lynn Jackson** **Governance: Contracts**



	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	Sep-16	Oct-16
MRSA	2	0	0	0	2	0	0	1	2	0	0	1	8	0	0	2	1	3	0	0
Threshold	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Key Risks and Issues:
T&G CCG have reported 6 cases of MRSA; 4 acute cases (1 at T&G ICFT, 2 at Central Manchester, 1 at South Manchester FT) and 2 community cases, against a plan of zero tolerance.
The PIR (Post Incident Review) investigations, for the 3 cases that T&G CCG are responsible for, were reviewed by the HCAI WHE Quality Improvement Group and confirmed that all cases were unavoidable with no lapses in care identified.
1 x T&G IC FT - urethral trauma caused by urinary catheter
1 x Community - leg ulcer all appropriate care in place
1 x Community unavoidable - patient non-compliant with catheter care
Actions:
Learning from MRSA and CDIF investigations form the WHE HACI action plan which aims to achieve the WHE strategic objectives of 1) to improve antibiotic stewardship and 2) to improve infection prevention practice. The CCG has also commissioned a 2 year quality initiative with T&G ICFT which aims to supporting residential and care homes with nursing to improve their infection prevention practice and reduce avoidable HCAIs.
The CCG also reviews monthly HCAI Quality Assurance Framework submitted by providers as part of the contracting process.

FORECAST

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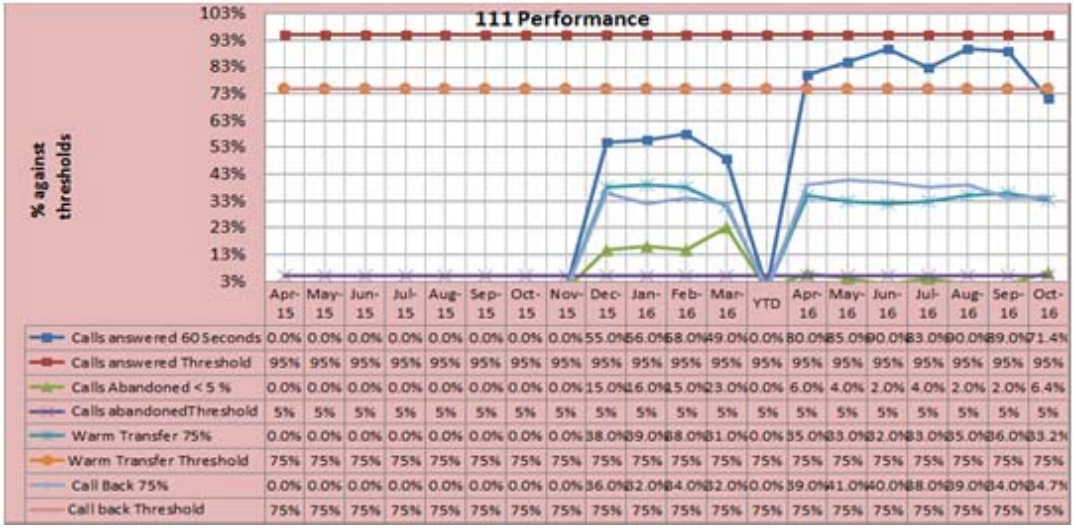
111- **Lead Officer: Elaine Richardson** **Governance: Contracts**



	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	Sep-16	Oct-16
Calls answered 60 Seconds	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	55.0%	56.0%	68.0%	49.0%	0.0%	80.0%	85.0%	90.0%	83.0%	90.0%	89.0%	71.4%
Calls answered Threshold	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Calls Abandoned < 5 %	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	15.0%	16.0%	15.0%	23.0%	0.0%	6.0%	4.0%	2.0%	4.0%	2.0%	2.0%	6.4%
Calls abandonedThreshold	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Warm Transfer 75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	38.0%	39.0%	38.0%	31.0%	0.0%	35.0%	33.0%	32.0%	33.0%	35.0%	36.0%	33.2%
Warm Transfer Threshold	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Call Back 75%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	36.0%	32.0%	34.0%	32.0%	0.0%	39.0%	41.0%	40.0%	38.0%	39.0%	34.0%	34.7%
Call back Threshold	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Oct:
- Calls Answered (95% in 60 seconds) = 71.35%
- Calls abandoned (<5%) = 6.42%
- Warm transfer (75%) = 33.22%
Call back in 10 minutes (75%) = 34.73%

Actions:
In October the NW NHS 111 service experienced a number of issues which lead to poor performance in the month against the four KPIs. Performance was particularly difficult to achieve over the weekend periods.
A full detailed report has been presented at SPB and a number of actions have been taken and are ongoing to improve performance over the winter period.

FORECAST

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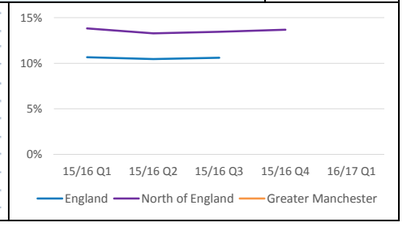
Better Health

Fewer GM Babies Will Have a Low Birth Weight Resulting in Better Outcomes For The Baby & Less Cost To The Health System

Maternal Smoking at Delivery — Better Is **Lower**

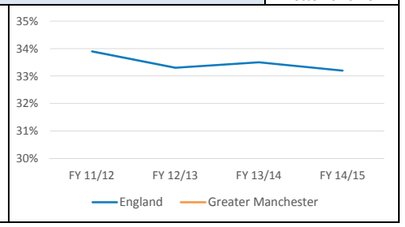
Central	6.2%
Trafford	6.8%
Stockport	11.7%
Bury	12.3%
Oldham	11.0%
Salford	11.4%
South	14.0%
Bolton	11.8%
North	13.8%
Wigan	14.3%
T&G	13.6%
HMR	16.5%



More GM Children Will Reach a Good Level of Development Cognitively, Socially & Emotionally

Percentage of Children Aged 10-11 Classified as Overweight or Obese — Better Is **Lower**

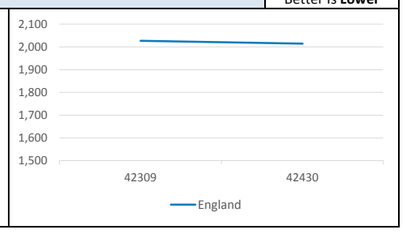
Trafford	29.8%
Stockport	29.8%
Bury	32.9%
Bolton	33.6%
T&G	34.1%
Oldham	35.2%
Wigan	35.2%
HMR	35.4%
Salford	36.6%
North	39.2%
Central	39.2%
South	39.3%



More People Will Be Supported To Stay Well and Live at Home for as Long as Possible

Injuries From Falls in People Aged 65 and Over — Better Is **Lower**

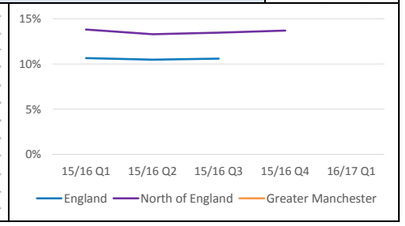
Bolton	1,626
Bury	2,005
T&G	2,116
Trafford	2,203
Oldham	2,319
HMR	2,351
Stockport	2,649
Wigan	2,693
South	2,761
Central	2,846
North	3,052
Salford	3,220



Fewer People Will Die Early From: Cardio-Vascular (CVD); Cancer; and Respiratory Disease

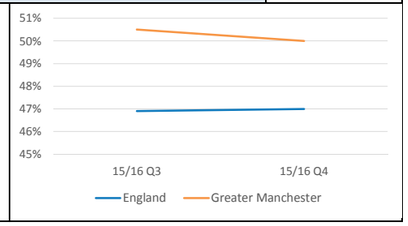
Maternal Smoking at Delivery — Better Is **Lower**

Central	6.2%
Trafford	6.8%
Oldham	11.0%
Salford	11.4%
Stockport	11.7%
Bolton	11.8%
Bury	12.3%
T&G	13.6%
North	13.8%
South	14.0%
Wigan	14.3%
HMR	16.5%



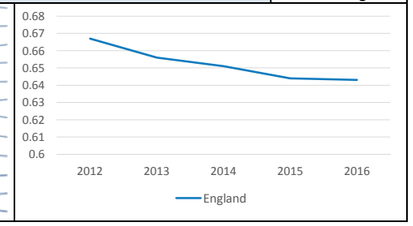
Percentage Of Deaths Which Take Place In Hospital — Better Is **Lower**

Bury	46.4%
HMR	46.4%
Bolton	46.5%
Oldham	47.0%
Stockport	48.9%
Salford	49.1%
T&G	50.7%
Wigan	52.1%
South	52.8%
Central	53.2%
North	53.9%
Trafford	57.2%



People With a Long-Term Condition Feeling Supported to Manage Their Condition(s) — Better Is **Higher**

Stockport	66.2%
Bolton	66.2%
South	66.0%
Salford	65.7%
Wigan	65.4%
Oldham	65.4%
Trafford	64.9%
Bury	63.1%
T&G	61.4%
Central	60.9%
North	59.8%
HMR	59.4%

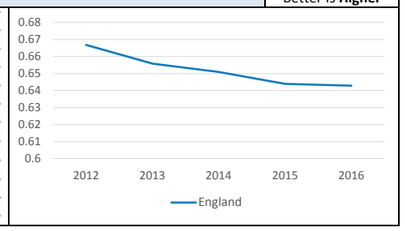


Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

People With a Long-Term Condition Feeling Supported to Manage Their Condition(s)

Better Is **Higher**

Stockport	66.2%
Bolton	66.2%
South	66.0%
Salford	65.7%
Wigan	65.4%
Oldham	65.4%
Trafford	64.9%
Bury	63.1%
T&G	61.4%
Central	60.9%
North	59.8%
HMR	59.4%

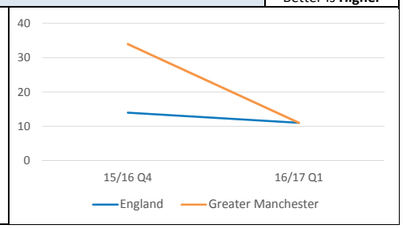


(Placeholder TBC)

Personal Health Budgets Per 100,000 Population

Better Is **Higher**

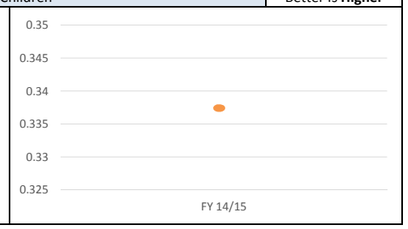
South	28
North	24
Central	23
Wigan	19
Stockport	12
HMR	8
Bolton	6
Bury	5
T&G	4
Trafford	3
Oldham	3
Salford	0



Diabetes Patients That Have Achieved All The NICE-Recommended Treatment Targets: Three (Hba1C, Cholestrol And Blood Pressure) For Adults And One (Hba1C) For Children

Better Is **Higher**

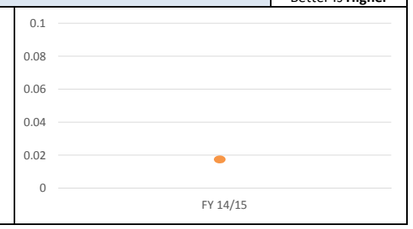
Wigan	48.0%
T&G	46.8%
Stockport	46.6%
Salford	44.0%
Trafford	42.5%
South	41.6%
Bolton	38.7%
Oldham	38.2%
North	38.1%
Central	32.7%
Bury	0.0%
HMR	0.0%



People With Diabetes Diagnosed Less Than A Year Who Attend A Structured Education Course

Better Is **Higher**

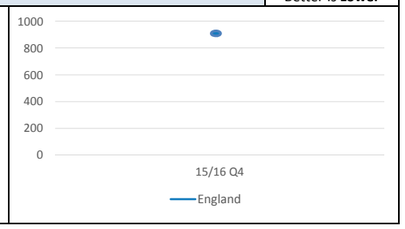
Wigan	5.7%
Trafford	3.4%
North	2.5%
Stockport	1.6%
Salford	1.0%
Oldham	0.8%
South	0.6%
Bolton	0.1%
Central	0.0%
T&G	0.0%
Bury	0.0%
HMR	0.0%



Inequality In Unplanned Hospitalisation For Chronic Ambulatory Care Sensitive Conditions

Better Is **Lower**

Bury	904
Wigan	1,048
Oldham	1,057
Bolton	1,103
Trafford	1,126
HMR	1,185
Salford	1,386
Stockport	1,422
T&G	1,475
North	1,700
Central	1,834
South	1,922



Inequality In Emergency Admissions For Urgent Care Sensitive Conditions

Better Is **Lower**

Bury	1,837
Trafford	1,939
Oldham	2,354
Bolton	2,418
HMR	2,479
Wigan	2,762
T&G	3,144
Salford	3,156
Central	3,409
South	3,422
North	3,583
Stockport	3,735

Anti-Microbial Resistance: Appropriate Prescribing Of Antibiotics In Primary Care

Better Is **Lower**

Central	1.1
Wigan	1.1
Trafford	1.1
T&G	1.1
Bolton	1.2
South	1.2
Stockport	1.2
Salford	1.2
North	1.2
Bury	1.2
HMR	1.3
Oldham	1.4

Anti-Microbial Resistance: Appropriate Prescribing Of Broad Spectrum Antibiotics In Primary Care

Better Is **Lower**

Stockport	4.9
Bury	6.0
Central	7.8
South	7.8
North	7.9
HMR	8.0
T&G	8.0
Wigan	8.2
Bolton	8.4
Oldham	9.4
Salford	9.7
Trafford	12.6

Medicine Optimisation (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

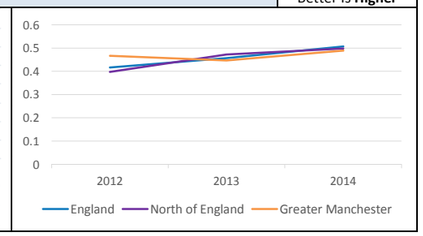
Better Care

Fewer People Will Die Early From: Cardio-Vascular (CVD); Cancer; and Respiratory Disease

Cancers Diagnosed at Early Stage

Better Is **Higher**

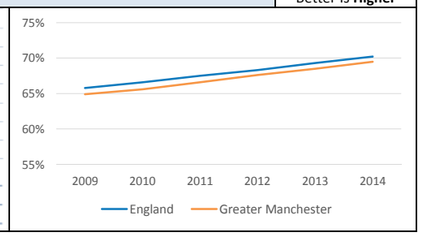
Bury	53.7%
Wigan	51.7%
Bolton	51.5%
Stockport	50.8%
HMR	50.1%
Oldham	49.4%
North	48.2%
Trafford	47.3%
South	47.2%
Salford	46.3%
T&G	44.2%
Central	37.4%



One-Year Survival From All Cancers

Better Is **Higher**

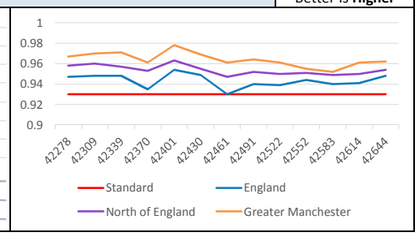
Stockport	72.3%
Trafford	72.0%
Bury	70.7%
Central	70.1%
South	69.9%
Wigan	69.5%
Bolton	69.2%
HMR	69.1%
Salford	68.8%
Oldham	67.9%
T&G	67.6%
North	66.9%



People Referred By Their GP With Suspected Cancer Within Two Weeks

Better Is **Higher**

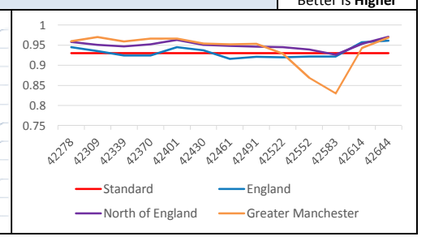
Bolton	98.9%
Salford	97.9%
Wigan	97.7%
HMR	96.8%
Stockport	96.6%
T&G	96.5%
South	96.1%
Bury	95.6%
North	94.7%
Oldham	94.7%
Central	93.7%
Trafford	93.3%



People Referred By Their GP With Suspected Cancer (Breast Symptoms) Within Two Weeks

Better Is **Higher**

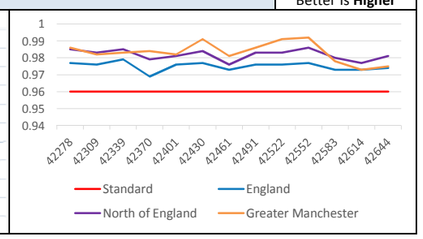
T&G	100.0%
Oldham	100.0%
Bolton	98.4%
Stockport	98.3%
South	98.2%
Wigan	97.8%
North	97.3%
HMR	96.3%
Trafford	94.9%
Bury	94.9%
Salford	92.0%
Central	91.3%



People Receiving First Definitive Treatment Within 31 Days Of A Cancer Diagnosis

Better Is **Higher**

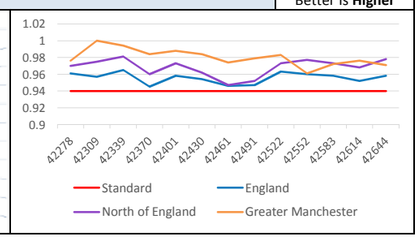
Stockport	100.0%
Central	100.0%
Trafford	99.1%
T&G	98.0%
North	97.8%
Wigan	97.2%
Oldham	97.1%
South	96.9%
Bolton	96.7%
HMR	96.3%
Bury	96.0%
Salford	94.4%



People Receiving Subsequent Cancer Treatments - Surgery Within 31 Days

Better Is **Higher**

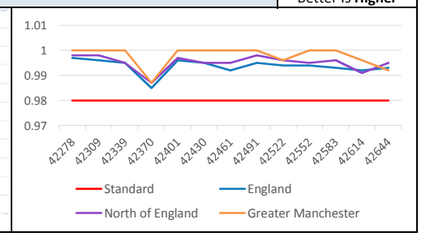
Trafford	100.0%
South	100.0%
Bolton	100.0%
Bury	100.0%
T&G	100.0%
Central	100.0%
Wigan	100.0%
North	100.0%
Oldham	100.0%
Stockport	96.2%
HMR	92.3%
Salford	86.7%



People Receiving Subsequent Cancer Treatments - Anti Cancer Drug Regimens Within 31 Days

Better Is **Higher**

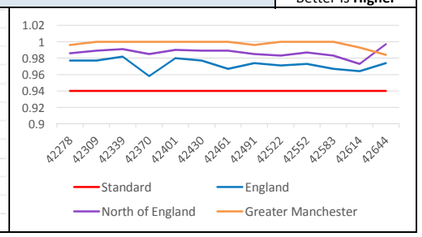
South	100.0%
Bolton	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
HMR	100.0%
Wigan	100.0%
North	100.0%
Oldham	100.0%
Trafford	94.1%



People Receiving Subsequent Cancer Treatments - Radiotherapy Within 31 Days

Better Is **Higher**

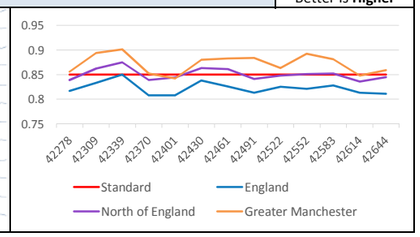
Stockport	100.0%
Bolton	100.0%
Trafford	100.0%
Bury	100.0%
South	100.0%
Central	100.0%
T&G	100.0%
HMR	100.0%
Wigan	100.0%
North	100.0%
Oldham	100.0%
Salford	95.7%



People With Urgent GP Referral Having 1st Definitive Treatment For Cancer Within 62 Days Of Referral

Better Is **Higher**

Salford	97.1%
Bolton	92.9%
T&G	91.3%
Central	90.9%
Trafford	87.0%
Bury	85.7%
HMR	85.7%
Stockport	84.1%
North	82.1%
Wigan	81.0%
Oldham	78.9%
South	77.4%

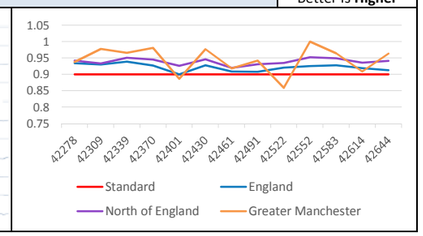


Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

62-Day Wait For Treatment Following A Referral From A Screening Service

Better Is **Higher**

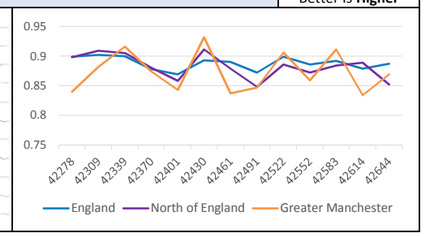
T&G	100.0%
South	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
North	100.0%
Wigan	100.0%
Bolton	100.0%
Oldham	100.0%
HMR	90.0%
Trafford	88.9%
Bury	85.7%



62-Day Wait For Treatment Following A Consultant Upgrade

Better Is **Higher**

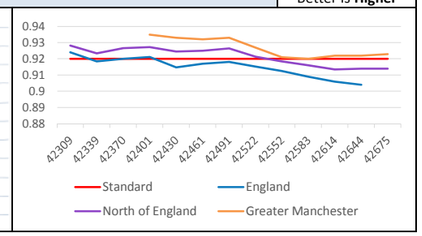
Bury	100.0%
Trafford	100.0%
North	100.0%
South	93.3%
Central	90.9%
Bolton	87.5%
Stockport	84.0%
Wigan	83.7%
T&G	78.3%
HMR	77.8%
Oldham	72.7%
Salford	72.2%



Patients Waiting 18 Weeks Or Less From Referral To Hospital Treatment

Better Is **Higher**

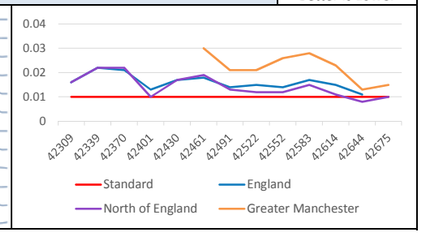
Wigan	95.1%
Oldham	93.7%
Bolton	93.3%
Salford	93.2%
HMR	93.1%
Bury	92.7%
T&G	92.6%
Stockport	92.4%
Central	92.1%
North	91.5%
Trafford	88.5%
South	87.8%



Diagnostics Test Waiting Times

Better Is **Lower**

Stockport	0.8%
Wigan	0.9%
Salford	1.2%
Bolton	1.3%
Bury	1.3%
HMR	1.3%
T&G	1.3%
Oldham	1.6%
Trafford	1.6%
South	1.7%
North	2.1%
Central	4.8%



Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

Primary Care Access (Placeholder)

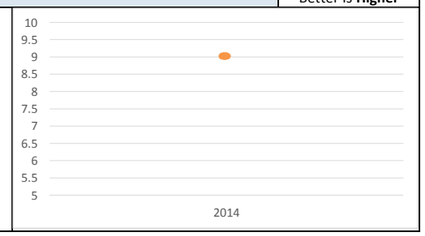
Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Cancer Patient Experience

Better Is **Higher**

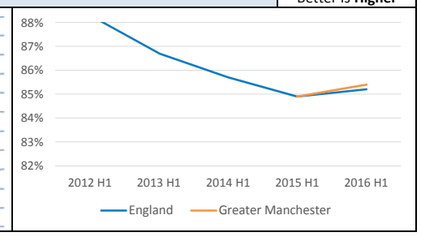
Salford	9.0
Bolton	8.8
HMR	8.8
Wigan	8.8
Stockport	8.7
South	8.7
T&G	8.7
North	8.7
Bury	8.7
Oldham	8.7
Central	8.6
Trafford	8.6



Patient Experience Of GP Services

Better Is **Higher**

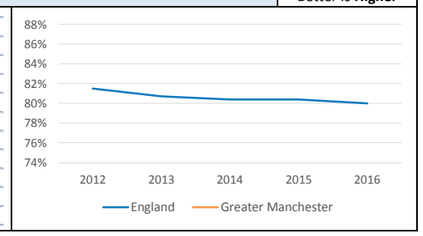
Stockport	88.9%
Wigan	88.2%
Bolton	87.2%
Bury	86.9%
Trafford	86.5%
Salford	85.3%
Oldham	84.7%
South	84.0%
T&G	83.2%
HMR	82.3%
Central	81.8%
North	81.5%



Quality Of Life Of Carers - Health Status Score (EQ5D)

Better Is **Higher**

Stockport	81.1%
South	79.9%
Trafford	79.0%
Salford	78.2%
Bury	77.8%
T&G	77.5%
Oldham	77.3%
Central	77.2%
Wigan	77.0%
Bolton	76.7%
HMR	76.5%
North	75.6%

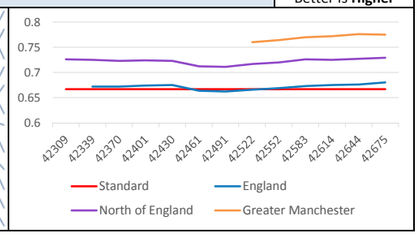


Improved Outcomes For People With Learning Disabilities/Mental Health Needs

Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

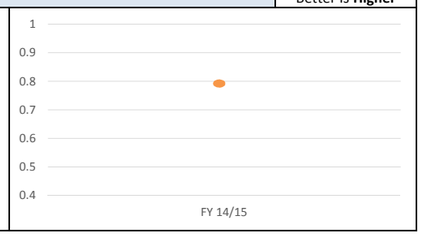
Wigan	97.6%
Bury	92.5%
North	92.3%
HMR	86.7%
Bolton	81.8%
Central	78.6%
Trafford	70.8%
Oldham	70.8%
Stockport	69.4%
T&G	67.8%
Salford	66.4%
South	63.6%



Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

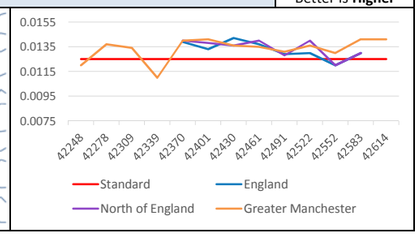
Central	83.2%
Stockport	82.9%
Bury	82.7%
Salford	81.4%
Bolton	80.1%
T&G	79.4%
Oldham	78.3%
Wigan	77.9%
Trafford	77.7%
South	77.2%
HMR	76.2%
North	75.7%



Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

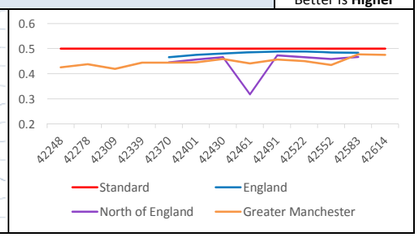
Oldham	2.0%
Salford	1.9%
Wigan	1.5%
HMR	1.5%
Bury	1.4%
North	1.4%
Stockport	1.4%
T&G	1.4%
Central	1.2%
Bolton	1.2%
South	1.1%
Trafford	1.0%



Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

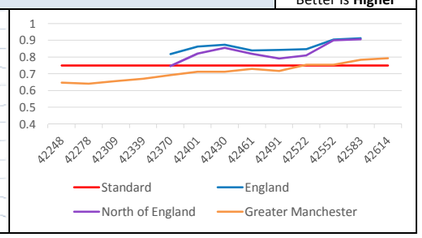
Wigan	54.3%
Trafford	53.8%
Stockport	52.0%
Bolton	51.8%
Bury	50.0%
T&G	50.0%
Salford	46.2%
HMR	43.6%
Oldham	43.1%
South	37.5%
North	36.7%
Central	33.3%



Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

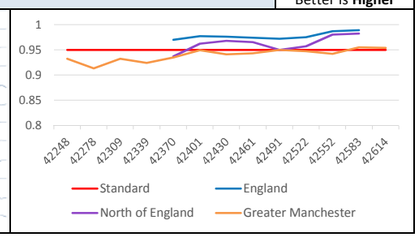
Wigan	100.0%
Oldham	89.7%
Trafford	83.3%
Bolton	83.1%
HMR	82.5%
Salford	80.6%
T&G	78.8%
Stockport	77.4%
Bury	76.8%
North	56.7%
Central	45.7%
South	45.5%



Improving Access to Psychological Therapies Seen Within 18 Weeks

Better Is **Higher**

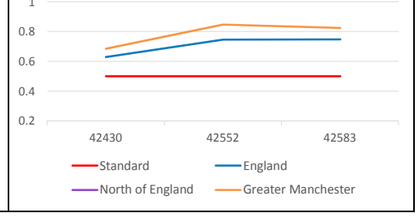
Wigan	100.0%
T&G	100.0%
HMR	100.0%
Oldham	100.0%
Bolton	98.3%
Trafford	97.6%
Salford	97.2%
Bury	96.4%
Stockport	92.5%
Central	88.6%
North	80.0%
South	72.7%



People with 1st Episode of Psychosis Starting Treatment With a NICE-Recommended Package of Care Treated Within 2 Weeks of Referral

Better Is **Higher**

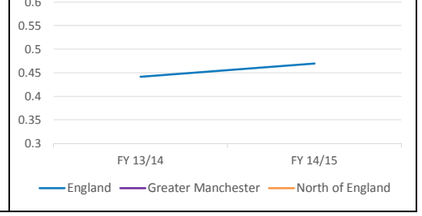
Bury	100.0%
North	96.7%
Bolton	94.2%
HMR	92.0%
Central	90.7%
South	88.2%
Salford	84.2%
Trafford	76.7%
Stockport	67.9%
T&G	66.7%
Wigan	62.5%
Oldham	58.1%



Proportion of People With a Learning Disability on the GP Register Receiving an Annual Health Check

