SINGLE COMMISSIONING BOARD

Day: Tuesday
Date: 14 February 2017
Time: 3.00 pm
Place: George Hatton 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 17 January 2017.	1 - 10
4.	**FINANCIAL CONTEXT**	
a)	**FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND** To consider the attached report of the Director of Finance, Single Commission.	11 - 36
5.	**QUALITY CONTEXT**	
a)	**PERFORMANCE REPORT** To consider the attached report of the Director of Public Health and Performance.	37 - 72
6.	**COMMISSIONING FOR REFORM**	
a)	**ROLE OF STRATEGIC COMMISSIONING - TAMESIDE AND GLOSSOP COMMISSIONING FUNCTION** To consider the attached report of the Director of Commissioning.	73 - 82
b)	**CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH LOCAL TRANSFORMATION PLAN UPDATE** To consider the attached report of the Director of Commissioning.	83 - 112
c)	**ATRIAL FIBRILLATION PATHWAY AND COMMUNICATIONS STRATEGY** To consider the attached report of the Director of Commissioning.	113 - 130
d)	**NHS RIGHT CARE PROGRAMME** To consider the attached report of the Director of Commissioning.	131 - 138
e)	**COMMUNITY HEALTH CHECKS CONTRACTS EXTENSION** To consider the attached report of the Director of Public Health and Performance.	139 - 148

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.

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f) WOMEN AND FAMILIES CENTRE 149 - 172

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

g) INCREASE IN NURSING HOME FEES TO REFLECT FUNDED NURSING CARE UPLIFT

To consider the attached report of the Executive Director (People).

FOR INFORMATION

7. EVALUATION OF THE PARKINSONS DISEASE SPECIALIST NURSE POST 173 - 198

To consider the attached report of the Director of Commissioning.

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 March 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

Commenced: 3.00 pm **Terminated: 4.40 pm**

PRESENT: Christina Greenhough (in the Chair) – Tameside and Glossop CCG
Councillor Brenda Warrington – Tameside MBC
Councillor Gerald P Cooney – Tameside MBC
Councillor Peter Robinson – Tameside MBC
Graham Curtis – Tameside and Glossop CCG
Alison Lea – Tameside and Glossop CCG
Jamie Douglas – Tameside and Glossop CCG

IN ATTENDANCE: Kathy Roe – Director of Finance
Clare Watson – Director of Commissioning
Aileen Johnson – Head of Legal Services
Angela Hardman – Director of Public Health and Performance
Michelle Walsh – Interim Director of Nursing, Quality and Patient Safety
Ali Rehman – Public Health
Anna Moloney – Public Health
Chris Easton – Head of Strategy and Development – Tameside and Glossop Integrated Care Foundation Trust
Simon Brunet – Head of Policy and Communications – Tameside MBC

APOLOGIES: Alan Dow – Tameside and Glossop CCG
Steven Pleasant – Chief Executive, Tameside MBC, and Accountable Officer, Tameside and Glossop CCG

109. DECLARATIONS OF INTEREST

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

110. MINUTES OF THE PREVIOUS MEETING

The Minutes of the previous meeting held on 14 December 2016 were approved as a correct record.

111. FINANCIAL POSITION OF THE INTEGRATED COMMISSIONING FUND

The Director of Finance, Single Commissioning Team, presented a jointly prepared report of the Tameside and Glossop Care Together constituent organisations on the revenue financial positon of the economy. It provided a 2016/17 financial year update on the month 8 financial position at 30 November 2016 and the projected outturn at 31 March 2017. There needed to be careful management of the pressures faced by the each of the Tameside and Glossop Care Together constituent organisations.

The overall financial position of the Care Together economy had improved month on month reducing the projected year end deficit to £5.9m. Work continued to deliver improvement on the CCG QIPP position of the recovery plan and there had been an improvement to the CCGs projected year end financial positon but it was important to note that the majority of this improvement was a result of non-recurrent means. Overall, the Tameside MBC year end forecast position had deteriorated since period 7 predominantly due to expenditure to address the outcomes of the recent Ofsted Inspection of children's social care services. The Tameside and

Glossop Integrated Care NHS Foundation Trust was currently forecast to achieve the planned £17.3m deficit.