Better Is **Lower**

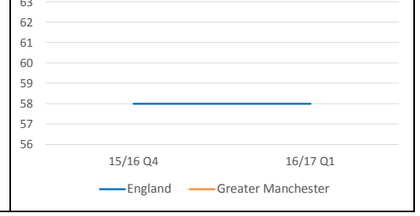
Stockport	30.0%
Central	33.0%
T&G	34.0%
Trafford	36.0%
South	37.0%
North	42.0%
Salford	48.0%
Oldham	53.0%
HMR	53.0%
Wigan	55.0%
Bolton	56.0%
Bury	59.0%



Reliance on Specialist Inpatient Care for People With a Learning Disability and/or Autism

Better Is **Lower**

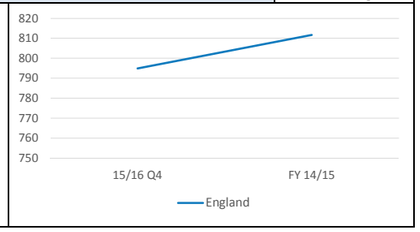
Bolton	62
Bury	62
Central	62
HMR	62
North	62
Oldham	62
Salford	62
South	62
Stockport	62
T&G	62
Trafford	62
Wigan	62



Management Of Long Term Conditions

Better Is **Higher**

North	1,563
Central	1,536
South	1,467
T&G	1,279
Salford	1,210
HMR	1,151
Stockport	1,100
Oldham	1,027
Trafford	955
Wigan	919
Bolton	880
Bury	859



Out Of Area Placements For Acute Mental Inpatient Care - Transformation

Better Is **Higher**

T&G	100.0%
Bolton	100.0%
Stockport	87.5%
Trafford	50.0%
South	50.0%
North	50.0%
Wigan	50.0%
Central	50.0%
Bury	25.0%
Salford	25.0%
Oldham	25.0%
HMR	12.5%

Children And Young People's Mental Health Services Transformation

Better Is **Higher**

Oldham	90.0%
Trafford	85.0%
Wigan	85.0%
Bury	85.0%
HMR	85.0%
Bolton	85.0%
Salford	70.0%
Central	70.0%
South	70.0%
North	70.0%
Stockport	DQ Issue
Tamside	DQ Issue

Crisis Care And Liasion Mental Health Services Transformation

Better Is **Higher**

Salford	95.0%
Bolton	87.5%
Trafford	82.5%
T&G	80.0%
Oldham	72.5%
HMR	70.0%
Bury	67.5%
North	67.5%
Central	67.5%
South	67.5%
Wigan	60.0%
Stockport	45.0%

Decreased Need For Hospital Services With More Community Support

Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

Bury	0.9
Wigan	0.9
HMR	0.9
Oldham	1.0
Bolton	1.0
North	1.1
Salford	1.2
T&G	1.3
Stockport	1.3
South	1.4
Trafford	1.4
Central	1.5

Emergency Admissions For Urgent Care Sensitive Conditions

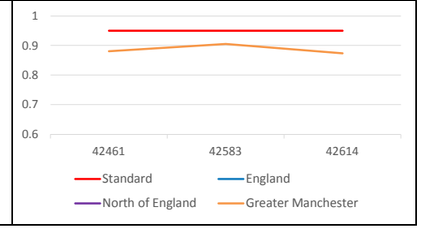
Better Is **Lower**

Bury	2,229
Trafford	2,336
Bolton	2,523
Wigan	2,671
Oldham	2,753
HMR	2,814
Stockport	3,022
South	3,234
T&G	3,269
North	3,271
Central	3,271
Salford	3,503

Percentage Of Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours

Better Is **Higher**

Central	93.9%
Wigan	92.0%
South	91.0%
T&G	90.5%
Salford	90.1%
Bury	87.1%
Bolton	86.1%
Stockport	77.0%
HMR	
Trafford	
North	
Oldham	

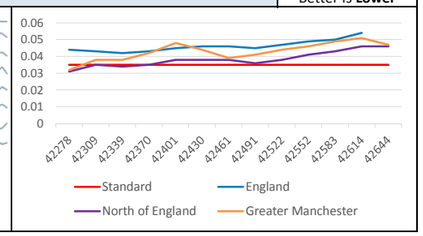


Improved Transition Of Care Across Health And Social Care

Delayed Transfers of Care - Bed Days

Better Is **Lower**

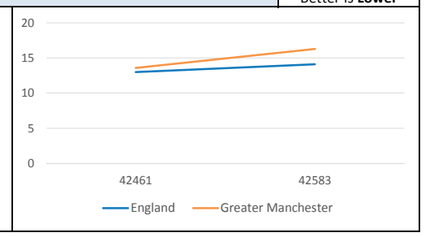
WWL NHS	0.0%
Pennine Ac	1.5%
Salford Roy	2.5%
CM NHS FT	3.1%
Bolton NHS	7.4%
Stockport N	9.5%
Tameside N	11.5%
UHSM NHS	11.7%



Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

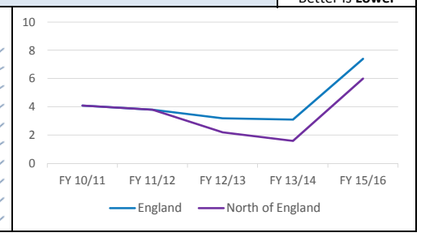
Oldham	3.4
Wigan	5.3
Salford	5.7
Bury	8.1
HMR	9.2
Bolton	15.5
South	19.0
North	19.4
T&G	21.2
Central	22.0
Stockport	30.6
Trafford	36.9



Delayed Transfers Of Care From Hospital, And Those Which Are Attributable To Adult Social Care Per 100,000 Population

Better Is **Lower**

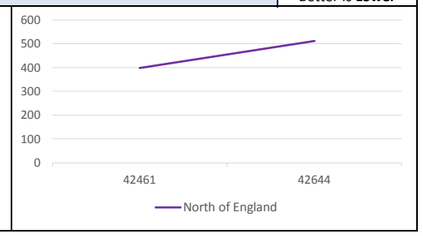
Oldham	2.3
Stockport	3.6
Salford	4.2
Bolton	4.4
HMR	4.6
Wigan	4.9
Bury	5.5
T&G	6.4
South	7.5
Central	7.5
North	7.5
Trafford	14.5



No Of Bed Days - Delayed Transfers Of Care Aged 18+ Per 100,000 Population

Better Is **Lower**

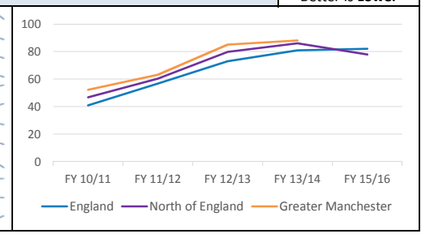
HMR	99.0
Salford	175.0
Wigan	178.0
Oldham	214.0
Bury	297.0
South	473.0
North	473.0
Central	473.0
Bolton	496.0
Stockport	963.0
Trafford	989.0
T&G	1065.0



Proportion Of People Using Social Care Who Receive Self-Directed Support, And Those Receiving Direct Payments

Better Is **Lower**

Trafford	49.1
North	65.2
South	65.2
Central	65.2
Salford	77.7
Wigan	85.3
Bury	85.9
Stockport	89.6
Oldham	96.0
T&G	96.2
Bolton	97.2
HMR	99.0



Long-Term Support Needs Met By Admission To Residential And Nursing Care Homes, Per 100,000 Population

Better Is **Lower**

Central	70.8
North	70.8
South	70.8
T&G	123.8
Trafford	128.7
HMR	170.6
Oldham	177.7
Bury	180.8
Wigan	190.8
Stockport	193.0
Salford	196.9
Bolton	225.1

Percentage Of People Aged 65+ Discharged Direct To Residential Care

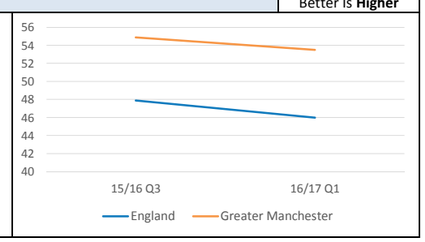
Better Is **Lower**

T&G	1.1
HMR	1.6
Bury	1.6
Trafford	1.8
Bolton	1.9
North	2.1
Central	2.1
South	2.1
Wigan	2.4
Oldham	2.9
Stockport	2.9
Salford	3.6

People Eligible For Standard NHS Continuing Healthcare

Better Is **Higher**

Salford	119.8
Wigan	80.7
South	78.3
T&G	63.9
Bolton	61.8
Trafford	55.5
North	31.7
Central	30.1
HMR	29.1
Stockport	27.7
Bury	26.3
Oldham	21.6

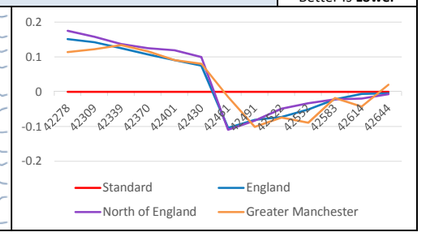


Placeholder TBC

C.Difficile (Ytd Var To Plan)

Better Is **Lower**

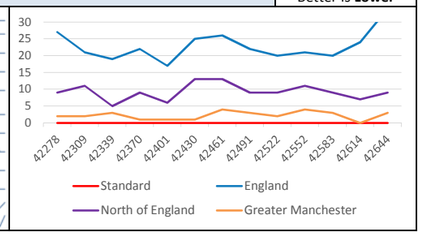
Trafford	-24.3%
Salford	-19.5%
T&G	-16.4%
Oldham	-16.1%
South	-7.4%
Bolton	-4.3%
North	8.7%
HMR	17.2%
Wigan	18.4%
Bury	20.8%
Central	39.1%
Stockport	43.2%



MRSA

Better Is **Lower**

Oldham	0
Bury	0
Wigan	0
South	0
HMR	0
Stockport	0
Central	0
T&G	0
North	0
Trafford	0
Salford	1
Bolton	2



Achievement Of Milestones In The Delivery Of An Integrated Urgent Care Service

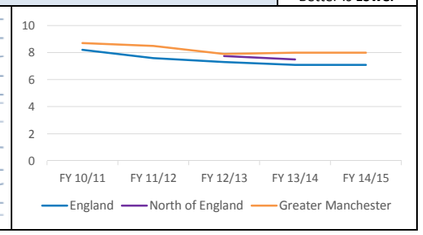
Better Is **Higher**

Bolton	4
Bury	4
Central	4
HMR	4
North	4
Oldham	4
Salford	4
South	4
Stockport	4
T&G	4
Trafford	4
Wigan	4

Neonatal Mortality And Stillbirths

Better Is **Lower**

Trafford	6.3
Stockport	6.8
Wigan	7.1
South	7.1
HMR	7.3
Salford	7.7
T&G	7.8
Bolton	8.5
Bury	8.5
Central	9.3
Oldham	9.4
North	10.3



Primary Care Workforce

Better Is **Higher**

Salford	1.1
T&G	1.0
Bolton	1.0
HMR	0.9
Stockport	0.9
Wigan	0.9
Bury	0.9
Oldham	0.9
South	0.8
Trafford	0.8
Central	0.8
North	0.8

Achievement Of Clinical Standards In The Delivery Of 7 Day Services (Placeholder)

Better Is **Higher**

Bolton	
Bury	
Central	
HMR	
North	
Oldham	
Salford	
South	
Stockport	
T&G	
Trafford	
Wigan	

Primary Care Workforce - GPs And Practice Nurses Per 1,000 Population

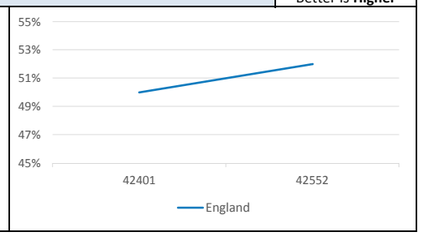
Better Is **Higher**

Salford	100.0%
T&G	90.0%
Stockport	90.0%
HMR	90.0%
Wigan	90.0%
Bolton	90.0%
Oldham	90.0%
Trafford	80.0%
South	80.0%
Bury	80.0%
North	80.0%
Central	80.0%

People Offered Choice Of Provider And Team When Referred For A 1st Elective Appointment

Better Is **Higher**

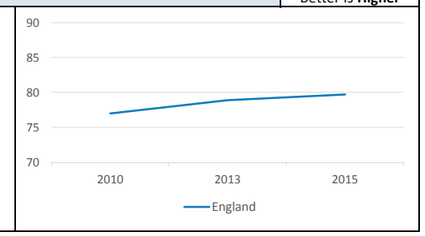
Bolton	103.9%
Oldham	98.1%
Salford	88.2%
Bury	78.3%
South	71.6%
North	70.0%
Trafford	62.2%
HMR	61.7%
Stockport	57.6%
Wigan	55.2%
Central	45.2%
T&G	11.1%



Women's Experience Of Maternity Services

Better Is **Higher**

Salford	83.5
Trafford	83.1
Stockport	82.5
North	82.3
Bury	82.2
Bolton	82.1
South	81.9
Wigan	80.5
HMR	77.6
T&G	77.6
Oldham	76.9
Central	74.3



Choices In Maternity Services

Better Is **Higher**

Salford	69.8%
Bury	69.7%
North	68.7%
HMR	68.7%
South	67.8%
Oldham	65.3%
Stockport	65.0%
Wigan	64.6%
Trafford	64.5%
Bolton	64.3%
Central	63.0%
T&G	61.4%

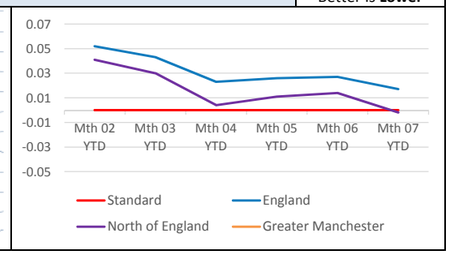
Sustainability

Reduced Demand for Reactive Health and Social Care Services and a Shift in Spend to Proactive Provision

Activity V Plan: Total Referrals (Specific Acute)

Better Is **Lower**

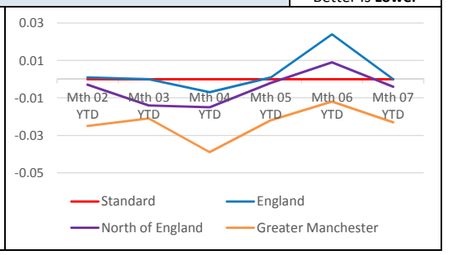
T&G	-5.7%
North	-5.2%
Salford	-4.8%
Trafford	-4.5%
Central	-2.9%
Stockport	-2.6%
Bury	-1.7%
South	-0.3%
HMR	1.5%
Oldham	4.6%
Wigan	5.0%
Bolton	12.1%



Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

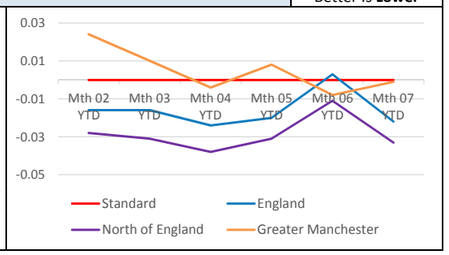
T&G	-9.5%
Oldham	-6.2%
Trafford	-6.0%
South	-4.8%
Central	-4.0%
Stockport	-3.8%
Bury	-1.5%
Bolton	0.2%
North	0.6%
HMR	0.9%
Salford	1.1%
Wigan	6.0%



Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

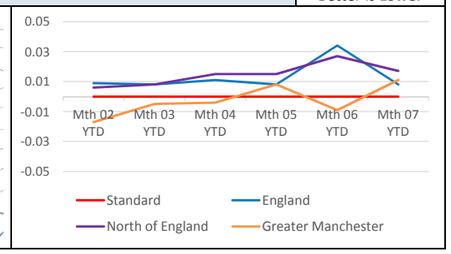
T&G	-12.7%
Oldham	-6.7%
HMR	-3.3%
North	-2.6%
South	-0.1%
Bury	0.4%
Trafford	1.8%
Bolton	3.2%
Salford	3.8%
Wigan	3.8%
Stockport	3.9%
Central	10.1%



Activity V Plan: Non-Elective Spells Complete (Specific Acute)

Better Is **Lower**

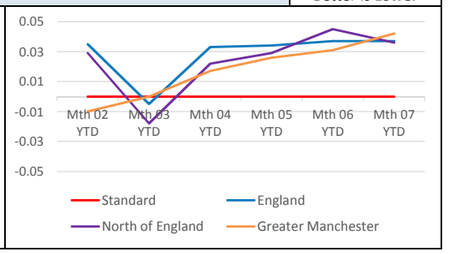
North	-4.0%
T&G	-3.7%
Stockport	-3.3%
Trafford	-1.4%
Oldham	-0.3%
Central	0.1%
Bolton	1.5%
Bury	3.4%
HMR	4.1%
Salford	6.0%
South	6.1%
Wigan	7.4%



Activity V Plan: Attendances At A&E (All Types)

Better Is **Lower**

Wigan	-0.7%
T&G	1.8%
North	2.0%
Oldham	2.2%
Stockport	2.2%
HMR	2.9%
South	3.1%
Bury	3.6%
Salford	4.7%
Trafford	5.6%
Central	8.6%
Bolton	17.8%



Digital Interactions Between Primary And Secondary Care

Better Is **Higher**

Bolton	80.0%
Oldham	72.8%
Bury	70.7%
Salford	69.4%
South	67.6%
HMR	65.3%
North	64.9%
Stockport	63.3%
Trafford	63.1%
Wigan	61.6%
Central	55.0%
T&G	52.6%

Financial Plan 16/17

In-Year Financial Performance 16/17 Q1

-

Better Is **Green**

Bolton	#REF!	#REF!	◀▶
Bury	#REF!	#REF!	◀▶
Central	#REF!	#REF!	◀▶
HMR	#REF!	#REF!	◀▶
North	#REF!	#REF!	◀▶
Oldham	#REF!	#REF!	◀▶
Salford	#REF!	#REF!	◀▶
South	#REF!	#REF!	◀▶
Stockport	#REF!	#REF!	◀▶
T&G	#REF!	#REF!	▼
Trafford	#REF!	#REF!	◀▶
Wigan	#REF!	#REF!	◀▶

Local Strategic Estates Plan (SEP) In Place

- -

Better Is **Yes**

Bolton	#REF!
Bury	#REF!
Central	#REF!
HMR	#REF!
North	#REF!
Oldham	#REF!
Salford	#REF!
South	#REF!
Stockport	#REF!
T&G	#REF!
Trafford	#REF!
Wigan	#REF!

Adoption Of New Models Of Care (Placeholder)

Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Local Digital Roadmap In Place (Placeholder)

Better Is **Higher**

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Expenditure In Areas With Identified Score For Improvement (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Outcomes In Areas With Identified Scope For Improvement (Placeholder)

Better Is **Higher**

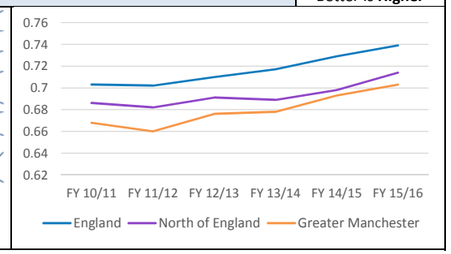
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

More People Will Be In Employment, With An Increasing Proportion In 'Good Work' And Able To Stay In Work For Longer

Employment Rate, Resident Population Aged 16-64

Better Is **Higher**

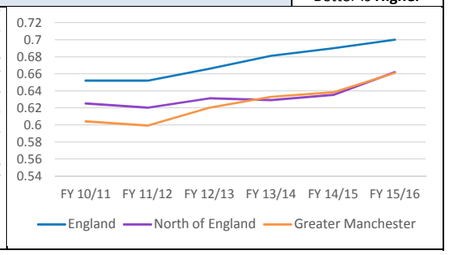
Trafford	79.0%
Stockport	77.9%
Wigan	76.9%
Tameside	71.2%
Bury	70.6%
Bolton	70.0%
Salford	69.2%
Oldham	67.0%
Rochdale	63.0%



Employment Rate, Resident Population Aged 50-64

Better Is **Higher**

Stockport	73.8%
Wigan	71.6%
Trafford	68.8%
Oldham	67.7%
Bolton	66.1%
Tameside	65.5%
Salford	64.0%
Bury	61.3%
Rochdale	61.0%



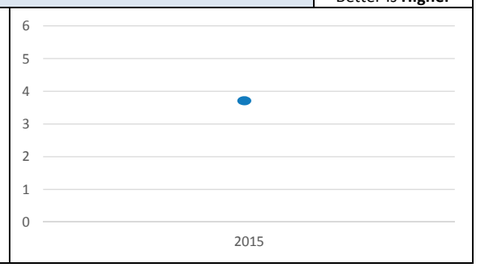
Well Led

Placeholder TBC

Staff Engagement Index

Better Is **Higher**

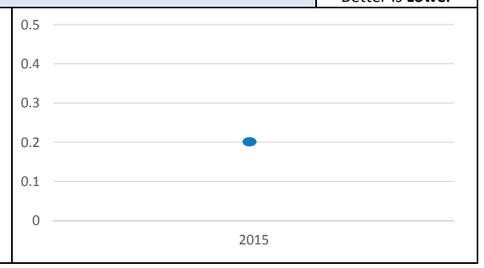
Wigan	4.0
T&G	3.9
Central	3.9
Bolton	3.9
Stockport	3.8
North	3.8
Trafford	3.8
Salford	3.8
South	3.8
Bury	3.7
HMR	3.7
Oldham	3.7



Progress Against Workforce Race Equality Standard

Better Is **Lower**

Central	0.0
Trafford	0.1
South	0.1
Oldham	0.2
Salford	0.2
HMR	0.2
North	0.2
Bury	0.3
T&G	0.3
Stockport	0.3
Bolton	0.5
Wigan	0.6



Effectiveness Of Working Relationships In The Local System

Better Is **Higher**

Bolton	74.4
Oldham	74.3
Salford	74.2
HMR	71.5
Central	71.0
Trafford	69.9
Wigan	69.8
South	69.8
Stockport	68.8
Bury	67.1
T&G	66.9
North	66.0

Quality Of CCG Leadership

\- | -

Better Is **Green Star**

Salford	Green Star
Bolton	Green
Bury	Green
Central	Green
HMR	Green
North	Green
Oldham	Green
South	Green
Stockport	Green
T&G	Green
Trafford	Green
Wigan	Green

Sustainability And Transformation Plan (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Probity And Corporate Goverance (Placeholder)

Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

Select a CCG

3	North		Select a region
2	2. STP		Select STP or DCO
4	3.	#VALUE!	Select an STP or DCO
	4.		Select a CCG
	5.		Select an indicator

NHS Tameside and Glossop CCG

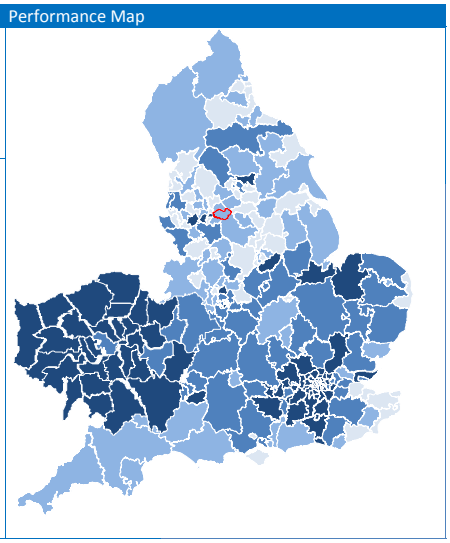
The 10 closest CCGs to NHS Tameside and Glossop CCG

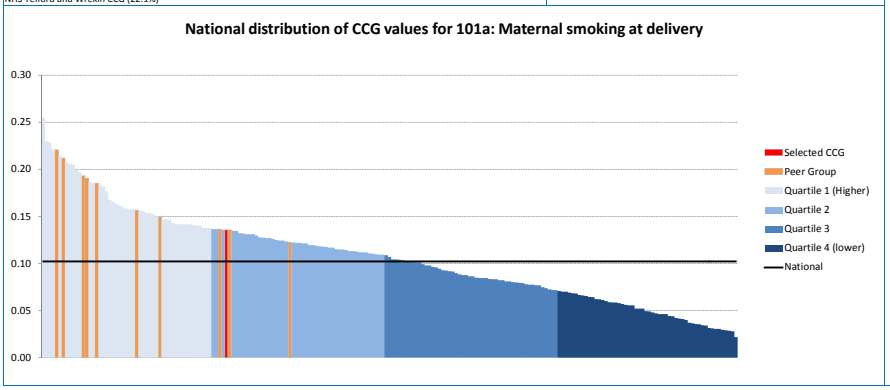
NHS Rotherham CCG (19.1%)
NHS Stoke on Trent CCG (18.5%)
NHS Bury CCG (12.3%)
NHS Wakefield CCG (19.3%)
NHS Hartlepool and Stockton-on-Tees CCG (13.6%)
NHS Barnsley CCG (15.7%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (15.0%)
NHS South Tees CCG (21.2%)
NHS Telford and Wrekin CCG (22.1%)

What you need to know...

- CCG and national values for each IAF indicator are presented in the table.
- Sparklines show the scores for each indicator over time.
- The spine chart shows how the CCG value compares other CCGs. A key is displayed over the chart to help with interpretation.

Performance Map





Please Note: If indicator is highlighted in GREY, this indicator will be available at a later date

If indicator is highlighted in BLUE, this value is in the lowest performance quartile nationally.

KEY
H = Higher
L = Lower
<> = N/A

	Improvement and Assessment Indicators	Latest Period	CCG	England	Trend	Better is...	Range
	Better Health						
▼	Maternal smoking at delivery	Q1 16/17	13.6%	10.2%		L	
◀▶	Percentage of children aged 10-11 classified as overweight or obese	2014-15	34.1%	33.2%		L	
▼	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA	2014-15	46.8%	39.8%		H	
◀▶	People with diabetes diagnosed less than a year who attend a structured education course	2014-15	0.0%	5.7%		H	
◀▶	Injuries from falls in people aged 65 and over	Mar-16	2,116	2,014		L	
▼	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	Jul-16	11.1%	52.0%		H	
◀▶	Personal health budgets	Q1 16/17	3.7	11.3		H	
▼	Percentage of deaths which take place in hospital	Q4 15/16	50.7%	47.0%		<>	
▼	People with a long-term condition feeling supported to manage their condition(s)	2016	61.4%	64.3%		H	
▲	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q4 15/16	1,475	929		L	
▲	Inequality in emergency admissions for urgent care sensitive conditions	Q4 15/16	3,144	2,168		L	
▲	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Jul-16	1.1	1.1		<>	
▼	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Jul-16	8.0%	9.3%		<>	
▲	Quality of life of carers	2016	77.5%	80.0%		H	
	Better Care						
◀▶	Cancers diagnosed at early stage	2014	44.2%	50.7%		H	
▼	People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	Q1 16/17	90.1%	82.2%		H	
▲	One-year survival from all cancers	2013	67.6%	70.2%		H	
◀▶	Cancer patient experience	2015	8.7			H	
▲	Improving Access to Psychological Therapies recovery rate	Jun-16	45.8%	48.9%		H	
▲	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	Jul-16	65.4%	72.0%		H	
▼	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q1 16/17	62			L	
◀▶	Proportion of people with a learning disability on the GP register receiving an annual health check	2014-15	34.0%	47.0%		H	
◀▶	Neonatal mortality and stillbirths	2014-15	7.8	7.1		L	
◀▶	Women's experience of maternity services	2015	77.6			H	
◀▶	Choices in maternity services	2015	61.4%			H	
▲	Estimated diagnosis rate for people with dementia	Aug-16	71.3%	67.3%		H	
◀▶	Dementia care planning and post-diagnostic support	2014/15	79.4%	77.0%		H	
◀▶	Achievement of milestones in the delivery of an integrated urgent care service	August 2016	4			H	
▼	Emergency admissions for urgent care sensitive conditions	Q4 15/16	3,269	2,359		L	
▲	Percentage of patients admitted, transferred or discharged from A&E within 4 hours	Aug-16	90.3%	91.0%		H	
▼	Delayed transfers of care per 100,000 population	Aug-16	21.2	14.1		L	
▼	Population use of hospital beds following emergency admission	Q4 15/16	1.3	1.0		L	
▼	Management of long term conditions	Q4 15/16	1,276	795		L	
▲	Patient experience of GP services	H1 2016	83.2%	85.2%		H	
◀▶	Primary care workforce	H1 2016	1.0	1.0		H	
▼	Patients waiting 18 weeks or less from referral to hospital treatment	Aug-16	92.1%	91.0%		H	
▲	People eligible for standard NHS Continuing Healthcare	Q1 16/17	63.9	46.0		H	
	Sustainability						
◀▶	Financial plan	2016	Amber			H	
◀▶	In-year financial performance	Q1 16/17	Red			H	
◀▶	Outcomes in areas with identified scope for improvement	Q1 16/17	CCG not incl	58.3%		H	
▲	Digital interactions between primary and secondary care	Q2 16/17	52.6%			H	
◀▶	Local strategic estates plan (SEP) in place	2016-17	Yes			H	
	Well Led						
◀▶	Staff engagement index	2015	3.9	3.8		H	
◀▶	Progress against workforce race equality standard	2015	0.3	0.2		L	
◀▶	Effectiveness of working relationships in the local system	2015-16	66.9			H	
◀▶	Quality of CCG leadership	Q1 16/17	Green			H	

Population Health

Appendix 1

	Domain	Level 1 Outcome	Level 2 Outcome	Outcome Indicators	Indicator Source	Lead for indicators	Frquency
1.1	**Start Well**	Our children get the best possible start in life	Babies are given the best start	Low birth weight babies	**PHBF**	Jacqui D	Quarterly (2 Qs behind)
				Maternal smoking at delivery	**NHS Digital**	Martin K/Ricky	Quarterly
				Neonatal and stillbirths per 1000 population	**PCMD**	Jacqui D	Quarterly
				Breastfeeding rates	**HV submission**	Jacqui D	Quarterly
				Number of babies born to obese mothers	**NHS Digital**	Jacqui D	Monthly
				Post natal depression rates	**Local Maternity**		Quarterly
				Perenatal depression rates	**Local Health Visiting team**	Geoff Luker?	Quarterly
			Children are well prepared for primary eduction	ASQ Development milestones (development at 2 & half yrs)	**Local Health Visiting team**	Geoff Luker?	Quarterly
				School readiness	**TMBC**	Dean McDonagh	Annual
			Young people are well prepared for employment	GCSE's achieved grade A*-C	**TMBC**	Dean McDonagh	Annual
				Rate of people leaving education with no qualifications			
				Youth unemployment rates			
		Our children and young people experience good health and wellbeing	Children and young people experience good physical health	Immunisation rates data	**PHOF**	Jacqui D	annually
				Physical activity rates amongst young people	**What About YOUth? survey**	Jacqui D	annually
				Pupil Absence	**PHOF**	Jacqui D	annually
				Tooth decay in children aged 5 (change to) Hospital admissions for dental caries (1-4 years)	**ChiMat**	Jacqui D	annually
				Excess weight in 4-5 and 10-11 year olds	**NCMP**	Jacqui D	annually
				Rate of 'underweight' children	**NCMP**	Jacqui D	annually
				Admissions related to alcohol in U18s	**ChiMat/SUS**	Jacqui D	annually/quarterly
				Hospital admissions caused by unintentional and deliberate injuries aged 0-14	**ChiMat/SUS**	Jacqui D	annually/quarterly
				Smoking rates at age 15	**What About YOUth? survey**	Jacqui D	annually
				Data relating to 'Healthy' Schools Programme	**?**		
			Children and young people experience positive mental wellbeing	Admissions related to self harm	**ChiMat/SUS**	Jacqui D	annually/quarterly
				Average wait to access CAMHS	**?**		
				Number of children and young people requiring inpatient mental health services	**SUS**	Jacqui D	annually
1.2	**Live Well**	Adults experience good quality of life	People live health lives for longer	Healthy life expectancy	**PHOF**	Jacqui D	annually
				U75 mortality rate for cancer	**PHOF/PCMD**	Jacqui D	annually/quarterly
				U75 mortality rate for resiratory conditions	**PHOF/PCMD**	Jacqui D	annually/quarterly
				U75 mortality for cardiovascular disease	**PHOF/PCMD**	Jacqui D	annually/quarterly
				U75 mortality for liver disease	**PHOF/PCMD**	Jacqui D	annually/quarterly
			People experience positive mental wellbeing	Measure from annual wellbeing survey (Self-reported wellbeing - people with a low satisfaction score)	**PHOF**	Jacqui D	Annually
				Measure relating to access to IAPT (finished a course of treatment within 6 weeks of referral and 18weeks)	**NHS Digital**	MartinK	Monthly/Quarterly
				Measure related to inpatient mental health (Emergency HAs for mental health conditions)	**SUS**	Jacqui D	Annually
			People feel part of a strong community	Measure of investment in asset based community approaches	**?**		
				Placeholder for survey measure relating to feeling part of a community (Whether people chat to their neighbours at le	**Community Life Survey**	Jacqui D	Annually
			People don't experience poverty	Percentage of households where income is less than 60 per cent of median household income before housing costs)(only available as children living in plus it is 2011)	https://www.gov.uk/governm	Jacqui D	Annually
			People take part in meaningful activity, including work	Employment rate of people with health condition or illness lasting 12 months or more (16-64) OR Those who are somewhat, mostly or completely satisfied with their job , ONS (struggling with up to date stats)			
				Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services	**PHOF**	Jacqui D	Annually
				Average Earnings difference (TamesidevEng/North West)	**ONS/NOMIS**	Jacqui D	Annually
				Percentage of people out of work	**ONS/NOMIS**	Jacqui D	Annually
			People live in good quality housing	Proportion of T&G residents living in a "Decent Home" OR Satisfaction with Accommodation (ONS)			
				Adults with a learning disability / in contact with secondary mental health services who live in stable and appropriate accommodation	**SCOF**	Andrea Staniforth	Quarterly
				Statutory homelessness - households in temporary accommodation	**PHOF**	Jacqui D	Annually
		People adopt healthy lifestyle behaviours	People are physically active	Proportion of adults achieving at least 150 minutes physical activity per week	**PHOF**	Jacqui D	Annually
			People maintain a healthy weight	Excess weight in adults	**PHOF**	Jacqui D	Annually
			People don't smoke	Prevalence of smoking amongst 15 year olds and over 18 year olds	**PHOF**	Jacqui D	Annually
			People don't use alcohol excessively	Number of admissions involving an alcohol related primary diagnosis or alcohol related external cause per 100,000 population	**PHOF**	Jacqui D	Annually
1.3	**Age Well**	Older people feel as independent as possible for as long as possible	Older people are supported to prevent falls	Number of falls amongst over 65s and over 80s	**PHOF**	Jacqui D	Annually
			People are supported to remain at home for as long as possible	Proportion of older people still at home 91 days after discharge	**SCOF**	Andrea Staniforth	Quarterly
				Emergency Admissions for Ambulatory Care Conditions per 100,000 population	**SUS**	Martin	Quarterly
				Delayed transfer of care attributable to health or social care per 100,000 population	**SUS**	Martin	Quarterly
				Permanent admissions of older people (aged 65 and over) to residential and nursing homes per 1000 population	**SCOF**	Andrea Staniforth	Quarterly
			Carers are supported, valued and involved	Carer related quality of life	**SCOF**	Andrea Staniforth	Annually
		Older people experience good quality of life	Older people live as long as possible in as good health as possible	Life expectancy at birth	**PHOF**	Jacqui D	Annually
				Life expectancy at 75 years	**PCMD**	Jacqui D	Annually
				Fraction of mortality attributable to particulate air pollution	**PHOF**	Jacqui D	Annually
				People with suspected cancer referred to by their GP within two weeks	**Open Exeter**	Ricky Hind	Monthly
				People receiving first definitive treatment within 31 days of diagnosis	**Open Exeter**	Ricky Hind	Monthly
				One year all cancer survival rate	**Cancerstats**	Jacqui D	Annually
				SHMI Measure	**NHS Digital**	Jacqui D	Annually
				Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population	**PCMD**	Jacqui D	Annually
				Directly age-standardised rate of mortality from causes considered preventable per 100,000 population	**PHOF**	Jacqui D	Annually
				Potential years of life lost (PYLL) from causes amenable to healthcare) i) adults ii) children	**NHS Digital**	Jacqui D	Annually
			Older people experience positive mental wellbeing	Placeholder to identify metrics			
			Older people feel safe and part of their community	Placeholder to identify metrics	**Tameside Insight**		
1.4	**Health Inequalities are Reducing**	People don't experience inequality related to health	People don't experience inequality of life expectancy	Slope index of inequality of life expectancy at birth within T&G	**PHOF**	Jacqui D	Annually
				potential years of life lost from causes considered amenable to healthcare	**NHS Digital**	Jacqui D	Annually
				Gap in life expectancy between the best and worst ward	**PCMD**	Jacqui D	Annually
			There is parity of esteem between physical and mental health	Excess mortality rate in adults with serious mental illness aged under 75 per 100,000 population	**NHS Digital**	Jacqui D	Annually
				IAPT access rate	**NHS Digital**	Martin	Quarterly
				IAPT recovery rate	**NHS Digital**	Martin	Quarterly
				IAPT seen within 6 weeks	**NHS Digital**	Martin	Quarterly
				IAPT seen with 18 weeks	**NHS Digital**	Martin	Quarterly
				Prevalence of Depression	**QOF**	Jacqui D	Annually
			People with a learning disability are supported effectively in their community	Excess under 60 mortality rate amongst people with a learning disability	**NHS Outcomes Framework**	Jacqui D	Annually
				Take up of annual health check in primary care for people with a learning disability	**PHE**	Jacqui D	Annually
				People with a learning disability and/or autism receiving specialist inpatient care per 100,000 population	**Needs confirming may not be available at CCG or LA level**		

Empowering People and Communities

	Domain	Level 1 Outcome	Level 2 Outcome	Outcome Indicators	Indicator Source
2.1	Self-Care and Supported Self Management	The public understand how to 'self-care'		Placeholder for number of people accessing A&E inappropriately	
				Antibiotic prescription rates	
				Placeholder for measure of population health literacy	
		People with long term conditions are supported to develop the knowledge, skills and confidence to manage their health and health conditions effectively		Mean increase in patient activation score amongst identified cohorts of people with long term conditions	
				% of people with diabetese accessing structured education programme post diagnosis	
				Placeholder: Consider rollout of Clinician Support for Patient Activation Measure	
2.2	Choice and Control	Care is well planned and takes account of individual goals and preferences		% of people with LTC with a person centred care and support plan	
				Placeholder for a measure of shared decision making in planned care	
		People experience choice and control over the care they receive		Proportion of people dying at home/place of their choosing	
				Number of people being offered personal budgets	
				% population with online access to records	
				People offered choice of provider when referred for first elective appointment	
				Choice of maternity services	
2.3	Asset Based Approaches	Individuals, families and communities are resillient and able to support one another		Year on year increase in joint place-based investment for asset-based community development (ABCD)	
				Brief Resilience Scale (BRS)	
				Social isolation measure (PHOF)	
				% of people scoring seven or more when asked whether satisfied with family life	
				% change in statutory investment in VCS to support health and wellbeing outcomes	
2.4	Patient and Public Voice	The voice of the public are at the heart of everything we do		Placeholder for measure of patient and public engagement	

System Performance and Sustainability

	Domain	Level 1 Outcome	Level 2 Outcome	Outcome Indicators
3.1	Financial Sustainability	The health and care system is in recurrent financial balance		Aggregate health economy financial position
		Activity across the system is reducing or stabilising	DN: NEED TO INSERT ACTIVITY ASSUMPTIONS FROM CBA WHEN AGREED	
		Waste in the system is reducing		Placeholder for measure of medication waste
3.2	High Quality Care	Care is effective		CQC inspection rating [new inspection regime for new models of care] OR % practices rated excellent
				Indirectly standardised percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission
				National PROMs: Total health gain as assessed by patients for elective procedures (hip replacement, knee replacement, groin hernia surgeries and varicose vein removal surgeries)
				Potential years of life lost (PYLL) from causes amenable to healthcare) i) adults ii) children
				National and local standards are adehered to [DN need to break down]
		Care is safe		Deaths attributable to problems in healthcare
				Number of never events / 1000 population
				Severe harm attributable to problems in healthcare
				Incidence of healthcare acquired infections
				Proportion of people who use services who say that those services have made them feel safe and secure
				Admissions to hospital as a result of medication error: Number of medicine related emergency admissions to hospital
3.3	Workforce stability	Placeholder: Meeting planned in NY with Kate Quinn to develop stronger workforce section		

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Officer of Single Commissioning Board:	Clare Watson, Director of Commissioning, Single Commissioning
Subject:	**NEW CONTRACTUAL AND PARTNERSHIP RELATIONSHIP BETWEEN TAMESIDE AND GLOSSOP'S CARE TOGETHER SYSTEM AND PENNINE CARE IN RELATION TO THE DELIVERY OF MENTAL HEALTH SUPPORT**
Report Summary:	This report sets out the current position in relation to commissioning of mental health services in Tameside and Glossop. The proposal, in line with a number of other Greater Manchester Clinical Commissioning Groups (CCGs) is that the Single Commissioning Function (SCF) move from its current Multi-Lateral Mental Health Contract with Pennine Care NHS Foundation Trust to a Bi-Lateral with the current provider Pennine Care NHS Foundation Trust with effect 1 April 2017. The report explains the position currently faced in securing a long term Mental Health partner for the Care Together system, working with the ICFT. It proposes a way forward over the next two years that allows the continuation of mental health services in the area whilst a review and redesign an all age mental health service is undertaken to deliver savings, and work towards integrating mental health within the ICFT.
Recommendations:	That Single Commissioning Board: 1. Approve the approach set out in the report with Pennine Care NHS Foundation Trust resulting in a bi-lateral contract for the delivery of mental health services for a two year period from 1 April 2017. 2. Approve the review and redesign of mental health services within the Care Together Programme as part of journey towards integration within the ICFT.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The CCG funding for this contract is within the Section 75 agreement of the Integrated Commissioning Fund (ICF). It should be noted that the Single Commissioning Board will make decisions on the Section 75 funding which are binding upon the CCG and the Council. The finance group support the progress of negotiations with Pennine Care to establish a bilateral contract for a period of 2 years. However, it is recommended that a collaborative approach is taken across the economy in respect of the provision of mental health services and the ICFT are involved in the negotiations to facilitate the development of the longer-term Care Together vision with the ICFT being the prime provider of services for the T&G economy. It is also important that those individuals charged with making decisions fully understand the requirements of Parity of Esteem for mental health services and the impact this proposal may have upon meeting this requirement. For contextual purposes, it is important to note that the Integrated Commissioning Fund also includes funding relating to mental health services within the Council. The 2016/2017 budget

	allocation for these services is £4.873m, of which £3.710m is within the Section 75 agreement and £ 1.163m is within the Aligned agreement of the fund. In addition to Section 75 agreement decisions previously mentioned, the Single Commissioning Board will also make recommendations on the utilisation of Aligned agreement funding. All recommendations will require ratification by the relevant statutory organisation, which would be the Council in this instance.
Legal Implications: **(Authorised by the Borough Solicitor)**	Under Regulation 32 (2) (c) of the Public Contracts Regulations 2015 a contracting authority can utilise the negotiated procedure without the prior publication of a contract notice where insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with. To rely on such an exemption the circumstances invoked to justify extreme urgency must not in any event be attributable to the contracting authority. The report details that as a result of actions of other commissioners; the current contract became financially unviable for the remaining parties and was brought to an end by agreement. It would not therefore be unreasonable to rely on Regulation 32 (2) (c) in the circumstances. This approach is not without risk of procurement challenge however given the intention to redefine the service (which cannot immediately be achieved) the risk is not seen as significant and it is more important that the commissioners get the right and most expedient service for service users. Board Members should be aware that the transitional provisions under Regulation 120 of the Public Contracts Regulations 2015 which exempted certain NHS Procurements from the application of the Regulations ceased to apply to procurements commenced after 18 April 2016. As a result, any NHS Procurement (which will mostly amount to Social and Other Specific Services or what are known as Light Touch Regime procurements which are not covered by the full application of the Regulations) which exceeds the current threshold of £589,148 must unless a specific exemption contained in Regulation 32 (Use of the negotiated procedure without prior publication) applies be advertised through the Official Journal of the European Union, and be let by procedures which shall be at least sufficient to ensure compliance with the principles of transparency and equal treatment of economic operators.
How do proposals align with Health & Wellbeing Strategy?	The development and negotiation of a new Bi-Lateral Mental Health Contract will include an assessment of whether or not the contracted services align with the Health & Wellbeing Strategies.
How do proposals align with Locality Plan?	The development and negotiation of a new Bi-Lateral Mental Health Contract will include an assessment of whether or not the contracted service aligns with the Tameside & Glossop Locality Plan and the agreed Model of Care for our locality.

How do proposals align with the Commissioning Strategy?	Any proposals/negotiations set out in this paper will be carried out in the context of the priorities included in the Single Commission's Commissioning Strategy. Mental Health is one of the SCF's top priorities.
Recommendations / views of the Professional Reference Group:	PRG supported the paper and the 2 recommendations, which are the ones presented to SCB. The Committee did not support 2 others recommendations: to ratify the decision made by the SCMT on the 26 July 2016 to formally withdraw from the multi-lateral contract, because the SCB is the decision making body. NB, the paper stated 'supports the recommendation of SCMT'. It also felt that the recommendation, to note the intention to undertake a procurement exercise in accordance with the Public Contracts Regulations 2015 was inconsistent with the rest of the paper, PRG discussions and Care Together programme.
Public and Patient Implications:	Commissioners leading on the newly proposed Bi-Lateral Mental Health Contract will be required to ensure that any patient and public implications of the contract/services are considered in the on-going monitoring and any proposals for redesign/recommissioning.
Quality Implications:	Commissioners leading on the development of the contract proposed in this paper will be required to ensure that quality implications are considered in the ongoing monitoring and any proposals for redesign / recommissioning. Quality Impact Assessments will be completed.
How do the proposals help to reduce health inequalities?	The Single Commissioning Function will ensure that the review of any new contractual arrangements include consideration of the impact on health inequalities.
What are the Equality and Diversity implications?	We will ensure that Equality Impact Assessments are carried out to support any contracting or commissioning decision arising from the proposals within this paper.
What are the safeguarding implications?	We will ensure that any new contract that is commissioned by the Single Commissioning Function is supported by the necessary safeguarding requirements, and that any service or service redesign complies with the appropriate safeguarding requirements.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Privacy impact assessments will be carried out for any recommissioning or service review processes.
Risk Management:	Risk management will be part of any contract management/performance management process for the contract identified in the attached paper, and will be monitored via the appropriate Single Commissioning governance processes.
Access to Information :	The background papers relating to this report can be inspected by contacting Clare Watson, Director of Commissioning, by: ☎ Telephone: 0161 304 5827 e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 NHS Tameside and Glossop has been a partner in a multi-lateral contract arrangement with Pennine Care NHS Trust since 2002 when the organisation came into being as a Mental Health Trust, and additionally contracted with its predecessor organisations for the provision of mental health services. Heywood, Middleton and Rochdale CCG have acted throughout the agreement as lead commissioner.

2. CURRENT SITUATION

2.1 The current multi-lateral contract term was scheduled to come to an end on 31 March 2017 however the contract includes provision to extend for up to 2 years. As a number of GM commissioners have served notice to withdraw from the contract the resultant arrangements are no longer viable.

2.2 It is our understanding that no other CCG in Greater Manchester Pennine Care Footprint has currently gone to the market with their proposed new mental health contracts and are believed to have approached Pennine Care NHS Foundation Trust to make a direct award through a negotiated process.

2.3 In line with the reviews undertaken by other CCGs, Tameside & Glossop Single Commissioning Function has made the decision to withdraw from the existing multi-lateral contractual arrangements. The decision in effect has been forced as the various withdrawals have meant the existing arrangements cannot continue beyond 31 March 2017. This decision will benefit the arrangements in relation to commissioning mental health services as Tameside and Glossop CCG have over the years held an excessive and disproportionate share of the costs of provision and risk share – all of which would be resolved in any bilateral contract. The break from the existing arrangement will also enable the single commissioning function to progress the CCG QUIPP for Recovery Plan in relation to mental health which has identified a saving of £500k for 2017/18 – the ability to achieve this saving as part of the existing multi-lateral arrangements would have proved difficult to deliver given the complexity of the agreement.

2.4 A recommendation to formally withdraw from the multi-lateral contract and move to a bilateral contract with effect from 1 April 2017 was made by the SCMT on the 26 July 2016. This recommendation needs formal approval under single commissioning governance arrangements.

2.5 The plan is to establish a programme budget approach to mental health services during 18/19 as part of the ICFT's provider agenda.

3. PROPOSAL

3.1 The Single Commissioning Function needs to manage its position with regards to the provision of mental health services from April 2017. An additional consideration is the requirement from NHS England to have contractual agreements in relation to Mental Health signed up by December 2016.

3.2 Advice received is that progressing anything other than a procurement exercise for a long term arrangements would need to be reconciled with the requirements of the Public Contracts Regulations 2015 which apply to NHS procurements which commence after 18 April 2016. A failure to do so would:

- Breach of the 2015 Public Procurement Regulations 2015;

- Could result in challenge from other service providers i.e. other NHS Trusts, private providers who have not been afforded the opportunity to bid for the work;
- Fail to provide value for money.

This will be considered in accordance with the economy's position whereby T&GICFT will become the lead provider of health and care services for Tameside & Glossop, and the SCF will manage a transfer of all contracted activity to the ICFT in line with appropriate due diligence.

3.3 The proposal is therefore that the Single Commissioning Function progress a negotiation with Pennine Care NHS Trust with a view to awarding an outcome based contract for two years from 1 April 2017. The basis of the contract would be that Pennine Care would continue to deliver the core service that it provides to the residents of Tameside and Glossop currently under the multi-lateral contract. In addition, the Single Commissioning Function and ICFT will work with Pennine Care over 2017/19 to progress the assimilation of mental health contracts into the overall Care Together programme, as part of the ICFT.

3.4 There is a high level of assurance in the proposal to continue with Pennine Care for the two years proposed as all monitoring undertaken indicates delivery of a high level of performance.

3.5 Under Regulation 32 (2) (c) of the Public Contracts Regulations 2015 a contracting authority can utilise the negotiated procedure without the prior publication of a contract notice where insofar as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with. To rely on such an exemption the circumstances invoked to justify extreme urgency must not in any event be attributable to the contracting authority.

3.6 The decision of other commissioners to withdraw from the multi-lateral contract has left insufficient time for the Single Commissioning Function to determine and consult upon requirements and run an open, transparent procurement exercise in time to meet NHS England's December deadline. Whilst a period of 2 years is longer than is required to undertake the tasks in isolation, the extension period and service to members of the public is commensurate with the terms of the multi-lateral contract and will enable the Single Commissioning Function to:-

- To re-negotiate its contract accordingly whilst ensuring the contract can be performance managed with a total focus on Tameside and Glossop;
- To consolidate mental health services into a single approach and build stronger relationships primarily between mental health provision, the Integrated Care Foundation Trust and the Single Commissioning Function;
- Align its commissioning plans to developments progressing under the GM Devolution Agenda;
- To redesign in a considered way an all age mental health service for the benefit of its population;

4. OTHER OPTIONS AVAILABLE

4.1 Due to the short timeframe under which arrangements must be put in place there is insufficient time to undertake an open and transparent procurement exercise and to potentially transfer the service to a new provider. Therefore the only reasonable option is to make a direct award to Pennine Care NHS Foundation Trust.

4.2 The Single Commissioning Function could look to extend a contract in excess of 2 years however this would increase the risk of a procurement challenge due to a failure to comply

with the Public Contracts Regulations 2015. A two year contract term is the minimum period considered necessary to undertake the tasks referred to in paragraph 3.6. This period is consistent with the terms of the current multi-lateral contract and would not impose significant procurement risk. The prospect of further developments alongside the ICFT for a long term contractual arrangement will also mitigate the risk of the award of a two year contract.

5. RECOMMENDATION

5.1 As stated at the front of this report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Reporting Member / Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**PRIMARY CARE – PRIORITIES & SCOPE 2017-2021**
Report Summary:	This report provides a briefing on the priorities and scope for primary care over the next two to five year based on the national and regional strategies set out through the Five Year Forward View, General Practice Forward View, New Models of Care: The multispecialty community provider (MCP) emerging care model and contract framework, NHS Operational Planning and Contracting Guidance 2017-19 and Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.
Recommendations:	The Single Commissioning Board are asked to: • Note the scale of the ambition for Primary Care nationally. • Support the delivery of this ambition through our local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme. • Acknowledge the competing priorities on scarce financial resource and the CCG investment already in place as part of the Primary Care Quality Scheme, noting the refresh of this aligned to national policy and GM standards, and the investment in respect of neighbourhoods through Transformation Fund.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Primary Care expenditure can fall into all three elements of the Integrated Commissioning Fund but this is predominantly in the Aligned and In Collaboration Budget areas. Although this briefing identifies potential funding streams for primary care collated from various operational planning guidance, this must be treated with caution. Clarity is required but it would be prudent to expect little, if any, additional resource and assume this resource inherent within CCG Baselines or Transformation Funds which are already significantly over subscribed with other clinical priorities. The CCG has committed £1.5m to the Primary Care Quality Scheme which, as referenced in the review paper brought to September PRG, will be refreshed with alignment to the priorities of the GP Forward View, planning guidance and GM standards to deliver optimum use of this resource.
Legal Implications: **(Authorised by the Borough Solicitor)**	The statutory requirements for submission of CCG plans and GP Forward View plans should be complied with.

How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health and Wellbeing Strategy.
How do proposals align with Locality Plan?	Strengthening and transforming general practice has a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims and key local elements of the GP Forward View into the Locality Plan.
How do proposals align with the Commissioning Strategy?	The transformation of general practice is key to Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	PRG members were supportive of the paper, recognising the scale of the ask nationally and the volume of work in the delivery of this agenda.
Public and Patient Implications:	The drive to achieve improvements in health and care across primary care is intended to make the most of every opportunity to give people the right support close to where they live with the key principles of people powered change and care delivered by population based models.
Quality Implications:	The Five Year Forward View describes a clear task to drive improvements in health and care and deliver core access and quality standards.
How do the proposals help to reduce health inequalities?	Actions to address health inequalities are a theme throughout the primary care strategy.
What are the Equality and Diversity implications?	The Primary Care strategy relates to total population.
What are the safeguarding implications?	None, this is a briefing paper only as any specific issues will be addressed in subsequent detail.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None, this is a briefing paper only as any specific issues will be addressed in subsequent detail.
Risk Management:	None, this is a briefing paper only as any specific issues will be addressed in subsequent detail.
Access to Information :	The background papers relating to this report can be inspected by contacting Tori O'Hare, Head of Primary Care Development:  Telephone: 07920 086397  e-mail: tori.ohare@nhs.net

1. INTRODUCTION

1.1 The strategy for Primary Care over the next two to five years is outlined throughout a number of national and regional documents, with links to each included at **Appendix 1**;

- The Five Year Forward View, published October 2014.
- The General Practice Forward View, published April 2016.
- New Care Models: The multispecialty community provider emerging care model and contract framework, published July 2016.
- NHS Operational Planning and Contracting Guidance 2017-2019, published September 2016.
- Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021), published September 2016.

1.2 These documents are closely aligned and interlinked and all outline the need for system wide changes to ensure the NHS can deliver the right care, in the right place, with optimal value. The framework was first outlined in the Five Year Forward View with the clear task to "drive improvements in health and care; restore and maintain financial balance; and deliver core access and quality standards". This is translated to describe localities position in their Sustainability and Transformation Plans.

2 CONTEXT

2.1 Primary Care – whether provided by doctors, dentists, optometrists, pharmacists or other health and care practitioners who support people outside hospital – already benefits our local population. It offers easy access, high quality care from professionals who know their patients and can make a big difference to health outcomes.

2.2 There are many health and care related issues that could be addressed by improvements both to primary care generally and to specific services, in particular by ensuring we all work together and make the most of every opportunity to give people the right support close to where they live. How people use, or do not use, primary care is an indication of the scale of the challenge; this is alongside an ageing population, an increasing number of people with more than one long term condition and health inequalities.

2.3 This can be summarised by the two key principles of the GM Primary Care Strategy:
People-powered change – making sure people receive the right support to take more control of their own health and behaviours
Care delivered by population based models – making the best possible use of resources available within localities and neighbourhoods.

2.4 Strengthening and transforming general practice will play a crucial role in the delivery of STPs and in integrating the aims of the GP Forward View into these plans. CCGs will need to document the aims and key local elements of the GP Forward View into more detailed local operational plans and submit one GP Forward View plan to NHSE on 23 December 2016; plans need to reflect local circumstances but must, as a minimum, set out:

- How access to general practice will be improved,
- How funds for practice transformational support will be created and deployed to support general practice,
- How ring fenced funding being devolved to CCGs to support the training of care navigators and medical assistants, and stimulate the use of online consultations, will be deployed.

3 OPERATIONAL PLANNING GUIDANCE 'MUST DOS' AND THE GOVERNMENTS MANDATE TO NHS ENGLAND

3.1 The operational planning guidance identifies 9 key 'must dos' for 2017-19, and primary care is a running theme throughout a number these. Primary care is also specified as a 'must do' under its own heading in the form of:

- Ensure the sustainability of general practice in your area by implementing the GP Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of Improving Access to Psychological Therapies in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.
- Support general practice at scale, the expansion of multi-speciality community provider or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

3.2 Alongside the documents outlined above NHS England are publishing a revised NHS Standard Contract for consultation. This refresh addresses ambition set out in the GP Forward View to enable more seamless care for patients, this includes the requirement for transmitting letter to GPs following clinic attendance in a progressively reducing timescale and also mandates, from April 2017, use of the e-Referral system with acknowledgement of the need to resolve practical issues which currently hinders the use and uptake of the e-Referral system in general practice.

3.3 The planning guidance details the government's mandate to NHS England setting the 2020 goals, as with the 'must dos', primary care is a theme through these and is also specifically referenced in the following:

- Patient Experience – measured by the Friends and Family Test, alongside other sources of feedback to improve services.
- New Models of Care – including 100% of population having access to weekend/evening routine GP appointments and 5,000 extra doctors in general practice nationally.
- Technology – 95% of GP patients being offered e-consultation and other digital services and 95% of tests to be digitally transferred between organisations.

3.4 Primary Care, across the whole workforce within General Practice, Pharmacy, Optometry and Dental, has a key role in preventative intervention and signposting to support in the delivery of, for example but not limited to, cancer, obesity and diabetes, dementia, health and social care integration and mental health, learning development and autism targets.

4 NEW MODELS OF CARE –MULTI-SPECIALITY COMMUNITY PROVIDER (MCP)

4.1 The theme throughout all the documentation is around system wide changes and transformation of services to change the way patients access care, self-care and benefit from population based care models. This place based approach of new models of care will break down the boundaries between different types of provider and foster stronger collaboration across services. This starts with Primary Care at Scale and grows to centre around a Multi-specialty Community Provider. This is not a new form of practice based commissioning or

the recreation of a primary care trust but is the delivery of primary and community based health and care services – not just planning and budgets.