Reference was made to the current prescribing positon and future pressure that could be mitigated by sustained efforts to reduce volumes and control spending. This area remained in need of a high level of focus and it was important that meetings planned to monitor progress took place as scheduled.

RESOLVED

(i) That the 2016/17 financial year update on the month 8 financial positon at 30 November 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 acknowledged.

112. PERFORMANCE REPORT

Consideration was given to a report of the Director of Public Health and Performance providing an update on quality and performance data as at the end of October 2016 and an update on the System Wide Outcomes Framework. The new report format aimed to provide a dashboard view of indicators and provide exception reporting as appropriate. This evolving report would align with the Systems Outcome Framework, other Greater Manchester and National dashboard reports.

The format would also include further elements on quality from the Nursing and Quality Directorate as the report evolved. It was also anticipated that the report would include elements of the Single Outcomes Framework and an update on the Framework was included with the report.

The following had 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 was no longer a challenge in diagnostics at Central Manchester.
- A&E standards were failed at Tameside Hospital Foundation Trust.
- The number of Delayed Transfers of Care recorded remained higher than planned.
- Ambulance response times were not met at a local or at North West level.
- Number of patients waiting over 52 weeks.
- Improving access to psychological therapies performance for Access and Recovery remained a challenge.
- 111 performance against Key Performance Indicators.
- MRSA.

In terms of the System Wide Outcome Framework, this was split into three themes detailed as follows:

- Population health;
- Empowering people and communities; and
- System performance and sustainability.

It was explained that the framework should first and foremost be viewed as a transformational approach and in order to deliver the changes in health and social care to meet the challenges faced thought needed to be given about the way services were designed, commissioned and provided.

The Leadership and development of the outcomes framework would sit with the Collaborative Intelligence Function drawing on expertise and capacity from across the Single Commission and Tameside and Glossop Integrated Care Foundation Trust. The health and wellbeing outcomes within the framework applied across all integrated health and social care services. There was 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.

In relation to next steps, the following was planned.

- A phase of engagement including a development session with key staff and stakeholders to comment on the framework, its content and to identify any omissions;
- Development of reporting approach and dashboards to provide effective reporting of the framework to be aligned with other reporting approaches to avoid duplication;
- Formal publication of the framework along with accompanying narrative for the workforce across the Single Commissioning Function;
- Series of briefing sessions for staff.

Members of the Board discussed and commented on the new format and approach and welcomed the proposed development session providing key staff and stakeholders and opportunity to comment on the framework.

RESOLVED

(i) That the contents of the performance and quality report and revised format be noted.

(ii) That the update on the System Wide Framework, structure, contend and next steps be noted.

113. 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

Consideration was given to a report of the Director of Commissioning setting out the current position in relation to the commissioning of mental health services in Tameside and Glossop. The proposal, in line with a number of other Greater Manchester Clinical Commissioning Groups was that the Single Commissioning Function would move from its current multi-lateral mental health contract with Pennine Care NHS Foundation Trust to a bi-lateral contract with the current provider with effect from 1 April 2017.

The report explained the position currently faced in securing a long term mental health partner for the Care Together system, working with the Integrated Care Foundation Trust. It proposed a way forward over the next two years that allowed the continuation of mental health services in the area whilst a review and redesign of an all age mental health service was undertaken to deliver savings and work towards integrating mental health within the Integrated Care Foundation Trust.

RESOLVED

(i) That 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 be approved.

(ii) That the review and redesign of mental health services within the Care Together Programme as part of the journey towards integration within the Integrated Care Foundation Trust be approved.

114. PRIMARY CARE – PRIORITIES AND SCOPE

Consideration was given to a report briefing PRG on the priorities and scope for primary care over the next two to five years based outlined throughout a number of national and regional documents as follows:

- The Five Year Forward View;
- The General Practice Forward View;
- New Care Models: The multispecialty community provider emerging care model and contract framework;
- NHS Operational Planning and Contracting Guidance 2017-19;
- Greater Manchester Primary Care Strategy (Delivering Integrated Care Across Greater Manchester: The Primary Care Contribution. Our Primary Care Strategy 2016-2021.