4.2 The building blocks of a multi-speciality community provider are the 'care hubs' of integrated teams, each typically serving a community of around 30-50,000 people. A multi-speciality community provider is a place based model of care, it serves the whole population and covers the sum of the registered lists of the participating practices. The multi-speciality community provider is designed to strengthen wider primary care provision and deliver transformed care provision out of hospital to pro-actively manage patients in the community and see a shift in people attending hospital who could be better supported in the community.

4.3 The multi-speciality community provider is a critical delivery vehicle for achieving the Five Year Forward View and making a reality of Sustainability and Transformation Plans. The transformation of care involves major shifts in the boundary between formal and informal care, in the use of technology and in the workforce and the opportunity for an MCP is across all three. An effective multi-speciality community provider engages and activates patients, their carers, families and communities in helping to take control of their own care, this cross references to the GM strategy empowering patients to achieve and multi-speciality community providers will be well place to deliver the improvements in access to general practice described in the GP Forward View.

4.4 The multi-speciality community provider is one way of reviewing and streamlining the urgent and emergency care system, making it easier to simplify the interactions between GP in hours, GP extended access services, walk in centres, community pharmacies, 111, GP out of hours and A&E into an outcomes based commissioning model. The multi-speciality community provider framework describes eight commissioning standards:

- Patients can make a single call to get an appointment out of hours
- Data can be sent between providers
- The capacity for NHS 111 and out of hours is jointly planned
- The summary are record is available in the clinical hub and elsewhere
- Care plans and patient notes are shared between providers
- The system can make appointments to in hours general practice
- There is joint governance across local urgent and emergency care providers
- There is a clinical hub containing (physically or virtually) GPs and other health professionals.

5 ENHANCED PRIMARY AND EXTENSIVIST MODELS

5.1 A multi-speciality community provider offers an enhanced primary care model which provides a broader range of services in the community integrating primary, community, social and acute care services and aims to improve the physical, mental and social health and wellbeing of the local population. They encourage diverse communities to look after themselves by supporting self care and connecting people to community assets and resources. They support staff to work in different ways with a focus on team based care and harness digital technology to achieve their goals.

5.2 The extensivist model provides additional support for a small group of patients with high needs and high cost. This model uses risk stratification supported by trigger tools and case finding to identify patients which would benefit and works to provide targeted out of hospital care, fewer unplanned admissions, shorter lengths of stay and few unplanned readmissions.

6 TECHNOLOGY

6.1 The mandate for technology is for 95% of GP patients to be offered e- consultation and digital services and that 95% of tests be digitally transferred between organisations. The GM strategy takes forward the innovative practice taking place across localities and provides links to the new Health Innovation Manchester partnership to accelerate the discovery, development and implementation of new treatments and approaches with a focus on improving health outcomes. This includes the use of digital technology to improve how people access care, how records are shared with the ambition of becoming paper free at the point of care to strengthen primary care to create easier access to services that fit around the patient's family and work life. In line with the self care culture of people powered change this also offers opportunities to improve access to advice and treatment through technology such as online, real-time video consultation.

7 PRIMARY CARE QUALITY

7.1 The Five Year Forward View, NHS Planning Guidance and Sustainability and Transformation Plans are all driven by the pursuit of the "triple aim":

- Improving the health and wellbeing of the whole population;
- Better quality for all patients through care redesign; and
- Better value for taxpayers in a financially sustainable system.

7.2 To this aim NHS England have introduced a new Improvement and Assessment Framework for CCGs and NHS Improvement have published the Single Oversight Framework. The key themes of the latter include quality of care; assessing whether a provider's care is safe, effective, caring and responsive.

8 GREATER MANCHESTER PRIMARY CARE MEDICAL STANDARDS

8.1 A suite of standards have been co-designed and agreed with the aim of transforming the delivery of primary care to reduce unwarranted variation, adopt a more pro-active approach to health improvement and early detection in order to improve health outcomes for the patient population. These standards are to be implemented by 2017, with similar standards also being developed in dental, optometry and pharmacy, all of which will contribute to the earlier detection of disease, proactive management within the community and supporting patients to self care. The nine GM medical standards are:

1. Improving access to general practice;
2. Improving health outcomes for patients with mental illness;
3. Improving cancer survival rates and earlier diagnosis;
4. Ensuring a proactive approach to health improvement and early detection;
5. Improving the health and wellbeing of carers;
6. Improving outcomes for people with long term conditions;
7. Embedding a culture of medication safety;
8. Improving outcomes in childhood asthma;
9. Proactive disease management to improve outcomes.

8.2 Locally, proactive engagement around quality and assurance, aligned to the Care Quality Commission work programme will dovetail the delivery of national and regional directives. Utilisation of risk stratification data to understand the needs of specific cohorts of patients and how services and care models can be used to better support these patients is also in place, linked also to the enhanced primary care and extensivist models outlined above.

9 WORKLOAD AND RESILIENCE

9.1 There is pressure on primary care from other parts of the health system resulting in increased workload, problems recruiting and retaining GPs therefore creates further workforce difficulties. The GM strategy illustrates that between 2002 and 2013 GP numbers only increased by 14% compared with a 48% rise in hospital consultants. A third of GPs hope to retire within the next five years and a fifth of current GP trainees plan to move abroad. Other parts of the primary care workforce face similar challenges, for example in practice nursing over 64% of nurses are over 50 and only 3% are under 40. A baseline collection of the current workforce, workload demands will form one element of our GP Forward View plan.

9.2 The potential for clinical pharmacists to reduce the burden on GPs and increase capacity within primary care is already being demonstrated. Locally there are success stories and feedback on the benefits being realised in our practices, resolving day to day medicine issues and requests from pharmacies, providing extra help for patients to manage long term conditions, advice to those on multiple medication and better access to health checks.

9.3 In GP Forward View plans CCGs will want to include a general practice workforce strategy that links to their service redesign plans. These should be clear about the current position, areas of greatest stress, examples of innovative workforce practices, the planned future model and actions to get there, building on the 10 high impact actions to release capacity described in the GP Forward View.

9.4 Improving the way different health and care professionals work together to get the most from what each profession brings to primary care services and individual patient care will help embed best practice in all services and will contribution to delivering the GM vision focusing on place and people rather than specific organisations and professional groups.

10 PRIMARY CARE ESTATES

10.1 The primary care estate varies significantly in terms of quality, condition and suitability and needs to cope with increasing patient activity as more services are developed out of hospital. Vision and direction for primary care estate needs to enable the delivery of place based services across neighbourhoods and make full use of buildings currently available, including patients' own homes, local community services, traditional primary care facilities and other public sector premises. Locally this agenda is being taken forward in a separate workstream.

11 FINANCE

11.1 Under delegated commissioning arrangements the CCG receives an allocation for core primary care commitments; the value of this for 2016/17 to 2020/21 is detailed below:

2016/17	£30.922m
2017/18	£32.075m
2018/19	£33.041m
2019/20	£34.108m
2020/21	£35.485m

11.2 Although this outlines increases in allocation year on year, this must be measured against unknowns around increased in global sum, changes to quality and outcomes framework and premises reimbursement regulations and changes in list size, though an element of list size growth is incorporated in allocation uplifts. It would be therefore be prudent to assume these allocation fully committed and any slippage be dealt with on an in year basis.

11.3 In addition to this allocation other primary care funding is potentially available as part of the £500m plus sustainability and transformation package announced in the GP Forward View including potential funding to support improvements. in access to general practice and improvements in estates and technology. As yet, GM Health and Social Care Partnership are seeking clarity on these resources, with particular reference to whether these are genuinely additional resources which GM can access, or whether these are either inherent in the GM Transformation Fund or already in CCG Primary Care baselines. Experience leads us to believe the latter two scenarios are the more likely and if so these resources are already significantly over-subscribed with other "must do" clinical priorities. It is therefore crucial that the whole health and social care economy work collaboratively to achieve optimal outcomes with the scare resources we have.

11.4 The different funding streams reported in various publications have been collated and are summarised in the table below. The third column reports the perceived reality of whether this is genuinely new funding and how this compares to CCG investment:

Operational Planning Guidance Headline	**Policy Description**	**Detail/T&G translation**
Transformational support 17/18 and 18/19 from CCG allocations	"CCGs should plan to spend a total of £3 per head of population as a one off non recurrent investment commencing in 2017/18 for practice transformation support as set out in the GP Forward View and can take place over two years, £3 per head in 17/18 or 18/19 or split over the two years. This investment is designed to stimulate development of at scale providers for improved access, stimulate implementation of the 10 high impact actions to free up GP time and secure sustainability of general practice."	This funding is included within CCG core allocations. For T&G, based on list size information at 1 July 2016 this would equate £735,750. The CCG has already committed £1.5m to the Primary Care Quality Scheme which more than adequately addresses this requirement and others noted below. In addition there may be a possibility to address this requirement with links to the Primary Care investment via the GM Transformation Fund.
Online General Practice consultation software systems	This was announced in the GP Forward View with £45m funding for this programme with £15m to be deployed in 2017/18 along with the rules, specification and monitoring arrangements and a further £20m in 2018/19.	For Tameside and Glossop, based on nationally estimated registered populations this will equate to £63,595 in 2017/18 and £84,672 in 2018/19. GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
Training Care Navigators and Medical Assistants	The £45m, over five years, announced in the GP Forward View for the Training Care Navigators and Medical Assistants programme totals £10m in each of 2017/18 and	Locally this allocation equates to, based on estimated registered populations, £21,229 in the current year, £42,402 in 2017/18 and £42,336 in 2018/19.

	2018/19 with £5m allocated in 2016/17.	GM Health and Social Care Partnership are seeking clarity on whether this is genuinely new funding and not already included in the GM Transformation Fund, or the CCG baseline.
General Practice Resilience Programme	The £40m non recurrent funding announced in the GP Forward View to be deployed over four years; £16m of which is being allocated in 2016/17. This resource will be delegated to NHS England local area teams on a fair share basis with a number of elements of the package being held centrally pending further information.	This resource will be held by the GM Partnership, detail of how this is to be allocated, including whether or not (and how) practices can self-refer is still unknown and requires confirmation.
Funding to improve access to general practice services	This funding stream allocates £6 per head to those CCGs who had Prime Minister's Challenge Fund pilot sites. The programme expands and includes £3.34 per head of population for remaining CCGs to provide access to pre-bookable and same day appointments to general practice services in evenings, 1.5 hours per day and provision of weekend provision on both Saturday and Sunday to meet local population need.	This should total a minimum additional 30 minutes capacity per 1000 population, rising to 45 minutes per 1000 population. For Tameside and Glossop this equates to £807k of which a recurrent allocation has been received in 16/17 are is therefore now within the CCG baseline with other competing priorities.
Estates and Technology Transformation Fund (ETTF)	CCGs were invited to bid for funding from 2016/17 onwards.	Tameside and Glossop are understood to have been successful in securing capital funding for Union Street Hyde and Hattersley integrated Hub. The details have yet to be verified and account taken of the the additional revenue costs associated with capital funding.

11.5 There is also the potential for some non-recurrent funding which is being held nationally to support GP Forward View commitments in a number of areas including growing the general practice workforce, premises and the national development programme. In addition there will be potential increases in a number of national lines to support the promised increase in investment for general practice, this includes:

- Increases in funding for GP trainees funded by Health Education England;
- Increases in funding for nationally procured GP IT systems;
- Increases in the section 7A funding for public health services, which support payments to GPs for screening and immunisation services; and

- 3000 new fully funded practice-based mental health therapist to help transform the way mental health services are delivered.

11.6 NHS England has retained some national funds to support workforce developments including international recruitment and clinical pharmacists and Health Education England and NHS England will produce frameworks and models to support the expansion of physician associates, medical assistants and physiotherapists.

11.7 Primary Care is a significant partner in the neighbourhoods for which Transformation Funding has been received of circa £8m and plans are being developed collaboratively with primary care colleagues to deliver holistic services in neighbourhoods.

12 LOCAL IMPLEMENTATION

12.1 Although the neighbourhood model of peer support has been in place for a number of years more recently this has developed and expanded to promote new ways of working across, and by, neighbourhoods. The ambition of this is to improve efficiency and achieve the care delivered by population based models approach. Further alignment of commissioning staff to neighbourhoods has strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model, is being implemented locally through this extended support and it is anticipated that this will become embedded in practice culture.

12.2 Following the GM New Models of Care event in early October, a local session was held on 20 October. The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, is moving forward and will further develop through the coming years. We have already seen a change in the way practices are working together; this has further been reflected in the alignment of practices, both formally and informally.

12.3 Neighbourhoods are designing care models for their populations based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods have been formed across all neighbourhoods bringing together providers to work in collaboration.

12.4 Different models of working and widening the range of professionals within the primary care workforce is a key strand throughout all the national documentation and this is being taken forward locally. This expansion of the primary care workforce, could comprise models such as for example: the use of community paramedics and pharmacists. These are currently in operation and may continue through 2017/18 and inform the further development of integrated neighbourhoods.

12.5 New models of care and the direction of the GP Forward View and GM strategy has been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model is not yet available, the context in which the contracts are being re-procured and the future vision for these practices has been outlined and will form part of the assessment of bids.

12.6 GM Health and Social Care Partnership have recently been able to access to the national GP Development Programme and invited practices, through their CCG, to express interest in the Productive General Practice Programme. This programme offers dedicated support to practices to help them plan and implement rapid changes to release time, remove waste and create headspace to work through current and future pressures and implement a means to approach and manage these. We have been able to secure funding to support cohorts of practices through this programme and will communicate this to practices in the coming weeks ahead of the programme launch mid December. Alongside this a QI

champion workshop session is being held in December. This is the first session of a two part programme which is being facilitated locally as part of the learning from year one of the Primary Care Quality Scheme and will further support practices to understand their own practice and population need and how changes can be implemented to address both the direction of national and regional strategy but also to ensure sustainable general practice locally.

12.7 As referenced in the paper to PRG in September, the Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape, both financially and policy. This is best summarised as the Primary Care Quality Scheme refresh must deliver the primary care quality "triple aim". This redesign must therefore address the direction for primary care outlined through the documentation to support the formation of new models of care and deliver people powered care and place based, population based models. This redesign will address the 'must do's' and mandates from the planning guidance outlined above as well as ensure Tameside and Glossop fulfils its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people access services will also be reflected, ensuring people powered change can be achieved. This refresh is underway and will go through a period of patient and practice consultation. This will be brought back to January PRG for review and endorsement.

13 RECOMMENDATIONS

13.1 As set out on the front of the report.

APPENDIX 1

Five Year Forward View

https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

General Practice Forward View

https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

New Care Models: The multispecialty community provider (MCP) emerging care model and contract framework

https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

NHS Operational Planning and Contracting Guidance 2017-2019

https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021)

http://www.gmhsc.org.uk/assets/GMHSC-Partnership-Primary-Care-Strategy.pdf

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**NEIGHBOURHOOD PRIMARY CARE INNOVATION SCHEME**
Report Summary:	The NHS Planning Guidance issued in December 2013 – 'Everyone Counts – Planning for Patients 2014/15 to 2018/19' [1]- set out proposals for the investment of the NHS budget 'so as to drive continuous improvement and to make high quality care for all, now and for future generations into a reality'. This included a section on 'wider primary care – provided at scale' and specified that: CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund. Tameside & Glossop CCG made the decision to allocate a budget of £1.2m to support member practices in the delivery of schemes to meet the criteria outlined above. Practices were invited to present proposals for approval via PIQ (Planning Implementation and Quality committee – predecessor to PRG) at either an individual practice level, or as groups of practices (up to neighbourhood level). During 2014/15 – 2015/16 a number of schemes have been designed, developed and implemented across the locality, with learning and results shared to inform future developments. The practices have been supported by CCG officers from the finance and commissioning teams, and by their neighbourhood clinical leads. In 2015/6 PIQ made the decision that from 1 April 2017 any schemes would need to be on a neighbourhood level, in line with the development of the Integrated Neighbourhood element of the locality's integration plans. The purpose of this report is to present the background and current position and provide recommendations for 2017-18.
Recommendations:	Single Commissioning Board are asked to review the attached proposal which was presented to the Professional Reference Group in December, requesting support for the allocation of £723,855 to a Neighbourhood Primary Care Innovation Scheme for 2017-8, to take forward the benefits from existing schemes, continue the alignment of primary care within the neighbourhood model, and contribute towards delivery of the benefits specified in the locality's integration plans.

[1] https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

	Single Commissioning Board are asked to consider and support the recommendation from the Professional Reference Group that the funding should be a call on the GM Transformation funding earmarked for the Integrated Neighbourhood model rather than a separate commissioner held budget. In supporting the recommendations; the SCB acknowledges that the process and governance to allocate the GM Transformation monies is still to be agreed by the system's Care Together Programme Board.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The CCG has included £723k in the budget setting exercise (part of the S75 agreement) to pay for this in 2017/18 as part of the wider neighbourhood proposition. The finance group support the recommendation made in the paper to progress the identification of schemes and proposals to be considered against the Neighbourhood Primary Care Innovation Scheme. All bids will need to be aligned to the economy wide transformation objectives and will need to be evaluated against the targets of the investment agreement, including the requirement to stem activity growth to the secondary care sector (hospital services). Where schemes have already been in place and are due to cease in March 2017, it will be necessary for a full benefits realisation assessment of that scheme to have been undertaken in order for it to be submitted as a further bid in 2017/18. Governance arrangements around the wider neighbourhood offer are still under development. It is important to ensure that primary care schemes are fully aligned with schemes under development within the ICO and to ensure there is no duplication of effort. As such the finance group propose that any primary care schemes supported by the panel this will only represent an initial approval, until a process has been established that links all neighbourhood investment into accountable structures which deliver the required benefits. This means that all neighbourhood investment proposals (including the neighbourhood pharmacy model and all proposals which have been generated within the ICO) would need to be reviewed and prioritised within new governance arrangements to assess value for money, deliverability within the financial envelope and to ensure milestones and targets as part of the investment agreement will be met. As such each proposal will be required to identify how it supports the delivery of the required benefits to stop growth in activity and close the £70m economy gap.
Legal Implications: **(Authorised by the Borough Solicitor)**	Provided it can be demonstrated this offer is driving continuous improvement it will be in line with the NHS planning guidance referred to in the report and there will be therefore a lawful outcome to the process, which is not only about outcomes for the public purse but about improved services for the public. Clearly governance arrangements will be key to this outcome, and so any decision to spend money should be made in principle subject to approval of these governance arrangements.
How do proposals align with Health & Wellbeing Strategy?	Improved care and outcomes, a focus on early intervention and prevention for all patients are priorities of the Health & Wellbeing Strategy, and are priorities for the Integrated Neighbourhood model. The Primary Care Neighbourhood Innovation proposals will need to address the objectives of the IN model.

How do proposals align with Locality Plan?	The development and implementation of the Integrated Neighbourhood model is a key part of the Tameside & Glossop Locality Plan. The vision to move quickly to a fully person-centred and integrated model of care, with a much heavier emphasis on prevention, supporting self-care and care closer to home is in line with the vision for Integrated Neighbourhoods.
How do proposals align with the Commissioning Strategy?	Integrated Neighbourhoods are key to the delivery of our commissioning strategy. The strategic commissioning priorities of a focus on the ***wider determinants*** of health and wellbeing, early intervention and prevention across the life course to encourage ***healthy lifestyles*** and promote, improve and sustain population health, creating a care model so that people with ***long term conditions*** are better supported and equipped with the right skills to manage their conditions more effectively, and supporting positive ***mental health*** in all that we do are clearly delivered by the IN model, of which this proposal is a key element.
Recommendations / views of the Professional Reference Group:	PRG recommended that the scheme should proceed but that the funding should be a call on the Transformation funding from GM earmarked for the Integrated Neighbourhood model rather than a separate commissioner held budget
Public and Patient Implications:	Section 4.6 of this paper states that any proposal submitted under this scheme will need to provide evidence of consideration of patient and public engagement and implications. The proposal is that the panel carrying out the assessment of proposals is inclusive of a patient / public representative to ensure this is a key part of the overall assessment process.
Quality Implications:	The delivery of the Integrated Neighbourhood model, of which this is a key part, will improve the quality of life of our population, improve the quality of interactions with health & social care professionals, and deliver improvements in our population's ability to be resilient and self-manage, on an individual and community basis. Neighbourhoods will be expected to produce evidence in their proposal of the quality implications of their scheme.
How do the proposals help to reduce health inequalities?	Neighbourhoods will be expected to provide evidence in their proposal of the impact on health inequalities.
What are the Equality and Diversity implications?	Neighbourhoods will be expected to provide evidence in their proposal of how any equality and diversity implications have been identified and addressed.
What are the safeguarding implications?	Neighbourhoods will be expected to provide evidence in their proposal of any safeguarding implications, and the panel carrying out the assessment will seek assurance that this has been carried out.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Neighbourhoods will be expected to provide assurance that all issues relating to information governance have been considered and addressed. The Commissioning Business Managers will provide support to ensure Privacy Impact assessments are carried out where required.

Risk Management:	Neighbourhoods will be expected to include in their proposals details of any potential risks, and a report on how these will be mitigated and managed.
Access to Information :	The background papers relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation, Tori O'Hare, Head of Primary Care, or Clare Watson, Director of Commissioning Telephone: 0161 304 5300 e-mail: clarewatson2@nhs.net tori.ohare@nhs.net alison.lewin@nhs.net

1 INTRODUCTION AND BACKGROUND

1.1 The NHS Planning Guidance issued in December 2013 – 'Everyone Counts – Planning for Patients 2014/15 to 2018/19' [2]- set out proposals for the investment of the NHS budget 'so as to drive continuous improvement and to make high quality care for all, now and for future generations into a reality'. This included a section on 'wider primary care – provided at scale' and specified that: CCGs will be expected to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund.

1.2 Tameside & Glossop CCG made the decision to allocate a budget of £1.2m to support member practices in the delivery of schemes to meet the criteria outlined above. Practices were invited to present proposals for approval via PIQ (Planning Implementation and Quality committee – predecessor to PRG) at either an individual practice level, or as groups of practices (up to neighbourhood level).

1.3 During 2014/15 – 2015/16 a number of schemes have been designed, developed and implemented across the locality, with learning and results shared to inform future developments. The practices have been supported by CCG officers from the finance and commissioning teams, and by their neighbourhood clinical leads.

1.4 In 2015/6 PIQ made the decision that from 1 April 2017 any schemes would need to be on a neighbourhood level, in line with the development of the Integrated Neighbourhood element of the locality's integration plans.

1.5 The purpose of this paper is to present the background and current position and provide recommendations for 2017-18.

2 CURRENT POSITION

2.1 The majority of the Tameside & Glossop practices have participated in the 'Over 75s' scheme since April 2014. The current position is that we have £931,752 invested in schemes across the locality:

Neighbourhood	Total 2016-17 investment
Ashton (North)	£144,458
Denton (West)	£189,935
Stalybridge (East)	£151,063
Hyde (South)	£313,310
Glossop	£132,987
TOTAL	**£931,752**

2.2 The funding has been used to develop and implement a number of different schemes, including in-house / practice based pharmacists, additional medical support for over 75s, PPG led 'care champion' roles, non-medical care co-ordination and support / community development, and hospital & care home in-reach.

[2] https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

2.3 Schemes were only offered to those aged 75 and over. The benefit of a number of the offers to all ages was noted in the design and evaluation, but due to the funding stream and criteria in use, it has not been possible to offer support to people under the age of 75.

2.4 The schemes funded during 2016-17 are currently undergoing evaluation against the aims included in their original proposals presented to PIQ, and will form part of the decision making process for the investments in 2017-18 as detailed below. These findings will be presented to PRG in January 2017.

2.5 To ensure we are adhering to the decision taken by PIQ during 2015-16 re the neighbourhood basis for future models, the Single Commission will communicate with all practices as appropriate. Practices with 'sub-neighbourhood' proposals will have notice served, and those who are participating in neighbourhood-wide projects will be reminded that funding is in place until 31 March 2017. All will be informed that a process for the allocation of 2017-18 funding is in development and that this will be shared as soon as possible.

2.6 PRG and SCB have approved a proposal for the development and implementation of a Neighbourhood Pharmacy Support Team. This proposal was developed following the learning from schemes introduced under the banner of the 'over 75s' programme and will therefore replace the individual practice-based arrangements currently in place. A programme of work is being undertaken to ensure clear transition from the current arrangements to a locality-wide offer from 1 April 2017. Discussions regarding the funding arrangements and the use of the GM Transformation Funding are also ongoing and at the time of writing this report, the £604,000 required to deliver the neighbourhood pharmacy model is included in the draft Investment Agreement between the Single Commission and the GM Health & Social Care Partnership.

3 FINANCIAL POSTION 2017/18

3.1 The budget in the CCG ledger for 2016-17 is a recurrent budget and was subject to the same evaluation and consideration as all CCG budgets during the development of the CCG Financial Recovery Plan. As a result, the budget has been reduced by £500k (recurrently) which has contributed to the CCG QIPP.

3.2 The budget available for 2017-18 has been confirmed as £723,855. This is the budget on which the proposals below are based.

4 PROPOSED APPROACH FOR 2017/18

4.1 The recent planning guidance[3] - NHS Operational Planning and Contract Guidance 2017-2019 - superseding that from 2014, does not include any reference to a requirement to offer the '£5 per head of population' for over 75s.

4.2 Despite the specific requirement to offer the '£5 per head' the proposal is to design and implement a 'Neighbourhood Primary Care Innovation Scheme' as an 'all age' scheme. Removing the restrictions of the over 75 age group, but encouraging innovative ways to manage the Tameside & Glossop population in a primary care setting, in line with our Locality Plan and integrated care model, specifically the Integrated Neighbourhood model.

4.3 It is proposed that we allocate the £723k available from 1/4/17 on a weighted registered population basis, identifying a share of this budget per practice (and with neighbourhood totals. On this basis, using July 2016 weighted registered population figures, the allocation per neighbourhood would be as follows:

[3] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Neighbourhood	Total registered population	Weighted registered population	% of weighted registered population	Allocation based on % share of £723k
Ashton (North)	56,690	60,722.74	23.57	£170,620
Denton (West)	49,714	51,710.47	20.07	£145,297
Glossop	32,082	30,820.47	11.96	£86,600
Hyde (South)	62,914	68,826.96	26.72	£193,391
Stalybridge (East)	43,850	45,535.47	17.68	£127,946
Total	**245,250**	**257,616.11**	**100**	**£723,855**

4.4 PIQ (and subsequently PRG) proposed that only neighbourhood wide schemes would be accepted from 1/4/17. This paper recommends that we adhere to this and proposals for 2017-18 will only be accepted at a neighbourhood level. Individual practice schemes will not be accepted. Proposals will be accepted which 'test' more than one way of working at a neighbourhood level and have more than one element to them, but only 5 proposals will be requested and accepted.

4.5 The economy put together a detailed 'cost benefit analysis' to support the successful proposal for GM Transformation funding. This proposal stated that the implementation of the Healthy Lives and Integrated Neighbourhoods projects would maintain activity over the next 5 years at the 2016-17 planned levels for A&E attendances, non-elective admissions, emergency excess bed days and outpatients, and reduce growth in elective and daycase admissions by 50%. This uses planned activity and budgets for 2016-17 as a baseline. We The figures relating to activity and finance are shown below:

£000	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	16/17 TOTAL	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	17/18 TOTAL	2018/19 TOTAL	2019/20 TOTAL	2020/21 TOTAL	Total
A&E	0	0	0	0	0	0	17	35	52	104	390	575	862	1,931
Non Elective	0	0	0	0	0	0	91	181	272	544	2,031	2,990	4,481	10,046
Non Elective XBD	0	0	0	0	0	0	8	17	25	50	190	279	419	938
Elective	0	0	0	0	0	0	29	58	87	174	648	953	1,429	3,204
Outpatients	0	0	0	0	0	0	59	118	176	353	1,317	1,939	2,907	6,516
TOTAL	0	0	0	0	0	0	204	409	612	1,225	4,576	6,736	10,098	**22,635**

Activity	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	16/17 TOTAL	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	17/18 TOTAL	2018/19 TOTAL	2019/20 TOTAL	2020/21 TOTAL	Total
A&E	0	0	0	0	0	0	147	293	440	880	3,287	4,840	7,191	16,198
Non Elective	0	0	0	0	0	0	55	110	165	330	1,235	1,818	2,701	6,084
Non Elective XBD	0	0	0	0	0	0	38	77	115	230	863	1,270	1,887	4,250
Elective	0	0	0	0	0	0	27	53	80	160	594	874	1,299	2,927
Outpatients	0	0	0	0	0	0	513	1,026	1,539	3,078	11,493	16,921	25,141	56,633
TOTAL	0	0	0	0	0	0	780	1,559	2,339	4,678	17,472	25,723	38,219	**86,092**

We will calculate/'allocate' these figures at a neighbourhood level and will expect proposals to identify how they will contribute towards delivery of these benefits.

4.6 Single Commission officers will ensure any proposals developed are aligned with the Locality Plan, Health & Well Being strategy, and Commissioning Strategy, and that patient / public involvement is evident. They will also ensure the proposals address issues relating to quality implications, the reduction of health inequalities, equality & diversity, safeguarding and information governance (including any necessary privacy impact assessment).

4.7 Practices will receive support from the Single Commission officers and Clinical Leads to develop their proposals and evidence how they meet the Cost Benefit Analysis expectations set out in our Integrated Neighbourhood model.

4.8 Proposals for the allocation of the 'over 75s' funding were presented by the Practices to PIQ, with a request that any proposals set out how they would meet the criteria set in the national guidance. This was a lengthy process, and in some cases involved presentation / comments

/ re-working / repeat attendances at PIQ committees. This resulted in some delays to implementation.

4.9 To ensure delays are minimised and proposals are considered in a timely and effective manner, the recommendation is that we establish a panel, working on behalf of PRG, to review the 5 proposals from the neighbourhoods against the cost benefit analysis referred to above. The expectation would be that this panel operates on behalf of PRG and provides a report and recommendations to the March PRG, enabling a decision to be taken and implementation to commence by the start of the new financial year. Thus maximising the in-year impact of the proposals.

4.10 The recommendation is that this panel consists of:

- PRG Co-Chairs;
- Clinical representatives (minimum 3);
- Finance Economy representative;
- ICO Healthy Neighbourhoods representative;
- Single commission officers x 2 (in addition to the Commissioning Business Managers who will be providing support to the development of the proposal);
- Patient / PPG representative / elected member (to ensure patient views are represented in any proposal presented to the Single Commission).

5 RECOMMENDATIONS

5.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF STRAIGHT AND CURVED STAIR LIFTS, VERTICAL LIFTS, STEP LIFTS AND OVERHEAD TRACK HOISTS INSTALLED IN DOMESTIC PROPERTIES IN TAMESIDE AND OLDHAM**
Report Summary:	The above service was jointly commissioned with Oldham MBC for an initial two year period from 20 January 2015 with the option to extend for up to an additional 12-months provided for within the contract.
Recommendations:	That authorisation is given to extend the contract where there is provision to do so in the contract.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	There is annual budget provision for this contract of £120,000 within the Section 75 pooled budget. The decision making body for this fund is the Single Commissioning Board. Extension of this contract will enable minor faults to be repaired quickly without the need for lengthy waits for new equipment, thus supporting people to continue to live independently. It is expected that spend will reduce over the next financial year as equipment on the old contract fails and service users are transferred onto the new contract agreement which means that the Council do not have ongoing maintenance liabilities
Legal Implications: **(Authorised by the Borough Solicitor)**	The contract was procured in accordance with the requirements in the Procurement Standing Orders and Public Contracts Regulations 2015 and included provision to extend. It would not be unlawful to extend the contract as proposed. As it is envisaged this service will ultimately transfer to the Integrated Care Organisation the extension should be contingent upon the relevant novation clause be included in the draft contract document and the provider and Oldham Council advised of this intention to ensure a smooth transition at the appropriate time.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Starting Well, Developing Well and Living Well programmes for action
How do proposals align with Locality Plan?	The proposals are consistent with the Healthy Lives (early intervention and prevention) strand of the Locality Plan
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.

Recommendations / views of the Professional Reference Group:	PRG approved authority to extend the contract as required.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness. There needs to be clear performance measures that capture the evidenced impact of the contract and also ensure it is being delivered as specified.
How do the proposals help to reduce health inequalities?	People are supported to continue living in their own homes.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	Safeguarding will be central to this service
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information will be maintained at all times by both purchaser and provider. The purchasers Terms and Conditions for services contains relevant clauses regarding Data Management
Risk Management:	The purchasers will work closely with the provider to manage and minimise any risk of provider failure consistent with the providers contingency plan
Access to Information :	The background papers relating to this report can be inspected by contacting Dave Wilson, Team Manager, Single Commissioning Function Telephone: 342 3534 e-mail: dave.wilson1@tameside.gov.uk

1. INTRODUCTION

1.1. This contract, for the provision of the Inspection, Servicing, Maintenance and Repair of Straight and Curved Stair-lifts, Vertical Through-Floor Lifts, Step Lifts and Overhead Track Hoists installed in Domestic Properties in Tameside and Oldham, is for two years, with the option of a contract extension of a further one year.

1.2. Tendered in August 2014 with Tameside as the lead commissioner, the contract was awarded to City Lift Services (NW) Ltd. The contract commenced on 20 January 2015 and the initial two year period is due to end 19 January 2017.

1.3. Although the service was commissioned for Tameside and Oldham specifically, it is available as a framework for use by other Greater Manchester authorities and associated partners including the following councils: Manchester, Stockport, Trafford, Rochdale, Bury, Salford, Wigan, Bolton, Blackburn with Darwen, Blackpool, Cheshire East and Warrington. To date no other local authority has used the framework agreement.

1.4 In parallel with this procurement, a new contract for the provision (and life of client maintenance) of stair lifts, ceiling track hoists and vertical and step lifts was developed between the two authorities, with Oldham as the lead commissioner. This contract is also due for an extension and is the subject of a separate report. It is considered by both local authorities that the advantages gained through economies of scale in letting larger contracts across both areas has resulted in robust and well run contracts - to the benefit of both authorities - which will continue by extending for a further twelve months.

1.5 Over the lifetime of the contract to date, the number of straight and curved stair-lifts has declined as they have become economically non-viable to repair, maintain or recondition. These items are being replaced with new ones that come with a five-year manufacturer's warranty, and as a result will not be subject again to this contract.

1.6 Newly-installed through-floor lifts, step lifts and overhead track hoists do not come with a five-year manufacturer's warranty, but with a 12-month warranty. Once warranties on these units have expired, they become subject to this contract. However, numbers of these items of equipment are fewer than straight and curved stair-lifts, so a gradual decline of the total number of items of equipment subject to this contract was anticipated pre-tender and has been borne out in practice over the last two years.

1.7 It is worth noting that currently, when the units on the service and maintenance contract fail and cannot be repaired the Council puts the client through the grant process in order to approve a Disabled Facilities Grant to replace them. This replacement is done on the basis that without the unit the client will turn to Social Care for assistance and that if this does not happen then the clients' needs are no-longer being met. This effectively reduces the number of units on the service contract.

1.8 In the region of seventy stair-lifts have been identified as being close to the age where they are having more than three call outs per year and where the cost of repairs is increasing. These are to be replaced over the coming months. Clients will still have to go through a grant application process, but will end up on the life of client scheme.

1.9 Units that were installed with a five year warranty do not belong to the Council; they remain in the ownership of the client; hence, in theory, the Council has no obligation to them. The five year warranty scheme, started in 2012, was an effort to stall the increasing numbers on the service contract. However, there was always the possibility that this would leave a number of people in limbo between the legacy service contract and any new scheme and, in the eventuality that has happened for some people.

1.10 The service, as procured, has increased value for money, enabling scarce Disabled Facilities Grant resources to support more people with disabilities to stay living independently in their own homes. The procurement process took full account of the both council's social value approach and this is monitored as part of contract management.

2. CURRENT SITUATION

2.1 The contract has been performance managed regularly over the first two years in conjunction with Oldham MBC. Overall, City Lifts have performed very well for both boroughs with nothing except occasional and minor complaints about the time it sometimes can take to get an engineer to site and the length of time it can take to acquire non-stock parts.

2.2 City Lifts has had issues in acquiring some replacement parts from certain suppliers. They have been made to wait inordinate lengths of time for parts and there is the suspicion that were these parts being provided to the suppliers own engineers, there would be a far shorter turn-around period.

2.3 Overall, call-outs and repairs are falling due to the fact the stock is now in a better state of repair than at the beginning of the contract and this is resulting in fewer call-outs, thereby reducing costs.

2.4 Costing on this contract is per job and varies depending on the type of job: maintenance of straight and curved stair-lifts, through-floor lifts, step and platform lifts, ceiling track hoists and removal, disposal and reconditioning.

2.5 2015/16, spend for Tameside was £119,000 and £74,000 for Oldham. 2016/17 spend for Tameside, though not yet complete, is projected to be the same as or less than the previous year with a spend so far of £74,000; £120,000 per annum is budgeted for this service. The forecast spend for Oldham is £64,000. This is within the procured financial envelope for both authorities.

3. GROUNDS UPON WHICH AUTHORISATION TO PROCEED SOUGHT

3.1 Authorisation is sought to extend the contract for a period of up to twelve months from 20 January 2017.

3.2 Oldham MBC have indicated that they are willing to continue with the current joint working arrangements and also participate in the re-procurement of a new contract which will commence in the new financial year.

3.3 Of the nine submissions received when the contract was market tested late 2014, City Lift's costings were the lowest and a contract recently tendered for an identical service in Stockport, Trafford and Rochdale was let with service rates higher than those Tameside and Oldham pay on this contract now, whilst the limit for inclusive repairs is also lower with City Lifts.

4. RECOMMENDATIONS

4.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONG BOARD**
Date:	17 January 2017
Reporting Member / Officer of Single Commissioning Board	Clare Watson, Single Commissioning Function
Subject:	**TENDER FOR THE PROVISION OF AN ADVOCACY HUB**
Report Summary:	The report details the intention to go out to tender for the provision of Independent Mental Health Advocacy (IMHA), independent Care Act Advocacy, independent complaints advocacy (ICA) – all of which represent a statutory duty – along with generic advocacy to be delivered via a single point of access from 1 April 2017.
Recommendations:	That authorisation is given to proceed with tendering a number of advocacy services, delivered via a single point of access - the hub – and a single contract.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	There is funding of £148,900 for this contract within the Section 75 agreement of the Integrated Commissioning Fund. It should be noted that the Single Commissioning Board will make decisions on the Section 75 funding which are binding upon the CCG and the Council. It should also be made clear to prospective providers that any increase in demand needs to be managed within the available budget to ensure that the contract delivers value for money whilst balancing the needs of the vulnerable people who require access to advocacy support services.
Legal Implications: **(Authorised by the Borough Solicitor)**	The tendering of the service will be required to be in line with the public procurement regime and in accordance with the Council's procurement standing orders. Retendering a service is the right time to review the previous outcomes and improve on the service to ensure continuous improvement and value for money. As it is envisaged this service will ultimately transfer to the Integrated Care Organisation the relevant novation clause should be included in the draft contract documentation and clearly stated that this is the intention in the tender documentation, so bidders are fully aware that this may happen during the life of the contract.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.

How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	PRG approved authority to go out to tender as required. PRG also recommended some exploration of whether there is other advocacy provision across the piece and if so, whether this could be incorporated.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	There are no anticipated financial risks given the very low value of the contract.
Access to Information :	The background papers relating to this report can be inspected by contacting Dave Wilson, Team Manager, Single Commissioning Function, by:  Telephone: 342 3534  e-mail: dave.wilson1@tameside.gov.uk

1. INTRODUCTION

1.1. The Council has a statutory duty Under the Mental Health Act 2007 and the Care Act 2014 to provide independent advocacy for adults (aged 18 plus) who are vulnerable including the following client groups:

- People with mental health needs including provision of Independent Mental Health Advocates (IMHA);
- People with learning disabilities;
- People with physical or sensory disabilities;
- People with an acquired brain injury;
- People with dementia;
- Older people;
- Carers.

1.2. The contract requires the provider to develop, implement and operate a flexible advocacy service that meets the needs of vulnerable people who require advocacy to:

- Make clear their own views and wishes;
- Express and present their views effectively and faithfully;
- Obtain independent advice and accurate information;
- Negotiate and resolve of conflict;
- Make informed choices;
- Do more for themselves and lessen their dependency on other people;
- Take more responsibility and control for the decisions which affect their lives.

2. BACKGROUND

2.1 The current advocacy contract commenced in July 2012 following a significant service redesign; previously separate contracts for older people, mental health, learning disability and carer client groups, all delivered by different advocacy providers, were brought together into a single arrangement to be provided under the auspices of a single provider.

2.2 In the event, Cloverleaf were successful and have gone on to deliver this service operating, in effect, as a single advocacy hub, for the last four years or so.

2.3 In April 2015, Cloverleaf took on provision of independent Care Act advocacy and the Level 5 casework advocacy element of Independent Complaints Advocacy (ICA) when the Council's contract with the Carers Federation ended and the local Healthwatch service took on Level's 1 – 4 of the ICA provision. Both additional elements were incorporated into the contract at no additional cost, largely, but not entirely, by using the generic advocacy provision capacity within the contract.

3. CURRENT SITUATION

3.1 The current contract runs through to 3 July 2017. Over the summer, meetings have been held with commissioners in Oldham MBC to explore the possibility of a collaborative approach to commissioned advocacy services. Unfortunately, although there is some scope for small-scale efficiencies, a model could not be agreed that accommodated the different circumstances pertaining in each borough and it was agreed to continue to commission services locally.

3.2 The approach currently commissioned in Tameside is consistent with the move – certainly across Greater Manchester - towards advocacy hubs that mean an individual can, if need be,

be supported by the same individual advocate through a set of different circumstances and disciplines so ensuring a degree of consistency. Access into the service is also simplified with all advocacy provision bar Independent Mental Capacity Advocacy (IMCA) delivered via the one contract. IMCA has, for the last nine years, been commissioned jointly across Tameside, Oldham and Stockport under a separate contractual arrangement.

3.3 Just under half of the referrals the service receives are for IMHA with the remaining provision being the now generic older people/learning disability/carer advocacy and some Care Act (2016/17 figures, below).

Advocacy case type	Q1	Q2	Q3	Q4	YTD
IMHA	45	56			101
Care Act	7	11			18
Generic	56	73			129
Total	**108**	**140**			**248**

3.4 While referrals for Care Act advocacy remain low, numbers are generally consistent with other authorities in the region. The sense across advocacy commissioners and providers alike is that referrals will increase steadily over time. One of the issues raised in this regard by Cloverleaf is that both they and referrers need to become more adept at recognising what is – and what is not – a Care Act referral.

4. FINANCIAL IMPLICATIONS

4.1 The current contract costs £148,900 per annum. There was agreement with Cloverleaf during negotiations in April 2015 regarding Care Act advocacy that we would keep a close eye on referral levels and, if necessary, spot purchase Care Act provision if it tipped their work-load beyond the capacity of the staffing model originally purchased.

4.2 Thus far, due to the low level of referrals and the fact that Cloverleaf have picked these up as part of the generic element of their advocacy offer, this has not been an issue, but with Care Act referrals likely to rise steadily over the next five year period, this may prove to be an issue in terms of the budget available.

5. COMMISSIONING INTENTION

5.1 Authorisation is sought to go out to tender early next year with a five year contract to deliver advocacy provision via a hub model. The service requires little in the way of re-design and remains fit for purpose.

5.2 The budget would be set at a maximum of £150,000.

6. RECOMMENDATION

6.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING GROUP**
Date:	17 January 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**CONTRACT FOR THE PROVISION OF MENTAL HEALTH SUPPORTED ACCOMMODATION**
Report Summary:	The report seeks permission to extend the current contract for up to twenty four months from 1 April 2017 to 31 March 2019 as allowed for within contract clause 3.2.
Recommendations:	That authorisation is given to extend the current contract for up to twenty four months.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The budget provision for this contract is within the Section 75 agreement of the Integrated Commissioning Fund (ICF). It should be noted that the Single Commissioning Board will make decisions on the Section 75 funding which are binding upon the CCG and the Council. The 2016/17 budget provision is £0.559m. The contract was subject to a 15% reduction in 2016/17 from the previous value of £0.660m. Ongoing dialogue with the provider has enabled them to absorb this by supporting people to live more independently and delivering care in a more cost effective way. Whilst the finance team support this proposal, it is important that the focus remains on recovery and rehabilitation aimed at equipping service users with the life skills necessary to live independently. This will avoid more expensive residential placements and/or hospital admissions. Work will continue with the provider to identify effective and efficient ways of delivering the service whilst meeting future financial challenges which will include increases in National Living Wage rates.
Legal Implications: **(Authorised by the Borough Solicitor)**	The contract was procured in accordance with the requirements in the Procurement Standing Orders and Public Contracts Regulations 2015 and included provision to extend. It would not be unlawful to extend the contract as proposed. As it is envisaged this service will ultimately transfer to the Integrated Care Organisation the extension should be contingent upon the relevant novation clause be included in the draft contract document and the provider advised of this intention to ensure a smooth transition at the appropriate time.
How do proposals align with Health & Wellbeing Strategy?	The proposals align with the Developing Well, Living Well and Working Well programmes for action
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care; • Locality-based services; • Planned care services.

How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering citizens and communities; • Commission for the 'whole person'; • Create a proactive and holistic population health system.
Recommendations / views of the Professional Reference Group:	PRG approved authority to extend contract as required.
Public and Patient Implications:	None.
Quality Implications:	Tameside Metropolitan Borough Council is subject to the duty of Best Value under the Local Government Act 1999, which requires it to achieve continuous improvement in the delivery of its functions, having regard to a combination of economy, efficiency and effectiveness.
How do the proposals help to reduce health inequalities?	Via Healthy Tameside, Supportive Tameside and Safe Tameside.
What are the Equality and Diversity implications?	The proposal will not affect protected characteristic group(s) within the Equality Act. The service will be available to Adults with a learning disability regardless of ethnicity, gender, sexual orientation, religious belief, gender re assignment, pregnancy/maternity, marriage/ civil and partnership.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The necessary protocols for the safe transfer and keeping of confidential information are maintained at all times by both purchaser and provider.
Risk Management:	There are no anticipated financial risks as the service delivers support in the community to people in their own tenancies and alleviates the potential for the need for more expensive residential or hospital care.
Access to Information :	The background papers relating to this report can be inspected by contacting Dave Wilson, Team Manager, Single Commissioning Function, by: Telephone: 342 3534 e-mail: dave.wilson1@tameside.gov.uk

1. INTRODUCTION

1.1 The purpose of this report is to seek the permission to extend the contract for up to twenty four months from 1 April 2017 to 31 March 2019.

2. BACKGROUND

2.1 The contract to provide supported accommodation to people recovering from mental health problems was awarded following a restricted tender exercise and commenced 1 April 2014 for a period of three years. The contract includes provision to extend for up to an additional two years.

2.2 The contract was awarded to Turning Point and provides 24-hour support across three properties in the Borough; as such, it is an integral part of a comprehensive community-based service. The properties are provided by registered social landlords.

2.3 The service is delivered mindful of recovery and rehabilitation principles and is aimed at equipping service users with the life skills necessary to move on to more independent living, whilst reducing the need for more expensive residential placements and/or hospital admissions. The contract works in parallel with a similar CCG-commissioned service, delivered by Richmond Fellowship, and panel of representatives from commissioners and the two support providers manages referrals to ensure the best possible outcomes for individuals.

3. CURRENT SITUATION

3.1 Thirty two tenants are supported by Turning Point across three properties as follows:

Property 1, Hyde	7 tenancies 1 short stay/respite The accommodation comprises of individual rooms with some shared facilities such as kitchen, lounge.
Property 2, Newton, Hyde	6 tenancies Bed-sits
Property 3, Hyde	20 tenancies 10 x self-contained flats 4 x female-only project (3 x room with shared facilities,1 x self-contained flat) 6 x 24-hour extra care (3 x room with shared facilities, 3 x self-contained flats)

3.2 The Council has worked with Turning Point to review the service over the current term. This has included a review of the respite provision at Property 1 as part of a wider adult service remit. This identified the need to implement a clearer access criteria based on supporting cares to have a break from there caring role. As a result, the number of people requiring this service was reduced and the decision was taken to move from two to one short stay/respite bed and to increase the number of long term tenancies to seven. The second area of development is around Property 2, Newton which has been identified by all partners - New

Charter, Turning Point, Tameside MBC - as not fit for purpose in the long term. Discussions have commenced to establish the notice required to the landlord in line with the housing management agreement, working with tenants to move on and how the levels of service offered to Lyne View will be utilised within the contract, i.e delivering community support.

3.3 Performance monitoring for both contracts has reported a high level of satisfaction from both commissioners, people who are supported by the service and families. In addition, the providers have had a number of successes in supporting people's recovery journey and a move to general let tenancies with community mental health team support.

4. FINANCIAL APPRAISAL

4.1 The current contract price for the year 2016/17 is £558,800.

4.2 The previous contract price for this contract had been circa £660,000.

4.3 Work will continue with Turning Point to identify effective and efficient ways of delivering the service whilst meeting financial challenges especially in relation to future living wage guidance.

5. RECOMMENDATION

5.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**PROPOSAL FOR A DERMATOLOGY ADVICE AND GUIDANCE AND INTERCEPTOR SERVICE**
Report Summary:	The need to manage demand from General Practice is fundamental to the delivery of the CCG financial Recovery Plan. Following the initial financial analysis of the Referral Management Service the need for a smaller scale was identified. The decision was taken to build on existing peer support amongst GPs and invite Orbit and Go To Doc to submit a proposal. The proposal suggests a five month pilot of Dermatology referrals using Glossop Neighbourhood activity as a control and all other neighbourhoods being required to submit non-cancer referrals to an Interceptor service that can clinically assess the referrals and provide advice and guidance for Primary Care Management or referrals to the nurse or consultant led services. GPs will send referrals and images to the service following consent and a clinical review will be undertaken and appropriate advice regarding the referral given within 3 working days. The pilot will be evaluated using activity, costs, a set of metrics and soft intelligence to establish quality and cost effectiveness following four complete months of operation and will inform the decision whether to transfer the pilot to business as usual or cease the service. The cost effectiveness will consider the benefit to the whole health and social care economy.
Recommendations:	Single Commissioning Board are asked to consider the implementation of the five month pilot which will include an evaluation of the cost effectiveness going forward and a recommendation to SCB of future commissioning.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The proposal has been shared with the Finance Task and Finish contract Group and was supported as a pilot but highlighted that it will involve an agreed double running cost until the decision of the review has been made as the Integrated Care Foundation Trust (ICFT) would need to consider what impact the reduction in activity from Tameside and Glossop patients would have. If the ICFT were not able to absorb the loss of the activity through increased activity from elsewhere or avoidance of any waiting list activities it may not be possible to cut its Dermatology Costs. The Trust will identify its fixed costs that cannot be saved and this will be included in the final evaluation of the cost effectiveness of the service.
Legal Implications: **(Authorised by the Borough Solicitor)**	These will be clearer following the outcome of any pilot.

How do proposals align with Health & Wellbeing Strategy?	Prompt access to Dermatology conditions will support children and adults to live well.
How do proposals align with Locality Plan?	Elective services that support people in the community and enable people to self-manage their conditions and maintain their independence is part of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The service will increase support within Neighbourhoods and reduce the use of specialist services when not clinically indicated.
Recommendations / views of the Professional Reference Group:	PRG agreed to implement a five month pilot as described in the paper with the evaluation being robust and including impact on waiting times at the trust.
Public and Patient Implications:	The pilot will involve explicit patient consent to share the referrals and will enable more patients to receive care closer to home. The desire to be treated closer to home has been tested through several engagement exercises and this pilot will help identify any concerns or patient identified benefits when plans are put into action.
Quality Implications:	An initial draft Quality Impact Assessment suggests positive improvements in patient access with no increased risks for clinical effectiveness, patient safety or safeguarding.
How do the proposals help to reduce health inequalities?	The improved access within the Tameside and Glossop Locality will support people with limited access to private transport. Increased support in the familiar surroundings of Primary Care may enable some patients to engage more fully in their treatment.
What are the Equality and Diversity implications?	The services are not expected to have negative impacts on any protected group.
What are the safeguarding implications?	The clinical pathways have no additional safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The pilot uses explicit patient consent to allow the sharing of the patient information. Strict protocols will be in place regarding storage of images and referrals and audits will be used to ensure compliance. A Privacy Impact Assessment will be completed by the provider prior to go live.
Risk Management:	There are no additional risk management implications.
Access to Information :	The background papers relating to this report can be inspected by contacting Elaine Richardson, Head of Delivery and Assurance Telephone: 07855469931 e-mail: elaine.richardson@nhs.net

1. INTRODUCTION

1.1 Demand Management was identified as a priority for financial recovery and the proposal was to implement a Referral Management Service within the Integrated Care Foundation Trust (ICFT). A project group involving the CCG, ICFT, Orbit and Go to Doc came together to scope the service.

1.2 The initial scope was:

- All referrals to all providers, excluding Mental Health, from all clinicians (GPs, Other Primary Care Practitioners, AHPs, Nurses and consultants).
- All requests for procedures that are subject to EUR either at initial referral stage or following Outpatient assessments.

1.3 It was also planned to use the service to support the delivery of the national expectation on the use of E-referrals.

1.4 An initial analysis of the potential costs undertaken by the ICFT suggested that £3.1m would be required to deliver the service, excluding overheads, which would require deflections of nearly £23k or 21% of all Tameside and Glossop CCG current referrals for the system to be cost neutral. The modelling found that, even in a prudent scenario the model was unlikely to deflect more than around £18k outpatients, leaving it £0.65m short of being cost neutral. The ICFT requested that the CCG 'pause' the implementation of the Referral Management Service to allow more analysis to be undertaken and to enable electronic solutions to be developed.

1.5 The Single Commissioning Fund then invited Orbit and Go to Doc to present a proposal for a GP Referral Interceptor service for diagnostic/OP or surgical activity (excluding 2 week waits) that built on best practice happening in Primary Care and that could be implemented as soon as possible to:

1.5.1 Maximise use of:

- Advice and Guidance services when available. You may wish to offer Advice and Guidance when it is not available through the NWCATS service or THFT;
- Cost effective alternatives to acute tariff based services;
- Services within the Tameside and Glossop economy.

1.5.2 Ensure no potential EUR activity is sent to an acute service without a clinical review to confirm the referral demonstrates it meets all the necessary criteria and that no low clinically indicated activity is requested.

1.5.3 Ensure e-referrals is used as the main mechanism for booking appointments and patients feel that their right to choice is respected.

1.6 The aim was to develop the informal GP peer review of referrals and contact with fellow GPs who were known to have expertise in key areas and build on the sharing amongst practice staff to ensure cost effective services are used.

1.7 The expectation was service would be as a minimum cost neutral and have an indicative funding envelope of £80k.

1.8 Following several meetings it was clear that it was not feasible to develop a large scale project as capacity was extremely limited, however, a focused pilot on Dermatology would enable Primary Care to test out the value of an Inceptor Service using the expertise within the local system.

1.9 The local Dermatology offer comprises the Tameside and Glossop ICFT Consultant led Dermatology services delivered on the hospital site and Nurse led services delivered from

community clinics and a community Consultant led service at Manor House Surgery in Glossop.

1.10 The Consultant Led services at the ICFT are frequently overloaded as they are one of a few strong acute based general Dermatology services in Greater Manchester. They accept patients from other CCGs with Oldham being a key user. Requests have been made in contract meeting to support the ICFT in managing the Dermatology demand.

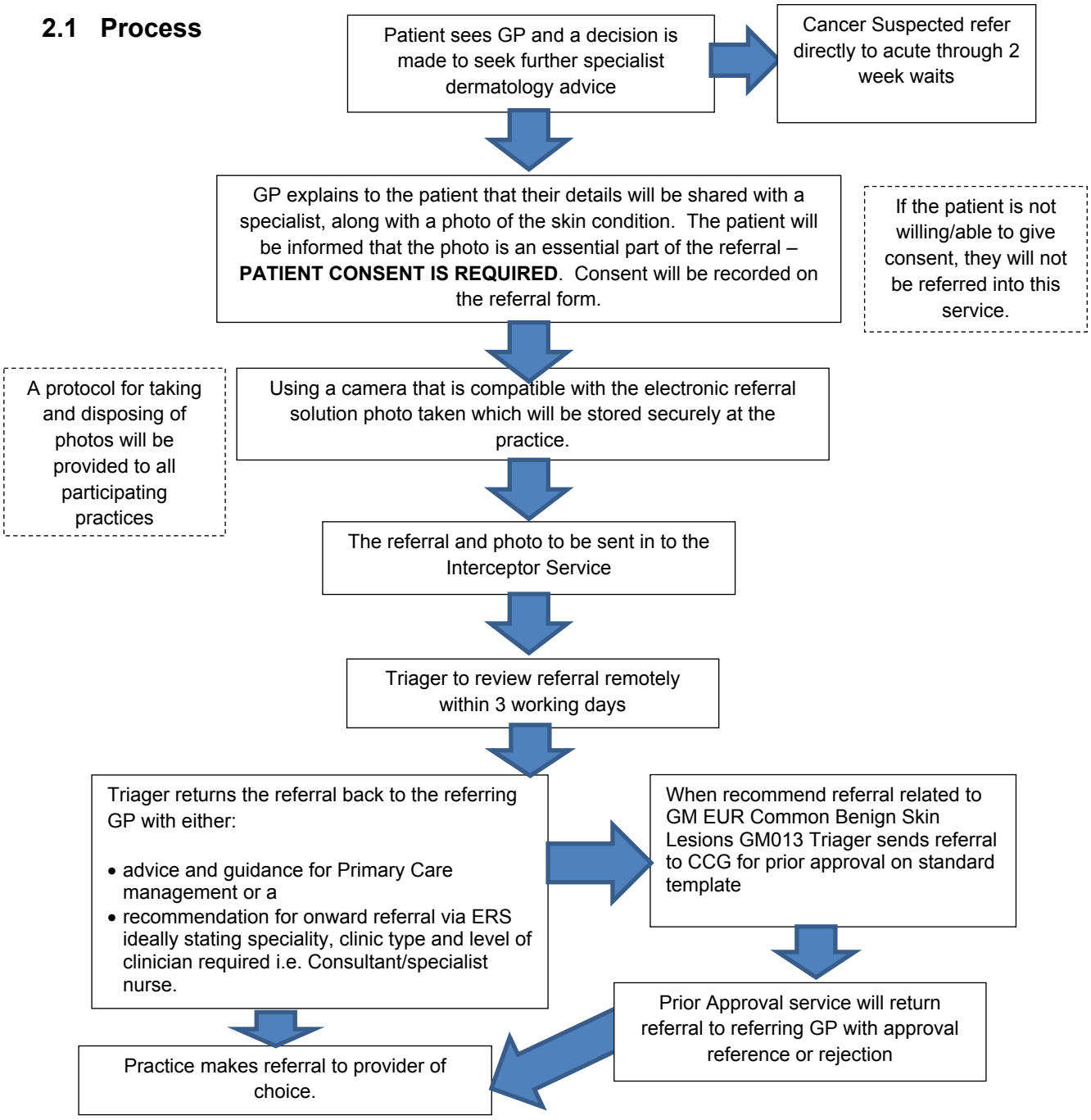
1.11 The following proposal for a short pilot to identify the effectiveness of a Primary Care based review of GP referrals with Advice and Guidance support has been submitted by Orbit and Go to Doc.