These documents were closely aligned and interlinked and all outlined the need for system wide changes to ensure the NHS could 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 care; restore and maintain financial balance; and deliver core access and quality standards'. This was translated to describe localities position in their Sustainability and Transformation Plans.

Strengthening and transforming general practice would play a crucial role in the delivery of Sustainability and Transformation Plans and in integrating the aims of the GP Forward View into these plans. CCGs would need to document the aims and key local elements of the GP Forward View into more detailed local operations plans and submit one GP Forward View plan to NHS England on 23 December 2016. Plans needed to reflect local circumstances, but at a minimum set out:

- How access to general practice would be improved;
- How funds for practice transformational support would 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, would be deployed.

In terms of local implementation, although the neighbourhood model of peer support had been in place for a number of years more recently this had developed and expanded to promote new ways of working across and by, neighbourhoods. The ambition of this was to improve efficiency and achieve the care delivered by population based models approach and further alignment of commissioning staff to neighbourhoods had strengthened the support offer and work programme with practices. The review of risk stratification patients, as outlined in the description of the extensivist model was being implemented locally through this extended support and it was anticipated that this would become embedded in practice culture. The national direction of new models of care described through national strategy, although in its infancy in Tameside and Glossop, was moving forward and would further develop over the coming years.

Neighbourhoods were designing models of care for their population based on local need, fostering relationships between providers to deliver the best outcomes. These Integrated Neighbourhoods had been formed across all neighbourhoods bringing together providers to work in collaboration. Different models of working and widening the range of professionals within the primary care workforce was a key strand throughout all national documentation and this was being taken forward locally. New models of care and the direction of the GP Forward View and GM Strategy had been fully reflected in the documentation for the Alternative Provider Medical Services re-procurement. Although a new contract model was not yet available, the context in which the contracts were being re-procured and the future vision for these practices had been outlined and would form part of the assessment of bids.

The Primary Care Quality Scheme refresh required for 2017/18 must reflect the current landscape both financial and policy. 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 empowered care and place based, population based models. This redesign would address the 'must do's' and mandates from the planning guidance outlined in the report as well as ensuring Tameside and Glossop fulfilled its commitment to the delivery of the GM standards. The drive to improve use of technology and change the way people accessed services would also be reflected,

ensuring people powered change could be achieved. This refresh was underway and would go through a period of patient and practice consultation.

RESOLVED

(i) That the scale of the ambition for Primary Care nationally be noted.

(ii) That the delivery of this ambition through local implementation, development of neighbourhoods and progression of new models of working and through the refresh of the Primary Care Quality Scheme be supported.

(iii) That 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 the Transitional Fund be acknowledged.

115. NEIGHBOURHOOD PRIMARY CARE INNOVATION SCHEME

Consideration was given to a report of the Director of Commissioning presenting the background, the current positon of the scheme and providing recommendations for 2017/18.

It was explained that the NHS Planning Guidance issued in December 2013 – 'Everyone Counts – Planning for Patients 2014/15 to 2018/19' 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 would 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 would be expected to provide additional funding to commission additional services which practices, individually or collectively, had identified would 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 equated to £50 for patients aged 75 and over. Practice plans should be complementary to initiatives through the Better Care Fund.

Tameside and 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 a decision was made 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.

RESOLVED

That the Neighbourhood Primary Care Innovation Scheme be approved but the funding for the scheme should be a call on the Transformation funding from GM earmarked for the Integrated Neighbourhood model rather than a separate commissioner held budget.

116. PROVISION OF THE INSPECTION, REPAIR AND MAINTENANCE OF LIFTS AND HOISTS

Consideration was given to a report of the Director of Commissioning advising that the 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.

The contract had been performance managed regularly over the first two years and overall the contractor had performed well for both Tameside MBC and Oldham MBC. Call outs and repairs were falling due to the fact that the stock was now in a better state of repair than at the beginning of the contract and this was resulting in fewer call-outs, thereby reducing costs.