2. PROPOSAL

Proposal for a Dermatology Advice and Guidance and Interceptor Service

Following on from the recent discussions about plans to introduce an Advice and Guidance and Interceptor Service for Dermatology referrals in Tameside and Glossop, we are pleased to provide an indication of the approach and outline costs for a pilot service from November 2016 up to 31 March 2017.

2.1 Process



Approach

2.2 During the pilot stage a phased approach will be used to roll this service out to all practices in Tameside. Glossop practices will be used as a control taking into account the local Primary Care based Dermatology service.

Phase	Practices	Week	No. of Triagers
1	5 GTD practices plus Hyde	1	3-4
2	All the above, plus Ashton Neighbourhood	2	3-4
3	All the above, plus Stalybridge Neighbourhood	3	3-4
4	All the above, plus Denton Neighbourhood	4	3-4

Assumptions

2.3 The following assumptions have been made:

- Patient consent is given and recorded appropriately.
- All referrals will include a photograph and the correct protocol is followed to take and dispose of the photograph.
- CCG to confirm that the use of photographs is IG-compliant.
- All referrals will be reviewed within 3 working days.
- Each referral will be processed within 5 minutes (this will need to be reviewed going forwards).
- The referring practice undertakes bookings for any onward referrals that are recommended by the triagers.
- A number of triagers will be recruited to enable a phased approach which will ultimately be available for all Tameside practices if it demonstrates cost effectiveness
- Referral form will be agreed by the GP triagers and the CCG.
- The service can go-live one week following approval.

Evaluation and monitoring

2.4 Based on the business intelligence provided by the triage team, the provider will submit data to the CCG on a weekly basis for the first month then every 2 weeks for the life of the pilot. The data will be at practice level and include:

- Number of referrals received;
- Number of referrals deferred with advice and guidance;
- Number of referrals requiring onward referral by clinic type;
- Number of referrals relating to EUR GM 013.

2.5 In addition the following will be provided after 10 weeks:

- Average time per referral for month 1 and month 2;
- Key areas where Education could reduce the number of referrals.

2.6 Based on the above data a final suit of metrics, including waiting times at the trust, and soft intelligence, including patient feedback, will be agreed to enable a full evaluation to establish quality and cost effectiveness to be produced. This will be produced following four complete months of operation and will inform the decision whether to transfer the pilot to business as usual or cease the service.

Management of the GP Workforce

2.7 The triage team will access the referrals via NHS Mail which they will have the option to access remotely. The referrals will be picked up on a first-come, first-served basis. The triagers will keep a record of the number of referrals they have dealt with and will monitor the outcome and time taken to process. This will be closely monitored by the Clinical Lead and Operational Manager. The triagers will submit invoices based on their time spent per month.

During the ramp-up phase, the triagers will be paid £8 per referral rate but this will be reduced to a rate of £5 per referral once the full service is up and running.

Benefits Realisation

2.8 The key benefits expected include the following:

- Improved access to the most appropriate treatment
- Increased care within Primary Care
- Reduced waiting times for acute care
- Reduced number of discharges with no treatment at First Outpatient in acute care
- Increased knowledge of Dermatology within General Practice
- Reduced First Outpatients appointments in acute care

2.9 The service must deliver both a quality and cost effective improvement.

2.10 Initial discussions suggest that an 11% reduction in First Outpatients through the Advice and Guidance provided is achievable.

Activity Plan

2.11 The pilot is based on the following GP and GDP referrals to Tameside Dermatology taken from Monthly Activity Reports (MAR).

Locality/Practice	2016/17					
	April	May	June	July	Total	Monthly Average
Ashton	**87**	**107**	**101**	**104**	**399**	**100**
P89003 Albion Medical Practice	14	16	17	18	65	16
P89008 Bedford House Medical Centre	7	12	14	15	48	12
P89011 Gordon Street Medical Centre	8	9	13	8	38	10
P89017 Chapel Street Medical Centre	11	16	14	14	55	14
P89020 Trafalgar Square Surgery	17	15	16	19	67	17
P89030 West End Medical Centre	5	9	2	3	19	5
P89033 Tame Valley Medical Centre	8	13	13	14	48	12
P89609 Stamford House	4	3	3	4	14	4
P89613 Waterloo Medical Centre	8	7	2	2	19	5
Y02586 Ashton Gp Service	5	7	7	7	26	7
Denton	**114**	**103**	**92**	**85**	**394**	**99**
P89010 Medlock Vale Medical Practice	18	20	20	22	80	20
P89015 Windmill Medical Practice	25	27	27	22	101	25
P89018 Denton Medical Practice	21	14	5	8	48	12
P89019 Churchgate Surgery	19	16	12	5	52	13
P89029 Market Street Medical Practice	10	16	9	15	50	13
Y02663 Droylsden Medical Practice	8	6	12	8	34	9
Y02713 Guide Bridge Medical Practice	13	4	7	5	29	7
Glossop	**29**	**36**	**27**	**35**	**127**	**32**
C81077 Howard Medical Practice	8	4	5	1	18	5
C81081 Manor House Surgery	7	13	9	11	40	10
C81106 Lambgates Surgery	11	12	9	14	46	12
C81615 Cottage Lane Surgery				2	2	1
C81640 Simmondley Medical Practice	3	3	1	2	9	2
C81660 Hadfield Medical Centre		4	3	5	12	3
Hyde	**81**	**88**	**118**	**81**	**368**	**92**
P89002 The Brooke Surgery	3	8	10	8	29	7
P89004 Awburn House Medical Practice	11	16	16	8	51	13
P89012 Clarendon Medical Centre	22	22	27	15	86	22
P89013 Hattersley Group Practice	6	6	5	6	23	6
P89014 Haughton Thornley Medical Centre	7	12	8	13	40	10
P89016 Donneybrook Medical Centre	17	13	30	19	79	20
P89021 Davaar Medical Centre	9	4	15	6	34	9
P89602 The Smithy Surgery	6	7	7	6	26	7
Stalybridge	**82**	**62**	**57**	**58**	**259**	**65**
P89005 Lockside Medical Centre	12	9	3	5	29	7
P89007 Staveleigh Medical Centre	15	5	9	10	39	10
P89022 King Street Medical Centre	3	4	3		10	3
P89023 St Andrews House	15	6	9	16	46	12
P89025 Town Hall Surgery	1	5	3	2	11	3
P89026 Grosvenor Medical Centre	10	11	7	4	32	8
P89027 The Hollies Surgery	6	7	12	8	33	8
P89612 Mossley Medical Practice	7	8	4	8	27	7
P89618 Pike Medical Centre	5	4	1	3	13	3
Y02936 Millbrook Medical Practice	8	3	6	2	19	5
Grand Total	**393**	**396**	**395**	**363**	**1547**	**387**
2 WW referrals					**725**	**181**
Total Non 2WW referrals					**822**	**206**

2.12 The 2WW referrals account for around 47% of all referrals so excluding Glossop the pilot will receive in the order of 200 referrals a month once fully implemented.

2.13 It is possible that with a prompt service referral numbers may increase either because GPs feel that the 2WW route is no longer the only way to get patients reviewed quickly or because GPs use the service when previously they would have managed the condition without advice.

2.14 Accounting for the roll out in month one there will be in the order of 1000 referrals in the five month period.

Costs

2.15 The pilot required some one-off costs as described below.

2.16 Camera equipment for practices and time to be invested in ensuring practices use it effective to minimise the risk of poor quality referrals. The assumption is no practices have access to appropriate cameras however, this will be confirmed before they are purchased. Clarity is needed as to who will own the cameras and the CCG may wish to provide them directly to practice.

2.17 The evaluation will be led by the CCG but clinical input will be required from the Orbit.

2.18 Recognising that any new service will take time to embed and the triagers will need longer at first to review referrals and document the management advice additional time has been identified for both the triager and the clinical oversight for the first 100 referrals.

2.19 All these costs are summarised in the one-off Set Up costs below:

One-Off Set Up

Items		Total (£)
Cameras for practices	35 @ £77.00 each	2695
Mobilisation support to each practice to ensure effective use of the system and high quality images (clinical and admin)	35 @ £20.00 each	700
Evaluation input	Up to one session of clinical time	350
Additional triage time to support process to become embedded	100 referrals @ £3	300
Additional Clinical Oversight to moderate triage quality	5.5 hours @ £100.00	550
Total		**4595**

Five Month Service Costs

2.20 The pilot service will be funded through a mixture of activity based costs and some fixed costs. These will be reviewed as part of the evaluation with the intention to move to an activity based tariff should the service demonstrate the required benefits.

Items		Total (£)
Triage	1000 @ £5.00 per referral	5000
Clinical Oversight	10 hours @ £100.00	1000
Management Cost (including admin)	25 hours @ £50	1250
Total		**7250**

Total pilot cost

2.21 The total cost for the pilot will be circa £11845 for 1000 referrals giving a cost per referral for the pilot including set up costs of £11.85 and £7.25 excluding them.

2.22 Based on a First Outpatient Cost of £113 the following shows the potential cost reductions in acute care if the cost per referral was £7.25.

Projected Deflection	PILOT (1000 referrals)				17/18 (2500 referrals)			
	No. of Ref Deflected	Acute Savings (1 FA)	Potential Savings inc Set up Costs	Potential Savings for operational Costs	No. of Ref Deflected	Acute Savings (1 FA)	*Potential Savings inc 17/18 Set up Costs	Potential Savings for operational Costs
		(£)	(£)	(£)		(£)	(£)	(£)
5%	50	5,650	-6195	-1600	125	14,125	-4582	-4000
6%	60	6,780	-5065	-470	150	16,950	-1757	-1175
7%	70	7,910	-3935	660	175	19,775	1068	1650
8%	80	9,040	-2805	1790	200	22,600	3893	4475
9%	90	10,170	-1675	2920	225	25,425	6718	7300
10%	100	11,300	-545	4050	250	28,250	9543	10125
11%	110	12,430	585	5180	275	31,075	12368	12950

*If a decision is taken to continue the service and include Glossop there will be additional costs for 6 cameras and support at £582.

3. TAMESIDE AND GLOSSOP HEALTH AND SOCIAL CARE ECONOMY IMPACT

3.1 The proposal was discussed at the Finance Task and Finish Group and was generally supported. The group highlighted that it will involve an agreed double running cost until the decision of the review has been made as the ICFT has activity within the block contract.

3.2 To deliver savings to the whole economy the ICFT would need to consider what impact the reduction in activity from Tameside and Glossop patients would have. If the ICFT were not able to absorb the loss of the activity through increased activity from elsewhere or avoidance of any waiting list activities it may not be possible to cut its Dermatology Costs.

3.3 The Trust will identify its fixed costs that cannot be saved and this will be included in the final evaluation of the cost effectiveness of the service.

4. RECOMMENDATION

4.1 As set out on the front of the report.

Report to: **PROFESSIONAL REFERENCE GROUP**

Date: 17 January 2017

Officer of Single Commissioning Board Clare Watson, Director of Commissioning

Subject: **PROPOSAL FOR AN INTERCEPTOR FOR KEY EUR PROCEDURES**

Report Summary:

A benchmarking exercise across GM highlighted that the level of patients who receive some of the EUR procedures is much higher than other CCGs. Ten key procedures have been identified where a more robust process to intercepting referrals/decisions to undertake the procedure could deliver significant reductions and bring the activity in line with other CCGs.

Two options are set out; - the first utilises the CSU GM EUR process and changes the Monitored Approval activity to Individual Prior Approval. The second utilises an internal Interceptor which retains the existing criteria but will allow all GP referrals to be intercepted and Other referrals from Tameside and Glossop Integrated Care Foundation Trust, GM EyeCare, Hyde Physio, Pioneer and NWCATS.

The cost benefit analysis takes into account the additional costs at CSU or the SCF to manage the referrals, additional capacity at T&G ICFT to support additional admin and the reduction in spend for the activity. It is recognised that it may not be possible to release all of the costs at T&G ICFT and a conservative estimate has been used.

Option		**Annual Net Saving to the economy**
1	All ten managed through CSU EUR as IPA or IFR	£290,544
2	All ten managed through the Interceptor	£311,746

Recommendations:

PRG are asked to recommend to SCB the implementation of the proposed Internal EUR Interceptor for the ten specified procedures and the recruitment of the additional Band 3s for a 12 month period at both the Trust and the CCG.

Financial Implications:

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

The approach outlined in the paper is welcomed, where depending on which option is approved there is a minimum saving to the economy after accounting for loss of income to the ICFT is between £245k and £266k (from the wider aligned ICF). In delivering those savings, CCG performance for those EURs in scope would improve to the average across GM.

Given the size of the financial challenge faced by the Health and Care economy there is a strong case to be made that as a minimum, improvement targets should aspire to deliver performance at the top quartile compared to a peer group or at the average performance of the best three CCG's in GM whichever is the better and at the same time maximise

	opportunities for efficiencies with providers. On that basis the options in this paper should be more ambitious and set out the potential benefits in achieving top quartile performance against comparable CCGs or the average of the top 3 GM CCGs.
Legal Implications: **(Authorised by the Borough Solicitor)**	The policy should be applied fairly and kept under review.
How do proposals align with Health & Wellbeing Strategy?	Prompt access to Dermatology conditions will support children and adults to live well.
How do proposals align with Locality Plan?	Elective services that support people in the community and enable people to self-manage their conditions and maintain their independence is part of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The service will increase support within Neighbourhoods and reduce the use of specialist services when not clinically indicated.
Recommendations / views of the Professional Reference Group:	PRG approved the implementation of the internal EUR Interceptor as set out in option 2 for 12 months. which would require capacity for band 3 post in both the ICFT and SCB ,both would look to see if this can be found across the whole economy, if this is not possible then there would be backfill funding as outlined in the business case, to offer a secondment type offer as an invest to save as highlighted in the paper There will be a four month evaluation of impact as part of a wider paper that includes options for the future commissioning /decommissioning of all EUR procedures.
Public and Patient Implications:	The pilot will involve explicit patient consent to share the referrals and will enable more patients to receive care closer to home. The desire to be treated closer to home has been tested through several engagement exercises and this pilot will help identify any concerns or patient identified benefits when plans are put into action.
Quality Implications:	An initial draft Quality Impact Assessment suggests positive improvements in patient access with no increased risks for clinical effectiveness, patient safety or safeguarding.
How do the proposals help to reduce health inequalities?	The improved access within the Tameside and Glossop Locality will support people with limited access to private transport. Increased support in the familiar surroundings of Primary Care may enable some patients to engage more fully in their treatment.
What are the Equality and Diversity implications?	The services are not expected to have negative impacts on any protected group.
What are the safeguarding implications?	The clinical pathways have no additional safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	The pilot uses explicit patient consent to allow the sharing of the patient information. Strict protocols will be in place regarding storage of images and referrals and audits will be used to ensure compliance.

A Privacy Impact Assessment will be completed by the provider prior to go live.

Risk Management: There are no additional risk management implications.

Access to Information : The background papers relating to this report can be inspected by contacting Elaine Richardson, Head of Delivery and Assurance:

 Telephone: 07855469931

 e-mail: elaine.richardson@nhs.net

1. INTRODUCTION

1.1. Tameside and Glossop CCG along with others in GM have identified a number of procedures that have limited clinical value and should only be used for the specific patients that will derive clinical benefit. These are subject to the Effective Use of Resources (EUR) system which agrees policies that set out the circumstances when a patient will derive clinical benefit and manages the route by which the treatments will be approved.

1.2. A benchmarking exercise across GM in 2015/16 highlighted that the level of patients who receive some of these procedures (using an agreed set of GM treatment codes) is much higher than other CCGs. This exercise has continued and whilst we have moved to be closer to the GM average in quarter 1 2016/17 we are still in the highest four CCGs for several.

	2015/16			Forecast 2016/17		
Procedure	**Number per 100k population**		**Rank**	**Number per 100k population**		**Rank**
	T&G	**GM**		**T&G**	**GM**	
Benign Skin Lesion of Eyelid	29	27		56	42	9
Breast (Correction of Nipple)	1	0		2	1	1
Breast (Gynaecomastia Male)	0	0		0	0	
Breast (Mastopexy)	0	1		0	0	
Breast Augmentation Revision	0	0		0	0	
Breast Reduction	1	0		0	0	
Bunion Removal	50	29	12	38	27	8
Cataract Surgery	881	654	11	775	640	9
Common Benign Skin Lesions	131	115	9	97	93	9
Correction of Eyelid Ptosis	8	5		8	5	4
Dupytrens Contracture	40	27	10	33	26	9
Ganglion Cyst Removal	21	20	9	20	21	6
Hyperhidrosis	33	14	11	40	16	11
Non-Specific Low Back Pain/Facet Injections	355	129	12	267	201	10
Pinnaplasty	2	2		3	2	7
Revision of Scarring	3	5		2	3	1
Sacral Neuromodulation	0	1		0	0	
Snoring	12	6		1	1	10
Tonsillectomy	124	75	12	23	20	9
Varicose Veins	68	53	10	59	49	10
Grand Total	**1,761**	**1,162**				

Table 1 GM Benchmarking Position

1.3. The activity levels in 2016/17 suggest that we have reduced activity for some procedures already. There are likely to be several reasons for the improvement including greater awareness by GPs of the EUR procedures, processes put in place by the ICO and the increased use of non-surgical community providers. The two providers who provide community based services have already been reminded that there should be no onward referrals unless patients meet the appropriate EUR policy and are reporting on the activity.

1.3.1. NWCATS have identified that some spinal injections are being onward referred and are auditing whether these cases come under the Facet Joint Injection for back and neck pain policy. They have instigated an MDT to review onward referrals and ensure adherence to IPA and IFR processes.

1.3.2. GM EyeCare onward referred 165 patients for cataracts out of 173 in Quarter 1 and 173 out of 182 in Quarter 2. They have been asked to ensure all their optometrists are accurately interpreting the criteria and to make it clear that a second eye must

not be operated on unless explicitly requested. GPs have also been asked not to directly refer patients who have not been through the cataract refinement service

1.4. Based on the benchmarking the Single Commissioning Function has decided to focus on ten procedures, nine of which are highlighted above plus Hyaluronic Acid Injections for Osteoarthritis. It is difficult to benchmark the latter as the coding is not straight-forward however local activity appears to be higher than expected hence it has been included in the ten priorities.

1.5. The need for a process that intercepts the referrals for these procedures before activity is undertaken has been highlighted and the following summarises two options for the proposed arrangements and potential impact.

2. CURRENT EUR ARRANGEMENTS

2.1. Each of the ten procedures is only commissioned under certain specific criteria but there are three types of approval across the ten as it is dependent on the procedure (table 2).

2.1.1. **Monitored Approval (MA)** – Referrals may be made or accepted for these procedures in accordance with the criteria set **without** the need to secure prior funding approval. It is the responsibility of the CCG to monitor the activity for these procedures.

2.1.2. **Individual Prior Approval (IPA)** – Funding approval is required **prior to** initiating treatment. This is obtained via a request to GM EUR that demonstrates that a patient meets the specific criteria.

2.1.3. **Individual Funding Request (IFR)** – when treatment is not routinely commissioned or may only be commissioned under certain specific criteria approval is required **prior to** initiating treatment. This is obtained by submitting an individual patient request to GM EUR detailing why the patient should receive the treatment.

2.2. Funding outside of the criteria may be considered on an individual patient basis if there is evidence of clinical exceptional circumstances and this follows the Individual Funding Request route.

2.3. CSU administers the system for Individual Prior Approval (IPA) and Individual Funding Requests (IFR) on behalf of the CCG and either the referrer or the treatment providers (whoever identifies the procedure as the required outcome) are expected to follow the process of gaining approval shown in **Appendix 1**.

2.4. No one intercepts Monitored Approval Referrals but as a CCG we monitor activity and raise concerns through the contracting route when activity appears high. A CCG can instigate an audit and discussions are ongoing with the lead commissioner around cataract levels at one provider.

Procedure	Type of Approval		
	Monitored Approval	Individual Prior Approval	Individual Funding Request
1. Tonsillectomy	Adults and Children		
2. Dupuytrens Contractures	All		
3. Bunion Surgery	All		
4. Ganglion Cyst	All		

Removal			
5. Hyperhidrosis	All		
6. Benign Skin Lesions	All		
7. Cataracts	All		
8. Varicose Veins Surgery	Severe varicose veins	Moderate varicose veins	
9. Facet Joint Injections	Existing patients with demonstrable improvement in quality of life measures following each treatment assessed using a validated research tool. No more than 2 injections a year.	All New Patients	
10. Hyaluronic Acid Injections			All

Table 2 Current Approval Arrangement

2.5. The type of approval that operates for each provider relates to the Lead Commissioner with all patients being treated at that provider following that Lead Commissioner criteria e.g. if Stockport CCG use Monitored Approval for Tonsillectomies all our patients referred for Tonsillectomies at Stockport Foundation Trust will be listed without going to CSU regardless of the criteria set by Tameside and Glossop CCG. However, if Stockport were IPA and T&G monitored Approval CSU would automatically approve the request as T&G have a lower criteria

3. PROPOSED APPROVAL ARRANGEMENTS

3.1. There are two options for the arrangements that will enable referrals to be intercepted and reviewed to ensure only those patients who meet the criteria are accepted for surgery.

3.2. Both will involve a request for approval either from a GP or a treating clinician as set out below:

3.2.1. When a **GP has a reasonable expectation that one of the ten procedures** will be the treatment then **they will be responsible for the request** by completing the referral proforma that sets out the criteria the patient must meet and sending it to the Internal EUR Service.

3.2.2. When a **GP makes a referral for assessment and or treatment but does not specify one of the ten procedures** then the **provider who decides that the procedure is required are responsible for the request** by completing the proforma that sets out the criteria the patient must meet and sending it to the Internal EUR Service.

3.3. It is expected that as part of agreeing a management plan with a patient, the GP or the treating clinician will have discussed the possibility of the procedure to enable a patient to make an informed decision around potential management plans and will explain that the procedure is only effective in specific circumstances. Having explained that they are required to discuss the clinical effectiveness with colleagues before finalising it as an option, patients must explicitly consent to this in order to enable the process to be followed. If patients refuse consent then they cannot be offered the procedure.

Option 1

3.4. The seven procedures that are Monitored Approval become Individual Prior Approval and the Severe Varicose Veins and existing patients for facet joint injections also become Individual Prior Approval in the same way as Moderate Varicose Veins and New Patients. The Hyaluronic acid injections will remain IFR.

3.5. The review of referrals and reporting to the CCG of approved activity will then follow the process shown in **Appendix 1**.

3.6. The arrangements will only apply in providers who have a direct contract with Tameside and Glossop CCG i.e. the ICO and GM EyeCare in 2016/17.

3.7. Current experience is that the three procedures that should go through the IPA/IFR do not do so which suggests that other arrangements will also need to be put in place at the ICO to ensure that no patient is listed for surgery without the necessary approval.

3.8. Any referral from a GP for a procedure that does not have the CSU approval letter attached will be rejected by the ICO but internal monitoring will be required to ensure Other referrals e.g. Consultant to Consultant are also sent to CSU.

3.9. The SCF will need a mechanism for linking the report from CSU with the activity submitted by providers.

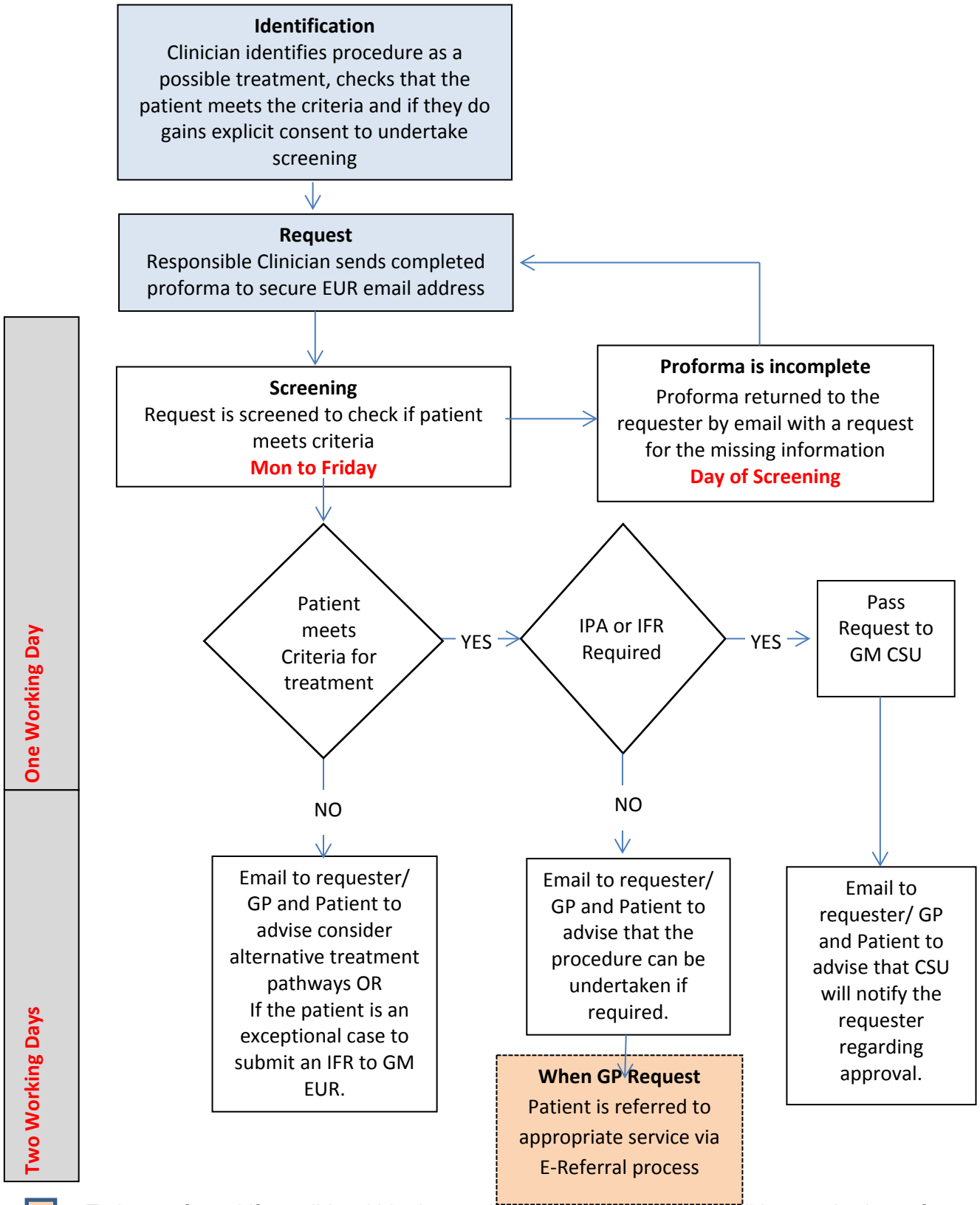
Option 2

3.10 Referrals for all ten procedures come to an Internal EUR Interceptor service that will screen them to ensure all criteria are met. For Moderate Varicose Veins, New patients for facet joints and Hyaluronic acid injections if the patient meets the screening criteria the IPA or IFR request will be passed on to CSU to follow the GM EUR process (**Appendix 1**).

3.11 A report on approved and rejected activity will be used to validate activity submitted by providers to ensure compliance.

3.12 The flow chart for the approval process is set out below.

Internal EUR Process



To be confirmed if possible within the service or whether practices will be required to refer

3.13 The outcome of the screening will be communicated to the requester within 2 working days and the requester, the GP and the patient will be notified of the screening decision and next steps.

3.14 There will be no right of appeal but if a requester or patient is unhappy with the decision they are able to make a complaint to the CCG through the complaints system.

3.15 The internal process will take up to two working days and this must be factored in by providers working to 18 week standards. For procedures that are IPA and IFR the screening at GM CSU EUR will take up to a further 3 working days and if a decision is appealed that can take up to a month. Complete and high quality requests will reduce the risk of delays as they will enable comprehensive clinical review to take place early in the process.

3.16 As in option 1, arrangements will also need to be put in place at the ICO to ensure that no patient is listed for surgery without the necessary approval. Any referral from a GP for a procedure that does not have the Interceptor approval reference will be rejected by the ICO but internal monitoring will be required to ensure Other referrals e.g. Consultant to Consultant are also sent to the Interceptor.

4. COST BENEFIT ANALYSIS

4.1. The CSU element of Option 1 is likely to cost £45,000.

4.2. The internal Interceptor process in Option 2 will require full time (band 3) administrative support with oversight of the CCG EUR manager. The CCG EUR Manager will be released to provide the oversight and ensure effective reporting on activity. The band 3 is an additional post at a cost of £23,798. This will manage around 3,800 requests based on existing activity.

4.3. For both options the additional work at the ICO to ensure that when required requests are made, tracked and responses received and enacted so patients do not breach waiting times will also require a Band three at a cost of £27,100. It is expected that around 1,000 requests will be made by the ICO based on existing activity.

4.4. When an alternative management plan is required to meet the patient's need there may be a cost to that for activity or medication however it is impossible to quantify this at this stage and this will be included in the cost effectiveness evaluation.