In 2015/16 the spend was £119,000 and £74,000 for Tameside MBC and Oldham MBC respectively and spend for 2016/17 was projected to be the same or less than the previous year and was within the procured financial envelope for both authorities.

Oldham MBC had indicated that they were willing to continue with the current joint working arrangements and also participate in the re-procurement of a new contract which would commence in the new financial year. Of the submissions received when the contract was market tested in late 2014, the current contractor's costings were the lowest. Authorisation was being sought to extend the contract for a period of up to 12 months from 20 January 2017.

RESOLVED
That authorisation be given to extend the contract for a period of 12 months from 20 January 2017.

117. TENDER FOR THE PROVISON OF AN ADVOCACY HUB

Consideration was given to a report of the Director of Commissioning detailing the intention to go out to tender for the provision of an Independent Mental Health Advocacy, Independent Care Act Advocacy, independent complaints advocacy, all of which represented a statutory duty, along with generic advocacy to be delivered via a single point of access from 1 April 2017.

It was explained that the current advocacy contract commenced in July 2012 and was due to cease on 3 July 2017. Over the summer, meetings had been held with the commissioners in Oldham MBC to explore the possibility of a collaborative approach to commissioned advocacy services. Unfortunately, although there was 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.

The approach commissioned in Tameside was consistent with the move, certainly across Greater Manchester, towards advocacy hubs that meant an individual could, if need be, be supported by the same individual advocate through a set of different circumstances and disciplines so ensuring a degree of consistency.

The current contract costs £148,900 per annum and there had been an agreement with the current contractor during negotiations in April 2015 regarding Care Act Advocacy that referral levels would be monitored and, if necessary, spot purchase Care Act provision if it tipped their work load beyond the capacity of the staffing model originally purchased. Thus far, due to the low level of referrals and the fact that the contractor had picked these up as part of the generic element of their advocacy offer, this had not been an issue but, with Care Act referrals likely to rise steadily over the next five year period, this could prove to be an issue in terms of the budget available.

Authorisation was being sought to go out to tender with a five year contract to deliver advocacy provision via a hub model. The service required little in the way of redesign and remained fit for purpose.

RESOLVED
That authorisation be given to proceed with the tendering a number of advocacy services, to be delivered through a single point of access, a hub model, and a single contract.

118. MENTAL HEALTH SUPPORTED ACCOMMODATION

Consideration was given to a report of the Director of Commissioning seeking authorisation to extend the current contract for up to 24 months from 1 April 2017 to 31 March 2019 as allowed for within contract clause 3.2.

The contact to provide supported accommodation to people recovering from mental health problems was awarded following a restricted tender exercise and commenced on 1 April 2014 for a period of three years and included provision to extend for up to an additional two years. It provided a 24 hour support service across three properties in the Borough and as such was an integral part of a comprehensive community based service. The properties were provided by registered social landlords. It was 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.

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

PRG raised concerns on the development around one of the properties that had been identified by all partners as not fit for purpose in the long term. Discussions had commenced to establish the notice period required to the landlord in line with the housing management agreement, working with tenants to move on and how the levels of service would be utilised within the contract in terms of delivering community support.

RESOLVED
That authorisation be given to extend the current contract for up to 24 months from 1 April 2017 to 31 March 2019 as allowed for within contract clause 3.2.

119. DERMATOLOGY AND GUIDANCE AND INTERCEPTOR SERVICE

Consideration was given to a report of the Director of Commissioning advising that the need to manage demand from General Practice was 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 would inform the decision whether to transfer the pilot to business as usual or cease the service. The cost effectiveness would consider the benefit to the whole health and social care economy.

RESOLVED
That the implementation of the five month pilot be approved, including an evaluation of the cost effectiveness going forward and a recommendation to the Single Commissioning Board of future commissioning.