4.5. The activity reductions required are indicated in table 3 below. For some procedures we cannot recover a GM rate e.g. Hyperhidrosis and are extremely unlikely to recover facet joint injections, or cataracts. Hyaluronic acid injections do not have a GM rate but these are not commissioned and only patients demonstrating exceptionality should be receiving them.

Procedure	T&G Activity							
	Current		Average Ambition				Top 3 Ambition	
	Apr to Sept	FYE	T&G No. @ GM Rate	Reduction Required	Activity Share at T&G ICFT	Activity Reduction at T&G ICFT	T&G No. if in top 3	Reduction Required
Bunion Removal	49	98	65	33	82%	27	44	54
Common Benign Skin Lesions	104	208	226		79%		121	87
Dupytrens Contracture	27	54	63		74%	0	44	10
Ganglion Cyst Removal	25	50	52		68%	0	39	11
Hyperhidrosis	48	96	38	58	58%	34	19	77
Tonsillectomy	39	78	48	30	61%	18	39	39
Cataract Surgery	967	1,934	1552	382	0%		1091	843
Varicose Veins	66	132	120	12	80%	10	73	59
Facet Joint Injections	322	644	488	156	95%	148	182	462
Total	**1,647**	**3,294**	**2,652**	**671**	**6**	**237**	**1,652**	**1,642**
Hyaluronic acid injections	222	444			76%	350		

Table 3 2016/17 Activity

4.6. If activity for those procedures shown in table 3 that are above GM average can be brought in line with the GM average there is the potential to save £630k in 2017/18 compared with 16/17. This would be increased to £1.356m if the activity was in line with the top 3 CCGs. The savings potential is detailed in the table 4 below.

	Potential Saving to SCF		
Activity Level	No change	At GM average	At level of top 3 CCGs
Bunion Removal	0	84,672	163,296
Common Benign Skin Lesions	0		55,071
Dupytrens Contracture	0		41,440
Ganglion Cyst Removal	0	1,834	10,087
Hyperhidrosis	0	28,914	36,498
Tonsillectomy	0		42,666
Cataract Surgery	0	276,660	670,185
Varicose Veins	0	3,318	65,254
Facet Joint Injections	0	234,724	326,634
hyaluronic acid injections	0		
Total	**0**	**630,122**	**1,411,131**

Table 4 Potential Saving to SCF

4.7. The activity share at the trust will mean that the loss of activity may be insufficient to release costs and if the capacity cannot be used effectively and reduce additional costs such as waiting list initiatives or use of external providers then there will be limited cost reduction to the economy as a whole. Table 5 shows the potential Health Economy savings.

Potential Savings			
Activity Level	At GM average	Income Loss to T&G IC FT	**Minimum Economy Tariff Savings**
Bunion Removal	84,672	69,120	15,552
Ganglion Cyst Removal	1,834	1,247	587
Hyperhidrosis	28,914	16,867	12,047
Cataract Surgery	276,660	0	276,660
Varicose Veins	3,318	2,664	654
Facet Joint Injections	234,724	223,061	11,663
hyaluronic acid injections			
Total	**630,122**	**312,959**	**317,163**

Table 5 Potential Savings 2017/18

4.8. Whilst not on a tariff based contract the potential income lost through tariff would be £316k with Tameside & Glossop Integrated Care NHS Foundation Trust. However, the SCF still has the potential to save £317k from activity going outside of the economy which would contribute towards the £70m economy financial gap. If the Trust can also make savings over the longer term this too will also help to support bridging the economy gap.

4.9. The EUR activity reduction along with other reductions through service redesign for Advice and Guidance, compliance with Consultant to Consultant protocols and reductions in Follow Up appointments may support the release of costs at the ICO and maximise income through delivery against National CQUIN Six Offering advice and Guidance (A&G). The ICO has identified £45,481 of costs that can be released these are not included in the savings below as the timing is to be agreed.

4.10. The net saving after taking account of investment at both the CCG and the Trust in order to implement the proposal would be as shown in Table 6.

Option		**Annual Net Saving to the economy**
1	All ten manged through CSU EUR as IPA or IFR	£290,544
2	All ten manged through the Interceptor	£311,746

Table 6 Net Saving

5. IMPLEMENTATION PLAN

5.1. For Option 1 the timeframe for implementation will depend on CSU and recruitment to the additional capacity, band 3 and band 4 to manage the requests.

5.2. For Option 2 the intention is the implement the process from 1 January 2017. It will be for 12 months in the first instance to enable detailed analysis of referral and request patterns, identification of training support for referrers and requester and identification of learning that can be taken into the ICO for further demand management. Recruitment to the Band 3 will be undertaken (on a fixed term contract initially) and the internal processes and monitoring set up.

5.3. The CSU guides to the policies and IPA/IFR proformas are planned to be uploaded to Practice Clinical Systems week of Dec 12th to support EUR procedures so this work will be ahead of any decision and will support both option 1 and option 2.

5.4. The initial implementation for both options will be with all Tameside and Glossop GPs and all providers who have a direct contact with Tameside and Glossop CCG. This includes:

- Tameside and Glossop ICFT
- GM EyeCare
- Hyde Physio
- Pioneer
- NWCATS – whilst only an associate to the bridging contract the provider will be included at stage 1.

5.5. Further to discussions across GM with Heads of Commissioning and Directors of Finance regarding GM adopting IPA for all policies it may be possible to extend across more providers.

5.6. There will be an initial review of usage after one month to measure compliance and the approval rate. Any improvements in processes within the service and across requesters will be agreed and implemented.

5.7. Activity and approval rates will be monitored monthly with an interim evaluation of cost effectiveness after three months to inform wider roll out/continuation of the service.

5.8. Following approval communication will take place with practice representatives through TARGET, Practice Manager's Forum and Neighbourhood meetings to ensure a full understanding of the new processes.

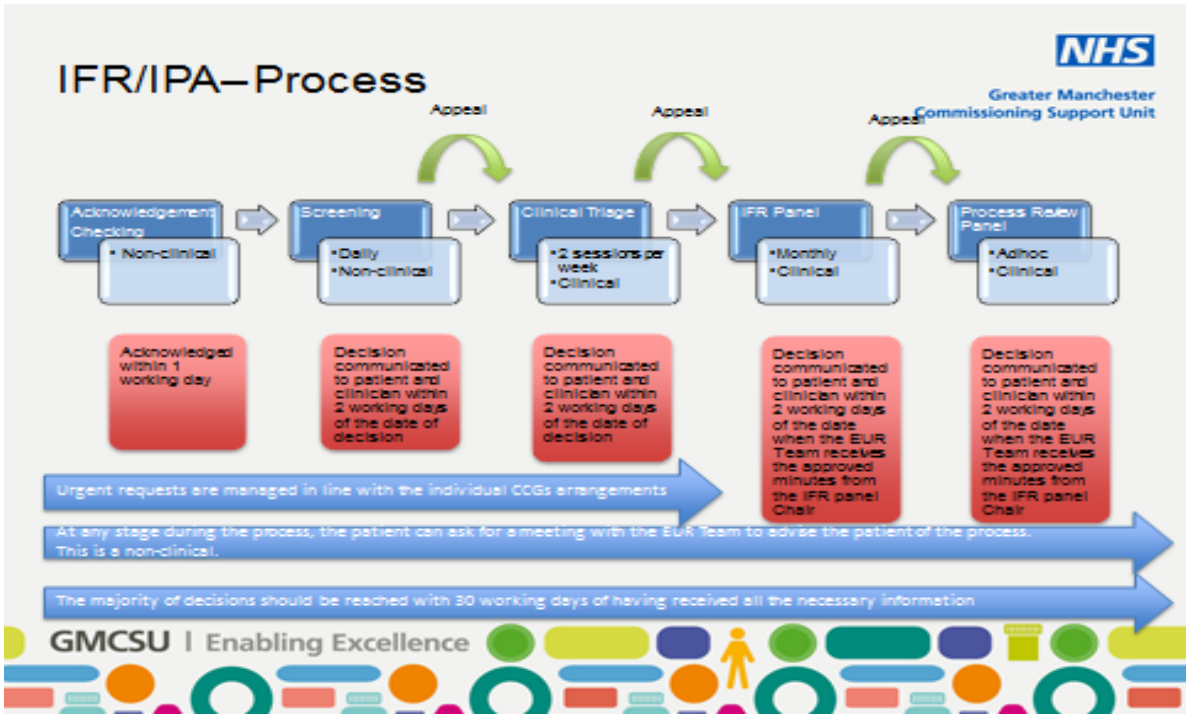
5.9. Providers will be asked to implement their own internal processes to ensure compliance with the process.

5.10. Discussions regarding the use of E-referral are ongoing and if possible we will look to refer from the service to maximise the use of E-referral which is a Quality Premium Indicator.

6. RECOMMENDATIONS

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

GM CSU EUR Process



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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	17 January 2017
Reporting Officer	Sandra Stewart – Director of Governance Michelle Walsh – Interim Director of Nursing, Quality and Patient Safety
Subject:	**EVIDENCE BASED DECISION MAKING – AN APPROACH TO EQUALITY, QUALITY & CONSULTATION**
Report Summary:	The Tameside and Glossop Single Commissioning Function came into effect from 1 April 2016. To assist the new single commissioning function in making robust evidence based decisions a number of requirements need to be met. This report summarises those requirements and the support available to contract and commissioning managers to ensure they discharge their obligation to provide robust and evidential reports to decision makers. The three areas covered are: • Equality and diversity • Quality and risk • Consultation and engagement (including ongoing patient participation) The joint approach outlined in the following sections seeks to provide a standard framework by incorporating and adapting the relevant elements used by the two organisations prior to the establishment of the Single Commissioning Function. The substantive documentation will be kept under review and amended to ensure it remains both compliant and effective.
Recommendations:	The following recommendations are made: • The Single Commissioning Board (SCB) is asked to note the content of the report. • The Single Commissioning Board (SCB) is asked to agree and support the approach as outlined. • The Single Commissioning Board (SCB) agrees workshops are held for relevant staff on the approach outlined and the need for robust evidential decision making. The substantive documentation will be kept under review and amended to ensure it remains both compliant and effective.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	No direct financial implications as a result of the report.
Legal Implications: **(Authorised by the Borough Solicitor)**	This report sets out a process to ensure both organisations stay legally compliant, reduce risk of challenge and importantly make good decisions.

How do proposals align with Health & Wellbeing Strategy?	The report outlines an approach that supports the delivery of the priorities of both Tameside Council and NHS Tameside & Glossop CCG including in the area of health and wellbeing.
How do proposals align with Locality Plan?	The report outlines an approach to equality, quality and consultation which will underpin the development and implementation of the Locality Plan.
How do proposals align with the Commissioning Strategy?	The report outlines an approach to equality, quality and consultation which will assist in ensuring the objectives of the Community Strategy are achieved.
Recommendations / views of the Professional Reference Group:	The Professional Reference Group (PRG) discussed the approach as outlined, in particular the practicality of the different templates. It was noted that those using it so far have found it helpful and that the approach will be kept under regular review to ensure it continues to be fit for purpose and evolve and improve through use and practice.
Public and Patient Implications:	The report outlines an approach to equality, quality and consultation which is dependent on effective public and patient involvement.
Quality Implications:	The report outlines an approach that ensures the Single Commissioning Function discharges its obligations with regard to undertaking a quality impact assessment.
How do the proposals help to reduce health inequalities?	None specifically arising from this report.
What are the Equality and Diversity implications?	The report outlines an approach to ensure both Tameside Council and NHS Tameside and Glossop CCG meet their equality and diversity obligations including the Public Sector Equality Duty (PSED).
What are the safeguarding implications?	None specifically arising from this report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	None specifically arising from this report.
Risk Management:	The report outlines an approach that ensures the Single Commissioning Function discharges its obligations with regard to undertaking a quality and risk impact assessment.
Access to Information :	The background papers relating to this report can be inspected by contacting Simon Brunet – (Acting) Head of Policy & Communications – Governance, Resources & Pensions – Tameside Council.  Telephone: (0161) 342 3542  e-mail: simon.brunet@tameside.gov.uk

1. BACKGROUND

1.1 The Tameside & Glossop Single Commissioning Function (SCF) came into effect from 1 April 2016. To assist the new Single Commissioning Function (SCF) in making robust evidence based decisions a number of requirements need to be met. This report summarises those requirements and the support available to contract and commissioning managers to ensure they discharge their obligation to provide robust and evidential reports to decision makers.

1.2 The three areas covered are:

- Equality and diversity;
- Quality and risk;
- Consultation and engagement (including ongoing patient participation).

1.3 The joint approach outlined in the following sections seeks to provide a standard framework by incorporating and adapting the relevant elements used by the two organisations prior to the establishment of the Single Commissioning Function.

1.4 The substantive documentation will be kept under review and amended to ensure it remains both compliant and effective.

2. CONTEXT

2.1 Summarised below is the context in which equality and diversity, quality and risk and consultation and engagement is undertaken and the obligations on both Tameside Council and NHS Tameside and Glossop CCG. The list is not exhaustive but highlights the key and most relevant aspects.

2.2 Equality and diversity

- Equality Act 2010 – Section 149: Public Sector Equality Duty (PSED):
  - Have due regard to the need to eliminate discrimination; advance equality of opportunity; and foster good relations;
  - Equality objectives;
  - Publication of information.

- Brown Principles – R (Brown) v Secretary of State for Work and Pensions (2008):
  - Decision makers aware of their duty to have due regard;
  - Due regard must be fulfilled before and at the time of decision making;
  - Exercise duty in substance with rigour & open mind;
  - Duty is on public authorities and non-delegable;
  - Duty is continuing;
  - Good practice to keep an adequate record.

2.3 Quality and risk

- Health and Social Care Act 2012 – Section 26 – Duty 14R (NHS Act 2006):
  - Secure continuous improvement in the quality of services provided;
  - Show the effectiveness and safety of services provided and the quality of experience of the patient.

- Health and Social Care Act 2012 – Section 26 – Duty 14S (NHS Act 2006):
  - Assist and support the Board in discharging its duty to secure continuous improvement in the quality of primary medical services.

2.4 Consultation and engagement

- Gunning Principles – R v London Borough of Brent ex parte Gunning (1985):
  - Be undertaken when proposals at a formative stage;
  - Include sufficient reasons for particular proposals to allow those consulted to give intelligent consideration and an intelligent response;
  - Give consultees sufficient time to make a response;
  - Be conscientiously taken into account when the ultimate decision is taken.

- NHS Act 2006 – Section 242:
  - Involve patients and the public in planning services, developing and considering proposals for changes in the way services are provided and decisions to be made that affect how those services operate.

- Health and Social Care Act 2012 – Section 14Z2:
  - Ensure that patients and the public are involved in the planning of services, developing proposals for any changes to services, and the operation of services.

2.5 Undertaking work in these three areas, and producing the necessary impact assessments for both quality and equality, is not optional. It is essential to ensure the contract and commissioning manager is presenting a report to the decision maker that makes him/her/they fully aware of all the impacts and implications of the decision being taken.

3. REQUIREMENTS

3.1 The table below outlines the requirements. Supporting documentation is outlined in the appendices.

	Requirement	Support & advice
Equality & diversity	Undertake an **Equality Impact Assessment (EIA)** using the framework template attached at **Appendix 1**. The completed template should be attached to decision reports to Professional Reference Group (PRG) and Single Commissioning Board (SCB).	Guidance on completion is provided within the template. For further support and advice contact Karen Goodhind or Jody Stewart
Quality & risk	Undertake a **Quality Impact Assessment (QIA)** using the framework template attached at **Appendix 2**. The completed template should be attached to decision reports to Professional Reference Group (PRG) and Single Commissioning Board (SCB).	Guidance on completion is provided within the template. For further support and advice contact Lynn Jackson

Consultation & engagement	Undertake an appropriate level of consultation consummate with the decision being taken. A template does not exist given the varied nature of consultations that take place making a single format for report impractical. However a summary of findings should be appended to the decision report that is presented to Professional Reference Group (PRG) and Single Commissioning Board (SCB).	The '**Toolkit for Engaging with Public, Patients and Service Users in Tameside & Glossop**' provides a guide on how to undertake appropriate consultation and engagement. The toolkit is attached at **Appendix 3**. For further support and advice contact Karen Goodhind or Jody Stewart

3.2 In all three areas above the findings should be summarised in the decision report and the QIA, EIA and consultation / engagement findings appended to the decision report.

3.3 It is incumbent on the relevant service / contract / commissioning manager to undertake and complete the three elements outlined above. Support and advice is available as outlined.

3.4 It is proposed to run a series of workshops for relevant staff on the approach outlined and the need for robust evidential decision making.

3.5 The templates and toolkit above will be kept under regular review to ensure they continue to be fit for purpose and evolve and improve through use and practice.

4. APPENDICES

4.1 The following appendices are attached.

- **Appendix 1** – Equality Impact Assessment (EIA) template
- **Appendix 2** – Quality Impact Assessment (QIA) template
- **Appendix 3** – Toolkit for Engaging with Public, Patients and Service Users in Tameside & Glossop

5. RECOMMENDATIONS

5.1 As set out on the front of the report.

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

Subject / Title	

Team	**Department**	**Directorate**

Start Date	**Completion Date**

Project Lead Officer	
Contract / Commissioning Manager	
Assistant Director/ Director	

EIA Group (lead contact first)	**Job title**	**Service**

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.

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

1a.	**What is the project, proposal or service / contract change?**	
1b.	**What are the main aims of the project, proposal or service / contract change?**	

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				
Disability				
Ethnicity				
Sex / Gender				
Religion or Belief				
Sexual Orientation				
Gender Reassignment				
Pregnancy & Maternity				
Marriage & Civil Partnership				
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health				
Carers				
Military Veterans				
Breast Feeding				
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)*				

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

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**
1e.	**What are your reasons for the decision made at 1d?**		

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

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

2b. Issues to Consider

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

2c. Impact

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
Impact1 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 2 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 3 (Describe)	*Consider options as to what we can do to reduce the impact*
Impact 4 (Describe)	*Consider options as to what we can do to reduce the impact*

2e. Evidence Sources

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

2f. Monitoring progress		
Issue / Action	**Lead officer**	**Timescale**
Required	*Required*	*Required*

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

Guidance below to be removed from the completed EIA template submitted to Professional Reference Group (PRG) and the Single Commissioning Board (SCB)

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

The purpose of an EIA is to aid compliance with the public sector equality duty (section 149 of the Equality Act 2010), which requires that public bodies, in the exercise of their functions, pay 'due regard' to the need to eliminate discrimination, victimisation, and harassment; advance equality of opportunity; and foster good relations. To this end, there are a number of corporately agreed criteria:

- An Equality Impact Assessment (EIA) is required for all formal decisions that involve changes to service delivery. All other changes, whether a formal decision or not, require consideration for the necessity of an EIA.

- The decision as to whether an EIA is required rests with the relevant Project Lead or Contract / Commissioning Manager, in consultation with the appropriate Assistant Director / Director where necessary. Where an EIA is not required, the reason(s) for this must be detailed within the appropriate report by way of a judgement statement.

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

- EIAs must be timely, with any findings as to the impact of a change in policy or procedure which affects residents, the public, service users, patients or staff, being brought to the attention of the decision maker in the body of the main accompanying report. As such, EIAs must be conducted alongside the development of any policy change, with appropriate mitigations integrated into its development where any potentially detrimental or inequitable impact is identified.

How to complete the EIA Form

EIAs should always be carried out by at least 2 people, and as part of the overall approach to a service review or service delivery change. Guidance from case law indicates that judgements arrived at in isolation are not consistent with showing 'due regard' to the necessary equality duties.

Part 1 – Initial Screening

The Initial Screening is a quick and easy process which aims to identify:

- those projects, proposals and service / 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 Assistant Director / Director.

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.

The table below is an example of what part 1c of the screening process may look like. In this example we have used a review of the services delivered at Children's Centres and the impact this may have.

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	✓			Children's Centre services are targeted

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

				to the 0 to 5 age group
Disability		✓		Some Children's Centre users may be disabled
Ethnicity		✓		Children's Centre users come from a range of ethnic backgrounds
Sex / Gender		✓		Children's Centres aren't gender specific but evidence shows service users are predominantly women
Religion or Belief			✓	
Sexual Orientation			✓	
Gender Reassignment			✓	
Pregnancy & Maternity	✓			Children's Centres provide services to pregnant women
Marriage & Civil Partnership			✓	
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health			✓	
Carers		✓		
Military Veterans			✓	
Breast Feeding	✓			Children's Centres provide services to pregnant women and new mothers
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**
Lone Parents		✓		Children's Centre users may include lone parents
Disadvantaged families	✓			Children's Centres support the most disadvantaged families, with an aim to reduce inequalities in child development and school readiness.

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

Part 2 – Full Equality Impact Assessment
If a full EIA is required then part 2 of the EIA form should be completed.

2a. Summary
In this section you should:

- Explain the reason why the EIA was undertaken i.e. the main drivers such as a change in policy or legislation etc. This can be a combination of factors.
- Outline what the proposals are
- Summarise the main findings of the EIA - what are the main impacts of the change in policy and what protected characteristic groups do they effect?
- Summarise what measures have been put in place to mitigate any negative impact and how the success of these measures will be monitored

It may be useful to complete this section towards the end of the EIA process.

2b. Issues to Consider

In this section you should give details of the issues you have taken into consideration when coming to your proposals / recommendations and outline the protected characteristic group(s) affected - Age, Ethnicity, Disability, Gender, Sexual Orientation, Religion / Belief, Gender Reassignment, Pregnancy/Maternity, Marriage/Civil Partnership, and how people associated with someone with a particular characteristic (i.e. a carer of a disabled and / or elderly person may be affected (you can refer to the information in 1c identifying those groups who may be affected).

Considerations should include (but are not limited to):-

- Legislative drivers. How have you considered the Equality Act, and the elimination of discrimination, victimisation and harassment, and the three arms of the PSED in coming to a decision / set of proposals i.e. the need to take into account the specific needs of disabled people above and beyond the general needs of other service users? You should consider similar circumstances where a similar service has been provided and changed, and whether this has been challenged. What rules / laws was it challenged under, and what lessons have you taken from this? This can include things such as Judicial Reviews or cases considered by the relevant Ombudsman.

- Comparative data and examples of learning from other areas / benchmarking (linked to legal issues as above)

- Financial considerations. How have your recommendation / proposals been shaped by finances / resources available (please note –legal rulings have indicated that the need to make savings alone is not likely to be deemed sufficient on its own to justify reduction in services – evidence of assessment of impact is required to ensure a safe and sound decision)

- Service user information. What information do you hold about service users and patients and their protected characteristics? How does this compare to comparative data i.e. national / regional picture?

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

- Consultation, engagement & feedback. What work has been done to ensure interested parties have been made aware of proposed changes, and that comments have been recorded and have the opportunity to influence the final decision? You should detail when consultation took place, those involved i.e. staff, service users, timescales. Any consultation should be timely in order to ensure that all participants are able to contribute fully.

2c. Impact

Use this section to outline what the impact of the changes being proposed is likely to be based on the evidence, and consultation & engagement? Will there be a disproportionate impact on a particular group/s? Does the evidence indicate that a particular group is not benefiting from the service as anticipated? What are the uptake / participation rates amongst groups? Where a greater impact on a particular group is recorded, is this consistent with the policy's aims? Does the project, proposal and service / contract change include provision for addressing inequality of delivery / provision?

Try to distinguish clearly between any negative impacts that are or could be unlawful (which can never be justified) and negative impacts that may create disadvantage for some groups but can be justified overall (with explanation). Similarly, does the evidence point to areas of good practice that require safeguarding? How will this be done?

2d. Mitigations

Where any potential impacts have been identified as a result of the EIA, you should detail here what can be done to reduce or mitigate these.

2e. Evidence Sources

Use this section to list all sources of information that the EIA draws upon. Evidence can include surveys & questionnaires, policy papers, minutes of meetings, specific service user consultation exercises, interviews etc

NB – this section is <u>not</u> asking you to give details of your findings from these sources, just the sources from which evidence and considerations were drawn.

2f. Monitoring Progress

Use this section to identify any ongoing issues raised by the EIA, how these will be monitored, who is the lead officer responsible and expected timescale.

Sign Off

Once the EIA is complete this should be signed off by the relevant Contract / Commissioning Manager and the Assistant Director / Director.

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside
Metropolitan Borough

Quality Impact Assessment

September 2016

Overview

The tool supports commissioners to assess the potential impact on quality of any new commissioning intention / decision.

Commissioning leads should undertake an initial screening assessment on all new projects to identify any potential impacts on quality, from any proposed changes to the way services are commissioned or delivered.

Where a potential negative impact is identified the potential level of risk should be calculated using the 'calculating impact tool'.

The likelihood of the risk occurring (risk score) should then be calculated for each potential impact using the 'risk matrix tool'.

The risk score will then indicate the overall level of risk which should be recorded in the screening tool.

All completed quality impact assessments must be signed and dated by the person carrying out the assessment

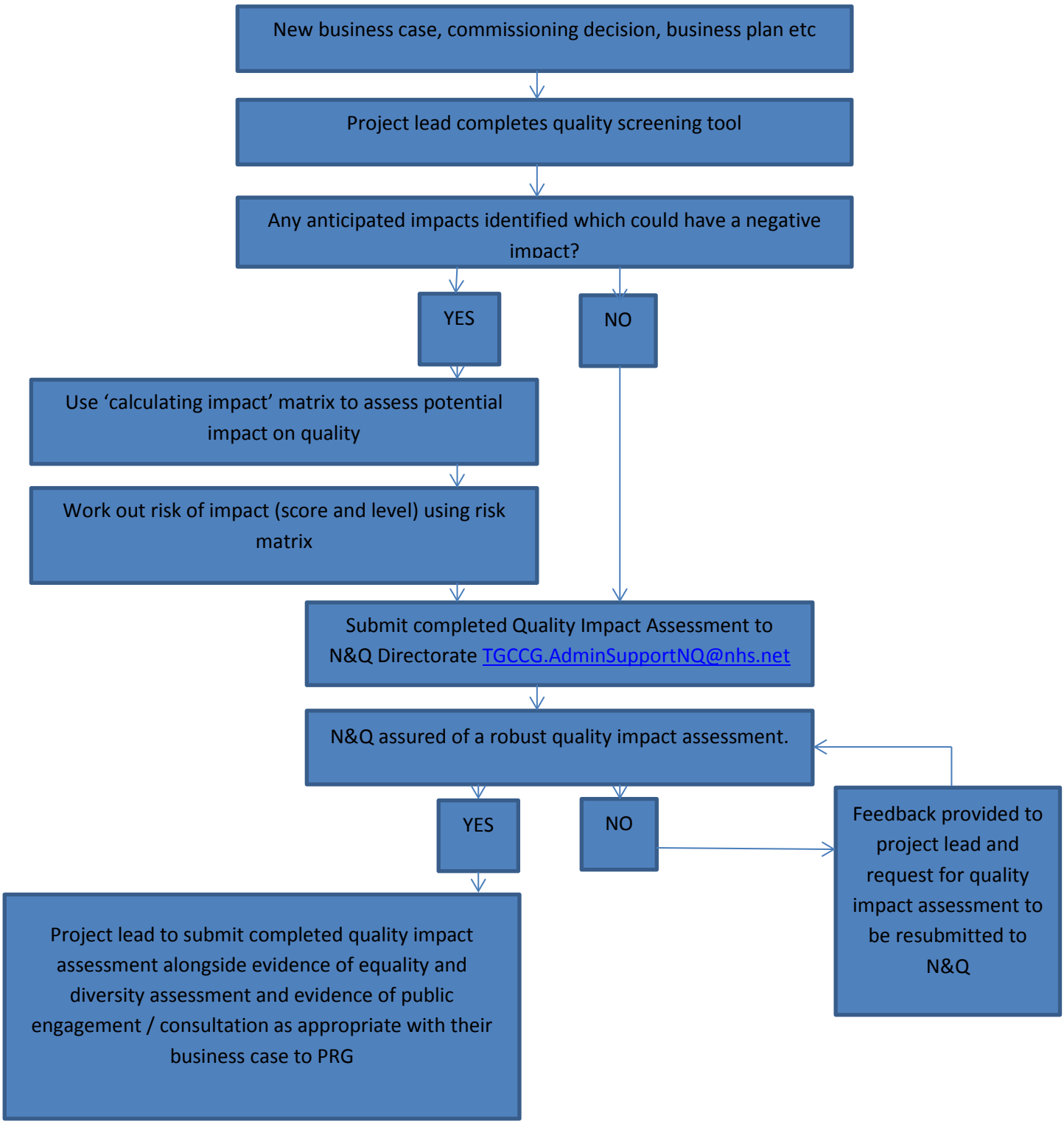
All completed quality impact assessments must be submitted to the Director of Nursing and Quality and their team for final sign off

All business cases submitted to PRG must be accompanied by a completed quality impact assessment.

All proposals containing HIGH level of risk should be clearly highlighted to enable further scrutiny at PRG and a decision as to whether risks are added to corporate risk register as appropriate

Approved cases should be monitored for risks during implementation and post implementation for changes

Quality Impact Assessment Process



Quality Impact Assessment:

Title of scheme:

Project Lead for scheme:

Brief description of scheme:

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.							What is the likelihood of risk occurring?						What is the overall risk score (impact x likelihood)			Comments
	Neutral / Positive Impact	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	Low	Moderate	High	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	
Patient Safety																
Clinical																

effectiveness															
Patient experience															
Safeguarding children or adults															

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**
	Neutral / Positive Impact	Negligible	Minor	Moderate	Major	Catastrophic	No risk identified	Rare	Unlikely	Possibly	Likely	Almost certain	**Low**	**Moderate**	**High**	
	0	1	2	3	4	5	0	1	2	3	4	5	0-5	6-12	15-25	

Human resources/ organisational development/ staffing/ competence															
Statutory duty/ inspections															
Adverse publicity/ reputation															
Finance															
Service/business interruption															
Environmental impact															
Compliance with NHS Constitution															
Partnerships															

Public Choice	0						0						0			No negative impact on quality anticipated; the service will enable appointments to be made outside traditional working hours and at different locations which will provide more choice and convenience. The service will offer choice for consultant activity.
Public Access	0						0						0			No negative impact on quality anticipated The service will enable appointments to be made outside traditional working hours and at different locations

Has an equality analysis assessment been completed?	YES / NO	Please submit to PRG alongside this assessment
Is there evidence of appropriate public engagement / consultation?	YES / NO	Please submit to PRG alongside this assessment

Sign off:

Quality Impact assessment completed by	
Position	
Signature	
Date	

Nursing and Quality Directorate Review	
Name	
Position	
Signature	
Date	

Appendix 1: Calculate the anticipated impact

When calculating the potential impact you should choose the most appropriate domain for the identified risk from the left hand side of the table then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5 (at the top of the column) to determine the anticipated impact score.

NB the narrative within the domains are neither prescriptive nor exhaustive; they should be used to guide judgement about level of impact.

IMPACT	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality – safety, clinical effectiveness and experience of services.	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention	Major injury leading to long-term incapacity/disability	Incident leading to death
	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

IMPACT	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality – safety, clinical effectiveness and experience of services	Peripheral element of treatment suboptimal	Overall treatment suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or effectiveness of treatment
	Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints/ independent review Low performance rating Critical report	Gross failure of experience if findings not acted on inquest/ombudsman inquiry Gross failure to meet national standards
	No time off work	Requiring time off work for >3 days	Requiring time off work for 4-14 days	Requiring time off work for >14 days	Multiple permanent injuries or irreversible health effects
		Increase in length of hospital stay by 1-3 days	Increase in length of hospital stay by 4-15 days	Increase in length of hospital stay by >15 days	An event which impacts on a large number of patients
			RIDDOR/agency reportable incident	Mismanagement of patient care with long-term effects	

IMPACT	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
			An event which impacts on a small number of patients		
	Peripheral element of treatment or service suboptimal	Overall treatment or service suboptimal	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients if unresolved	Totally unacceptable level or quality of treatment/service
	Informal complaint/ inquiry	Formal complaint (stage 1)	Formal complaint (stage 2) complaint	Multiple complaints/ independent review	Gross failure of patient safety if findings not acted on
		Local resolution	Local resolution (with potential to go to independent review)	Low performance rating	Inquest/ombudsman inquiry
		Single failure to meet internal standards	Repeated failure to meet internal standards	Critical report	Gross failure to meet national standards

IMPACT	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Medium term low staffing level / high dependency of agency / temporary staff that reduces services quality >1 day	Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/service due to lack of staff
				Unsafe staffing level or competence (>5 days)	Ongoing unsafe staffing levels or competence
			Low staff morale	Loss of key staff	Loss of several key staff
			Poor staff attendance for mandatory/key training	Very low staff morale	No staff attending mandatory training /key training on an ongoing basis
				No staff attending mandatory/ key training	
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation	Single breech in statutory duty	Enforcement action	Multiple breeches in statutory duty
		Reduced performance rating if unresolved	Challenging external recommendations/ improvement notice	Multiple breeches in statutory duty	Prosecution
				Improvement notices	Complete systems change required

				Low performance rating	Zero performance rating
				Critical report	Severely critical report
IMPACT	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity/ reputation	Rumours	Local media coverage –	Local media coverage –	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)
	Potential for public concern	short-term reduction in public confidence	long-term reduction in public confidence	Major and long term loss of public confidence	Total loss of public confidence
		Elements of public expectation not being met			
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 % over project budget	5–10 % over project budget	Non-compliance with national requirements 10–25 % over project budget	Incident leading >25% over project budget

		Schedule slippage	Schedule slippage	Schedule slippage	Schedule slippage
				Key objectives not met	Key objectives not met
IMPACT	**1**	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance including claims	Small loss Risk of claim remote	Loss of 0.1-0.25 per cent of budget	Loss of 0.25-0.5 per cent of budget	Uncertain delivery of key objective/service due to lack of staff	Non-delivery of key objective/ Loss of >1 per cent of budget
		Claim less than £10,000	Claim(s) between £10,000 and £100,000	Claim(s) between £100,000 and £1 million	Failure to meet specification/slippage
				Purchasers failing to pay on time	Loss of contract/payment be results
					Claim(s)>£1 million
Service/business interruption	Loss/interruption of >1 hour	Loss/interruption of >8 hours	Loss/interruption of >1 day	Loss/interruption of >1 week	Permanent loss of service or facility
Environmental impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment

Appendix 2: Calculate how likely the risk is to happen (likelihood)

Now work out the likelihood score. Look at the frequency and probability columns and identify which best describe how often you think the risk is likely to occur. Now make a note of the corresponding 'risk score' (1-5 in the right hand column).

Likelihood	Description	Risk Score
Almost Certain	Will undoubtedly occur, possibly frequently	**5**
Likely	Will probably occur but it is not a persistent issue	**4**
Possible	May occur occasionally	**3**
Unlikely	Do no expect it to happen but it is possible	**2**
Rare	Cannot believe that this will ever happen	**1**

Appendix 3: Calculate risk score: An overall risk score is achieved by assessing the level of impact and the likelihood of this occurring and assigning a score to each. These scores are then multiplied to reach an overall risk score.

Risk Score = Impact x Likelihood - The following table defines the impact and likelihood scoring options and the resulting score.

CONSEQUENCE OR IMPACT	LIKELIHOOD					
		1	2	3	4	5
	1	1	2	3	4	5
	2	2	4	6	8	10
	3	3	6	9	12	15
	4	4	8	12	16	20
	5	5	10	15	20	25

Determine Level of Risk.

LOW RISK = 1-5	**MODERATE RISK – 6-12**	**HIGH RISK – 15-25**

Clearly record level of risk in completed impact assessment ensuring all HIGH risks are clearly highlighted for further scrutiny at PRG and consider adding risk to corporate risk register as appropriate.

NHS
Tameside and Glossop
Clinical Commissioning Group

Tameside
Metropolitan Borough

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Single Commissioning Function:
NHS Tameside and Glossop Clinical Commissioning Group and Tameside Metropolitan Borough Council

NOVEMBER 2016

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Introduction

NHS Tameside and Glossop Clinical Commissioning Group (T&G CCG) and commissioners at Tameside Metropolitan Borough Council (TMBC) have recently come together to create a Single Commissioning Function (SCF). The Single Commissioning Function is committed to involving members of the public, patients and service users in the way it shapes and commissions its services.

Engagement and / or consultation with the public, patients and service users is necessary where the aspects identified below are changing, or when there will be some impact as a result of a policy, project or proposal being implemented:

- Thresholds, triggers and entitlement to receive services
- Physical location of services or method of access to services
- Types of equipment, adaptations, treatments or therapies provided
- Length of time or frequency services and treatments are provided for

NHS Policy also enshrines the duty of the SCF to ensure public, patients and service users are involved and consulted with, in the commissioning of services.

The relevant statutory provisions are incorporated in the following documents:

- The Health and Social Care Act 2012
- The Equality Act 2010
- The NHS Constitution
- Domain 2 of the CCGs authorisation process

This toolkit provides templates and practical advice on how to go about public engagement and consultation to make it an integral part of health and social care commissioning at all levels. It has been written to provide guidance for anyone who needs to engage with the public about health and social care related issues.

Section One will help you to identify if you **need to engage** with public/patients and will help you identify who your key **stakeholders** might be

Section Two will help you identify the purpose of your engagement and assess the different **types of engagement** you can use to get input from public/patients

Section Three will provide you with checklists for **planning** your engagement activity, which includes timescales and event/venue considerations

Section Four will provide you with guidance on **analysing data and feedback** from your engagement activity

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Section One – Identifying the need to engage and who to engage with

Name of project you plan to undertake	
Champion/responsible lead	
What are the main aims of your engagement project?	
Do you need to involve patients/public?	
Are you planning health and social care service provision?	*e.g. developing the strategic plan from the SCFs budget*
Are you developing/considering changes in the way a health and social care service is provided?	*e.g. closing a service, reducing a service, moving a service, starting a new service*
Would the implementation of your plans impact on the way services are delivered?	*e.g. move the location of a service*
Would the implementation impact on the range of services available?	*e.g. change the criteria for referral/change how public/patients access the service*
Are you taking a decision that will affect the operation of the service/s	*e.g. cutting the budget*
Would the decision being made impact on the way services are delivered?	*e.g. the service may now only be open in the morning*
Would the decision impact on the range of services available	*e.g. reduction in service provision/providers*
If you have answered YES to ANY OF the questions above you will need to involve public/patients. Go to next section (Scale of Involvement) to help you plan the timescales and type of engagement you need to plan	
SCALE OF INVOLVEMENT	

Where public involvement is required, any arrangements must be ***fair*** and ***proportionate***.

Fair
The courts have established guiding principles for what constitutes a fair consultation exercise. These principles (known as the *Gunning* principles) were developed by the courts within the context of what constitutes a fair *consultation* and will not apply to every type of public involvement activity. However, they will still be informative when making plans to involve the public.
The *Gunning* principles are that the consultation:
✓ Takes place at a time when proposals are still at a formative stage. If involvement is to be meaningful, it should take place typically at an early stage. However, it is often permissible to consult on a preferred option or decision in principle, so long as there is a genuine opportunity for the public to influence the final decision.
✓ Gives the public sufficient information and reasons for any proposal to allow the public to consider and respond.
✓ Allow adequate time for the public to consider and respond before a final decision is made.
✓ The product of the public involvement exercise must be conscientiously taken into account in making a final decision.

Proportionate
As a general rule, the greater the extent of changes and number of people affected, the greater the level of activity that is likely to be necessary to achieve an appropriate level of public involvement. However, the nature and extent of public involvement required will always depend on the specific circumstances of an individual commissioning process.

Although 12 weeks is often cited as the advisory standard period for consultations, there may be

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

some cases where a shorter period is adequate.

Additional information on patient and public participation can be found in the Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning www.england.nhs.uk/wp-content/uploads/2015/11/ppp-policy-statement.pdf.

Likewise, the government has published a revised set of government consultation principles. These principles give clear guidance to government departments on conducting consultations and can be found at www.gov.uk/government/uploads/system/uploads/attachment_data/file/492132/20160111_Consultation_principles_final.pdf

For further advice, speak to the SCF's Policy, Communications and Engagement Team:
Karen Goodhind (Head of Communication & Engagement – Tameside & Glossop CCG)
karen.goodhind@nhs.net
or
Jody Stewart (Policy, Research & Improvement Manager – Tameside MBC)
jody.stewart@tameside.gov.uk

STAKEHOLDERS

You will now need to identify who you need to engage with, it may help you to talk this through with the Policy, Communications and Engagement Team but the following questions will help you in your thought process. It should be noted that the suggestions below are not exhaustive lists and it may be appropriate for you to engage other individuals / groups depending on your proposal, policy or service change:

Who is likely to be affected by this change?	➢ Patients ➢ Service users ➢ Carers ➢ Wider public ➢ Disabled people ➢ Men ➢ Women ➢ Older people ➢ Younger people ➢ Ethnic minority groups ➢ Lesbian/gay/bisexual people ➢ Transgender groups ➢ Religious minorities ➢ Pregnant women ➢ Military veterans ➢ Those on a low income
Are there any local groups that are likely to be impacted by the change and could give you advice?	➢ Healthwatch (Tameside and/or Derbyshire) ➢ Equality and Diversity Group (EDG) ➢ Patient Participation Groups (Tameside and Glossop) ➢ Patient Neighbourhood Groups (Tameside and Glossop) ➢ Patient Network ➢ Tameside Carers Forum ➢ Action Tameside ➢ High Peak CVS ➢ Glossop Volunteer Centre ➢ Age UK Tameside ➢ MIND ➢ Tameside Carers

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

	➢ Derbyshire Carers ➢ Tameside Sight ➢ Glossop Visually Impaired Group ➢ Mental Health service user groups ➢ Learning disability groups (People First Tameside) ➢ Lesbian and Gay Foundation ➢ Town Councils ➢ Town Teams ➢ Residents Associations ➢ Specific interest groups e.g. Youth Council, Hyde Community Action, Cranberries ➢ Derbyshire County Council
Within the SCF and / or ICFT whose work may be directly affected by the change?	➢ GPs making referrals into the service ➢ Service Providers ➢ Pharmacies ➢ Opticians ➢ Social Care team ➢ Staff working in the service ➢ SCF and / or ICFT employees
Please identify the stakeholders you wish to involve:	

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Getting started

This section will help you when completing section two of the toolkit.

There are a range of approaches that you can take to engage with public, patients and service users in the work of the SCF. Below are just a few of the possible reasons for engaging which will support and guide you to choose the type of engagement to undertake:

- to inspire public, patients and service users to take an interest in the project you are working on
- to disseminate the results of any research you may have undertaken
- to engage with public, patients and service users to ask for their views about your specific project
- to communicate with the public, patients and service users to help them to understand the work of the SCF
- to collaborate with the public, patients and service users in developing and running a project or activity

There are also different types of ways in which people might participate in health and social care depending upon their personal circumstances and interest.

The 'Ladder of Engagement and Participation' is a widely recognised model for understanding different types of public, patient and service user engagement. The ladder of engagement is based on the work of Sherry Arnstein (1969). The ladder explains how public, patient and service user engagement is valuable. Arnstein does not suggest that one type of engagement is better than any other but that depending on the purpose of your engagement, different levels are suited to different things in order to meet the expectations of different interests.

Sherry Arnstein's ladder is available in full here

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Below are the different levels of participation which will be useful in helping you decide the type of your engagement activity you would like to undertake:

Devolving	Placing decision-making in the hands of public, patients and service users e.g. Personal Health Budgets or a community development approach
Collaborating	Working in partnership with public, patients and service users in each aspect of the decision making process, including the development of alternatives and identifying preferred solutions
Involving	Working directly with public, patients and service users to ensure that concerns and aspirations understood and considered e.g. partnership boards, reference group and public/patients participating in policy groups
Consulting	Getting feedback from public, patients and service users on analysis, alternatives and/or decisions, e.g. surveys/focus groups/events etc., and using the feedback to influence the way in which services are delivered.
Informing	Giving public, patients and service users balanced and objective information to assist them in understanding

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Section Two – Purpose of engagement and deciding which type of activity to undertake

Types of engagement activity	
There are a range of different types of engagement you can use to get input from public, patients, service users and internal stakeholders. The type of engagement you undertake should be linked to the scale of your engagement and the best methods for the stakeholders you would like to reach. It is crucial that the chosen method allows you to achieve your objectives whilst being suitable for your target audience. This could mean using a combination of approaches or concentrating on one in particular. You will need to decide at this stage whether you require quantitative or qualitative research, or a combination of both. **Quantitative Research** – this is used for less complex issues and aims to measure people's views or perceptions. Quantitative methods may be preferred as statistical tests can be applied to the results to demonstrate robustness. However, their very structured format means that respondents are unable to raise additional topics and only limited information can be gathered in response to each question. **Qualitative Research** – this is used for issues that need to be explored in more depth. Qualitative research is often carried out in the form of focus groups. Although the outputs may not be as statistically reliable, this method gives participants the opportunity to discuss topics in further detail. Qualitative research can be invaluable in coming to a full understanding of what people really think of a particular issue. If selecting this method, it is important to ensure skilled moderators are in place to ensure effective and meaningful results. It should be noted that the methods outlined below are not exhaustive and it may be appropriate for you to engage using alternative methods depending on your proposal, policy or service change.	
What engagement methods do you plan to use?	➢ Information leaflets ➢ Existing patient experience feedback e.g. complaints data/patient opinion ➢ Patient stories ➢ Online survey ➢ Paper survey ➢ Face to face survey ➢ Presentation at a local group meeting ➢ Information stall at a local event ➢ Public event ➢ Focus group ➢ Workshop ➢ Interviews/case studies ➢ Publication of a formal document for comment ➢ Citizens Panel ➢ Roadshows ➢ Exhibitions ➢ Participatory Budgeting
How do you plan to inform people of your engagement activity and your plans?	➢ Put a survey/information on the CCG and/or TMBC website ➢ Send a link of your survey to local groups ➢ Communication to relevant stakeholders

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

	➢ Copies of surveys in relevant venues e.g. GP practices, customer service points ➢ Social media includingTwitter, Facebook and Instagram ➢ You Tube ➢ Radio ➢ Press release ➢ Newspaper ➢ Posters (in practices/pharmacies/libraries etc.)
Please identify the type of engagement activity you plan to undertake:	

For advice, speak to the SCF's Policy, Communications and Engagement Team:

Karen Goodhind (Head of Communication & Engagement – Tameside & Glossop CCG)
karen.goodhind@nhs.net

or

Jody Stewart (Policy, Research & Improvement Manager – Tameside MBC)
jody.stewart@tameside.gov.uk

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Section Three – Planning your engagement activity

The next section provides you with checklists to help you plan each engagement activity

Ask yourself	Consider
Who is your correct audience?	**Do you need to refine your draft list from Section One?**
What are the protected characteristics of the people you will engage with? e.g. BME group/visually impaired groups etc.	**If you are engaging with protected characteristic groups what approaches are more likely to engage them?**
How will you engage with your audience?	• **Personal invitation** • **Existing relationships with individuals and groups** • **Through an intermediary organisation (especially for hard to reach groups)** • **Leaflets/adverts/online channels/email** • **If engaging via survey, will you need to recruit a good cross sample to ensure that your engagement is robust**
What are your objectives for engaging with public/patients?	**Are any aspects of your engagement activity 'a given' e.g. NICE guidance/legal or contractual requirement/directive from NHS England which you might want to inform people about from the beginning?** **For other aspects of your engagement activity are you looking to:** • **Raise awareness of your project** • **Influence behaviour** • **Gather data** • **Understand people's perceptions** • **Seek advice** • **Gather opinion and jointly develop something new**
How much preparation do you need to put into your message?	**From the very beginning when proposals are in their formative stages public, patients and service users will need to understand what you want to engage with them about, what you are asking them and what you will do with the results from your engagement activity. Public, patients and service users will need background information to help them make sense of what you are trying to engage with them about.** **It would be useful to spend time at the**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

	beginning preparing a clear and concise brief which can be worked through with the SCF's Policy, Communications and Engagement Team. This will avoid confused messages and misconception from the beginning of your engagement activity.
What methods should I use to engage with the audience?	**For guidance see Section Two of the toolkit**
When should the engagement start/end?	**Build in time to plan, run and analyse the feedback from your engagement activity** **Make allowances in your timescales that key participants will need time if they are to attend/commit to your engagement activity** **i.e. as a general rule a lead time of AT LEAST four weeks should be given to promote any type of engagement activity**
How will you communicate the opportunity to engage and/or report the outcomes of your engagement?	**See section two**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Designing a Questionnaire

Ask yourself	Consider
What are you trying to find out?	**What kind of information do you want to gather from your questionnaire?** **A good questionnaire is designed so that your results will tell you what you want to find out.** **Start by writing down what you are trying to do in a few clear sentences, and design your questionnaire around this.**
How are you going to use the information?	**There is no point conducting research if the results are not going to be used – make sure you know why you are asking the questions in the first place.**
Who are your target audience?	**Is there a certain group of people who you want to target with your questionnaire? If a service change, policy or proposal will impact on a particular group of people you will need to engage directly with them in addition to the wider population.**
What question type or types do you want to include?	**Depending on the information you wish to gather, there are several possible types of questions to include on your questionnaire, each with unique positives and negatives. These include:** • **Closed questions e.g. yes/no, agree/disagree** • **Open ended questions** • **Multiple choice questions** • **Rank-order scale questions** • **Rating scale questions**
How long should the questionnaire be?	**Keep your questionnaire as short as possible. More people will be likely to answer a shorter questionnaire, so make sure you keep it as concise as possible while still collecting the necessary information.**
How will the questionnaire be carried out?	**There are many methods used to ask questions, each with their own positives and negatives e.g. postal surveys can result in low response rates and take a long time to receive but will reach a wider audience, face-to-face can be resource intensive but will generate the fullest responses, web surveys can be cost-**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

	effective but may not be accessible by everyone. It is important to consider who your target audience is when deciding how to carry out the questionnaire. A mixed method may be required.
Have you explained the purpose of the questionnaire?	**Many people will not answer a questionnaire without understanding what the goal of the questionnaire is. Explain what the purpose is and how the information respondents provide will be used.**
How will you record the demographics of respondents?	**Make sure you cover everything you will need when it comes to analysing the answers. e.g. maybe you want to compare answers given by men and women or different age groups. You can only do this if you have remembered to record the gender and age of each respondent on the questionnaire.**
What is the deadline for your research?	**Ask respondents to have the questionnaire completed and returned to you by a certain date to ensure that you have enough time to analyse the results. Ensure the time scale for consultation is proportionate to the service change, policy or proposal you are consulting on.**
Have you tested the questionnaire?	**No matter how much time and effort you put into designing your questionnaire, there is no substitute for testing it. Complete some interviews with your colleagues BEFORE you ask the real respondents. This will allow you to time your questionnaire, make any final changes and get feedback from your colleagues.**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Event and venue checklist

Ask yourself	Consider
What venue will you choose?	**Use a venue that is recognised by public/patients as an accessible venue e.g. steps/lifts/door width and other accessibility issues to be considered** **Make sure you have considered the option of two venue choices, one in Tameside and one in Glossop**
Can everyone get to the venue?	**The distance people will need to travel and what is their means of travel. Location of bus stops/car parks and drop off points near to the venue**
Is the venue acceptable to everyone?	**Temperature, posture, ambience for long sessions, taking account of people's physical and mental conditions** **Ease of moving around at the venue – corridors, break out rooms, toilets etc.** **If you are paying for a commercial venue, you should be able to rely on the expertise of staff at the venue who will be able to help you with any problems that may arise**
Is your event being held on a day or time that suits those who you want to reach?	**Holding your event on a certain day or at a time that suits participants will not only be better for people who are attending but will provide you with better outcomes from your engagement activity**
How do you want your event to look and feel on the day?	**When booking your venue make sure that you have considered the following:** • **Size of room (make sure your room is neither too big/small for the number of participants)** • **Roving microphones** • **Hearing loops** • **Laptops which include sound** • **Presentation Screen** • **Table layout**
Catering	**Catering can be considered if this is at no cost to the public purse.** **Hot drinks and biscuits on arrival may put people at ease, especially if getting there has been an effort.** **For longer events, consider extra**

	refreshments or if the event is running over a mealtime e.g. lunch/dinner consider providing sandwiches
Running your engagement event	
Have you got all the practical details in place?	• **Participants identified and briefed in good time** • **Venue and equipment booked** • **Laptops/table layout/podiums etc., are all up and running and checked to make sure they are working properly** • **Interpreters and signers (if required) are on hand** • **Papers, hand-outs and other materials are ready in sufficient quantity**
Have you asked participants for their permission to be filmed and/or photographed during the event?	**Photography consent forms can be found in appendix 1 of the toolkit**
Have you prepared attendance sheets for participants to sign in upon arrival	**A standard attendance sheet template can be found in appendix 2 of the toolkit**
Is your event working?	• **Do people understand what you are telling them or do they appear confused?** • **Evaluate early – what do participants think of the engagement so far, use this feedback to tweak the process as you go along** • **Are you covering the issues you need to cover?** • **Is your event overrunning, are people getting left behind or getting too far ahead – check at this point as participants may start to disengage if they have to wait for others to catch up.** • **Evaluate verbally at the end, from your own viewpoint and the viewpoint of the participants**
Have you ask participants to evaluate your event?	**A standard evaluation template can be found in appendix 3 of the toolkit**
Have you asked participants how they would like you to feedback back to them after the event?	• **Agree with participants a timescale for feedback** • **Agree with participants mechanisms for feedback**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Section Four – Analysis and feedback

Analysis & Feedback

Ask	Consider
How will you process the feedback?	• **Quantitative analysis** • **Qualitative analysis**
How will you present the feedback?	• **Charts or diagrams** • **Tables of data** • **Text, quotes, facilitators commentary** • **On paper in the form or a report, online, as a live talk, in a video or as a story?**
What support and resources will you need?	• **Any administrative support for collating and organising the feedback** • **Time and capacity for mapping and understanding the feedback**
What conclusions can you draw from the feedback?	**What story does the feedback tell?** **What does the feedback say about:** • **The current position** • **Future needs** • **Opportunities for better outcomes or to lower costs (or both)** • **The likelihood of drawing a successful conclusion**
Can we rely on the feedback as a sound basis for decision making	**How your feedback can be captured in your business case in a "You said, we did" format**

Speak to the Policy, Communications and Engagement Team : Karen Goodhind (Head of Communications & Engagement – Tameside & Glossop CCG) karen.goodhind@nhs.net or Jody Stewart (Policy, Research & Improvement Manager – Tameside MBC) jody.stewart@tameside.gov.uk
SIGN OFF YOUR PLAN
A copy of this activity plan should be sent to the Head of Communications and Engagement: karen.goodhind@nhs.net for direct approval
Date of approval
RECAP / NEXT STEPS • **Engage** • **Analyse** • **Include the recommendations from the engagement / consultation activity into your business case** • **Present your recommendations at the SCF's Public & Patient Impact Committee (PPIC)**

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

PHOTOGRAPHY CONSENT FORMS – INDIVIDUAL AND SCHOOL/GROUPS

- The Single Commissioning Function requires signed consent from all individuals clearly identifiable in a photograph (unless it is a crowd shot in a public place).
- Obtaining this consent is as important as taking the photograph as we will not be able to use the image without it.
- Responsibility for obtaining the signed consent lies with the photographer commissioned to do the work.
- When briefing people being photographed about the consent, it is important they understand that the consent is not time limited and similarly the images may be used in the future for other campaigns and via all media (eg social media, hoardings, publications etc).
- A disk or a link to a file storage site is needed the day following the photography at the latest to ensure the images are available for use asap.
- All consent forms are needed either in hard copy or scanned and emailed by the following day also – otherwise we cannot use the images.

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

Photography Consent Form

Office use - Photo ID No:

Under the Data Protection Act 1998 we need you to give your permission by completing this form for the Single Commissioning Function (Tameside and Glossop CCG and Tameside MBC) to use these images for all promotional purposes. This may include: printed publications, adverts, audiovisual and electronic materials, media work, display materials, social media and any other media we may use in the future.

Title of photography shoot/event	
Date	
Description and location of photograph(s)	

A seperate consent form must be filled out for each individual of a different residing address.
Please print names in BLOCK CAPITALS.
If individual is under 18 years of age, the named parent/guardian should sign the consent.

Name of individual	Name of parent/guardian if individual is under 18 years old	Signature of consent

Address	
Contact number	

Please note that the terms and conditions for use of these images are on the back of this form.

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Tameside Metropolitan Borough

NHS Tameside and Glossop Clinical Commissioning Group

School/Group Photography Consent Form

Office use - Photo ID No:

Under the Data Protection Act 1998 we need you to give your permission by completing this form for the Single Commissioning Function (Tameside and Glossop CCG and Tameside MBC) to use these images for all promotional purposes. This may include: printed publications, adverts, audiovisual and electronic materials, media work, display materials, social media and any other media we may use in the future.

Title of photography shoot/event	
Date	
Description and location of photograph(s)	

Please print names in BLOCK CAPITALS.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

School/Group Name	
Address	
Contact number	

Headteacher/Group Leader
I have checked parents are happy for their children's images to be used for promotional purposes.

Signed _____

Print Name _____

Date _____

Please note that the terms and conditions for use of these images are on the back of this form.

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

Terms and conditions of use

- Signed consent continues with no time limit - Images will be stored and can be used for any future promotional purposes.
- Once images are published and in the public domain consent cannot be removed.
- We will not include details or full names (which means first name and surname) of any child or adult in an image on video, on our website, or in printed publications, without good reason. For example, we may include the full name of a competition prize winner, however we will not include the full name of a model used in promotional literature.
- We may use group or class images with very general labels, such as “a science lesson” or “making Christmas decorations”.
- We will only use images of pupils who are suitably dressed, to reduce the risk of such images being used inappropriately.

Please note - Websites and social media can be viewed throughout the world and not just in the UK where UK law applies.

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

ATTENDANCE SHEET

Name of event/meeting: _____

Date _____

Print name in full	Representing organisation (if applicable)	Signature

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

EVENT/MEETING EVALUATION FORM

Event name _____

Location _____

Date_____

In order for Tameside and Glossop Single Commissioning Function to improve on any future events we would like to have your feedback about today's event and future meetings. Please help us by completing the following information:

	Excellent	Good	Fair	Poor
What were your overall feelings of the event?				
How would you rate the location of the event?				
How did you rate the quality of the information you were given before and during the event?				
Were you given enough time to register onto the event to enable you to plan in advance?				
How did you rate the overall performance of the speakers?				
How did you rate the overall subject knowledge of the speakers?				

Overall, how did the event meet your expectations on a scale of 1-5 (1 being the lowest, 5 the highest – please tick as appropriate:

1 2 3 4 5

Please explain why_____

TOOLKIT FOR ENGAGING WITH PUBLIC, PATIENTS AND SERVICE USERS IN TAMESIDE AND GLOSSOP

On a scale of 1 to 5 do you think you were listened to during the group discussions and that your points of view were valued? (1 being the lowest score and 5 being the highest) – please tick as appropriate:

1 2 3 4 5

Other information (please add any comments below that you think we would find useful for the future in helping us improve the way we engage with public/patients:

_____
_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete the evaluation form your comments are valuable to us!

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