120. PROPOSAL FOR AN INTERCEPTOR FOR KEY EUR PROCEDURES

Consideration was given to a report of the Director of Commissioning explaining that a benchmarking exercise across GM had highlighted that the level of patients who received some of the EUR procedures was much higher than other CCGs. Ten key procedures had 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 were set out in the report. The first utilised the Clinical Speciality Unit GM EUR process and changed the Monitored Approval activity to Individual Prior Approval. The second option utilised an internal interceptor which retained the existing criteria but would allow all GP referrals to be intercepted and other referrals from Tameside and Glossop Integrated Care Foundation Trust, GM EyeCare, Hyde Physio, Pioneer and North West Clinical Assessment and Treatment Service. An implementation plan for both options was detailed in the report.

A cost benefit analysis was detailed, taking into account the additional costs at CSU or the Single Commissioning Function to manage the referrals, additional capacity at Tameside and Glossop Integrated Care Foundation Trust to support additional administration (Band 3) and the reduction in spend for the activity. It was recognised that it might not be possible to realise all of the costs at Tameside and Glossop Integrated Care Foundation Trust and a conservative estimate had been used.

Approval was sought for the implementation of the internal EUR Interceptor as set out in option 2 for 12 months which would require capacity for band 3 posts. If funding could not be found across the whole economy, then there would be backfill funding as outlined in the business case to offer a secondment as an invest to save as highlighted in the report. There would be a four month evaluation of the impact as part of a wider paper that included options for the future commissioning / decommissioning of all EUR procedures.

RESOLVED
That the implementation of Option 2, a 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, be approved.

121. EVIDENCE BASED DECISION MAKING – AN APPROACH TO EQUALITY, QUALITY AND CONSULTATION

Consideration was given to a report of the Director of Governance and the Interim Director of Nursing, Quality and Patient Safety explaining a number of requirements to be met to assist the new single commissioning function in making robust evidence based decisions. The report summarised the requirements and the support available to contract and commissioning managers to ensure they discharged their obligation to provide robust and evidential reports to decision makers.

The three areas covered were highlighted as follows:

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

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

RESOVLED
(i) That the content of the report be noted.
(ii) That the approach outlined be agreed and supported.

(iii) That the proposal for workshops to be held for relevant staff on the approach outlined and the need for robust evidential decision making be supported.

122. URGENT ITEMS

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

123. DATE OF NEXT MEETING

It was noted that the next meeting of the Single Commissioning Board would take place on Tuesday 14 February 2017 commencing at 3.00 pm at Dukinfield Town Hall.

CHAIR

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 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 31 DECEMBER 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 9 financial position (at 31 December 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 9 financial position (at 31 December 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 31 December 2016 (Month 9 – 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 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:	Associated details are specified within 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: M9

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

14 February 2017

Kathy Roe
Claire Yarwood
Ian Duncan

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

	Year to Date (M9)			Year End Forecast			Movement	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Tameside & Glossop CCG	284,385	285,484	(1,099)	384,790	386,126	(1,336)	(2,517)	1,181
Tameside MBC	51,936	54,568	(2,632)	69,272	72,781	(3,509)	(3,371)	(138)
Total Single Commissioner	336,321	340,052	(3,731)	454,062	458,907	(4,845)	(5,888)	1,043
ICFT Deficit	(12,971)	(12,881)	90	(17,300)	(17,300)	0		
Total Wole Economy			(3,641)			(4,845)	(5,888)	1,043

The overall financial position of the Care Together Economy has improved by £1.04m month on month reducing the projected year end deficit to £4.85m or 1.1% of the full year budget. The key driver of this improvement has been an improvement in the CCG QIPP of £1.2m. 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 £4.85m 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.
- The final year settlement agreed with ICFT has mitigated any risk for the rest of the year including any caused by winter pressures.

Tameside & Glossop CCG

	Year to Date (M9)		
	£000's	£000's	£000's
Description	Budget	Actual	Variance
Acute	148,541	148,290	251
Mental Health	21,694	21,688	6
Primary Care	61,535	62,313	(778)
Continuing Care	8,740	9,071	(331)
Community	20,560	20,571	(11)
Other	20,057	20,179	(122)
QIPP			
CCG Running Costs	3,258	3,372	(114)
CCG Sub Total	**284,385**	**285,484**	**(1,099)**

	Year End		
	£000's	£000's	£000's
	Budget	Forecast	Variance
	197,343	197,575	(232)
	28,993	29,018	(25)
	81,655	82,754	(1,099)
	12,251	12,651	(400)
	27,493	27,511	(18)
	31,893	30,735	1,158
		1,336	(1,336)
	5,162	4,546	616
	384,790	**386,126**	**(1,336)**

	Movement	
	£000's	£000's
	Previous Month	Movement in Month
	121	(353)
	(55)	30
	(1,081)	(18)
	(386)	(14)
	39	(57)
	758	400
	(2,517)	1,181
	604	12
	(2,517)	**1,181**

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Overall there has been an improvement to the CCG's projected year end financial position of almost £1.2m 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 (including the receipt of GM levy funding of £669k) which have increased again by £1.181m to £12.164m against a target of £13.5m. As a result a residual gap of £1.336m remains
- Other changes in the outturn position by directorate:
  - **Acute**: Detailed breakdown of movements in acute providers is detailed separately
  - **Prescribing**: A detailed report on the current prescribing position is detailed separately
  - **Community –** Transfer of Telehealth saving to QIPP (£39k) and increase in overspend on Community IT (£18k)
  - **Other:** The first allocation of the Transformation funding from Greater Manchester Health & Social Care Partnership has been received. This is an allocation of £5.2m in M9 for the remainder of 16/17 out of the full funding of £23.2m. The funding is expected to be fully utilised across the economy before the end of the financial year in line with the approved Investment Agreement.

- The CCG has a plan to close this residual gap and has reported a post mitigation risk of zero to NHSE, 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.
- The final year settlement is currently being finalised with the ICFT to mitigate any risk for the remainder of the year including any caused by winter pressures.
- 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 M9 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)

Key Movements & Narrative: CCG

Acute Provider Drilldown

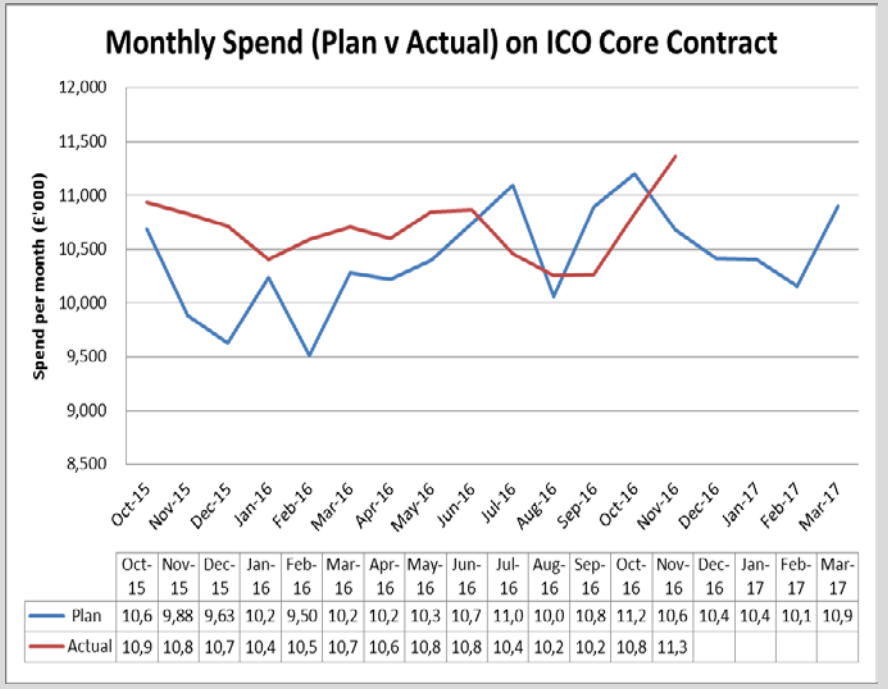
- **ICFT**: The year end settlement is currently being finalised which will mitigate against any overspend on budget.
- **Central Manchester**: Adverse movement of the full year forecast (£92k) due to recognising the reduction in readmissions
- **Stockport:** Adverse movement of the full year forecast (£23k) due to additional funding for RTT pressures (£60k). Underspends on Critical Care & Neuro rehab have partially offset this by £27k.
- **SRFT:** Adverse movement of Year To Date position due to Pain Management (£45k) and Outpatients (£15k).
- **UHSM:** Adverse movement of Year To Date position due to Outpatients (£25k) and Critical Care (£33k).

Provider	Year to Date			Forecast		
	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's
TFT	95,504	95,192	312	126,575	126,575	()
CMFT	16,796	17,463	(667)	22,280	23,150	(870)
SFT	8,965	8,301	664	11,969	11,138	831
UHSM	4,863	5,107	(244)	6,568	6,813	(246)
PAHT	3,024	2,916	108	4,029	3,865	164
SRFT	2,412	2,531	(119)	3,226	3,468	(242)
WWL	1,045	924	121	1,409	1,258	151
BOLT	60	60	()	80	80	
Total	**132,668**	**132,492**	**176**	**176,135**	**176,346**	**(212)**

- **NWAS:** Additional £20k included in Year end forecast regarding PES based on a current Year to Date trend of over performance.

Acute ICFT Movement

- The year end position once finalised will take account of expected activity levels and provide certainty to both the ICFT and the CCG for 2016-17 year end.
- We continue to monitor activity trends and the below graph shows a marked increased in activity from October. This is due to an increased number of long length of stay discharges and emergency admissions which is in line with the national pressures recently reported.

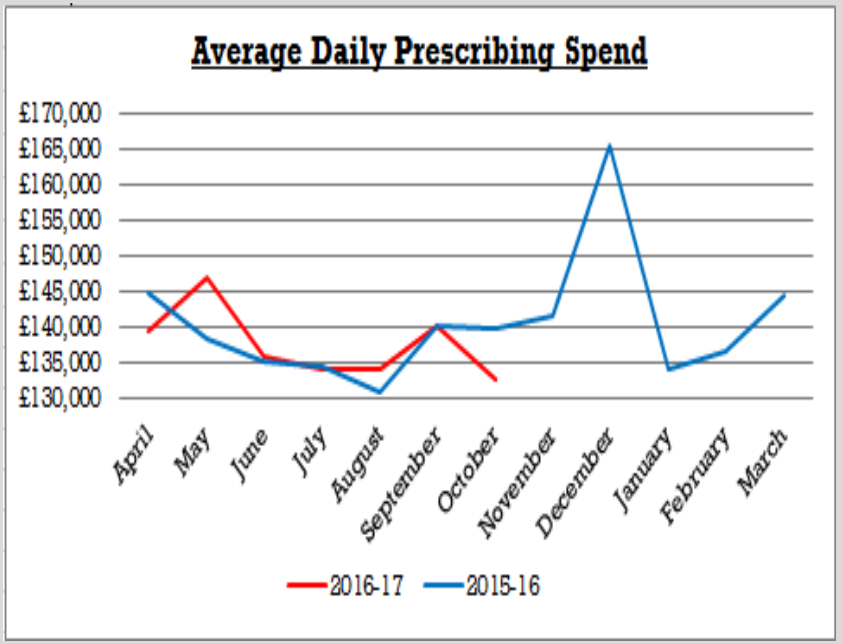


	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Plan	10,6	9,88	9,63	10,2	9,50	10,2	10,2	10,3	10,7	11,0	10,0	10,8	11,2	10,6	10,4	10,4	10,1	10,9
Actual	10,9	10,8	10,7	10,4	10,5	10,7	10,6	10,8	10,8	10,4	10,2	10,2	10,8	11,3				

Key Movements & Narrative: CCG

Prescribing

- As reported last month a detailed review of prescribing costs identified an additional pressure on the budget of £757k. Along with a cross-year pressure identified earlier in the year this created a total pressure on the budget of £1m. The additional pressure was caused by an adjustment relating to the number of prescribing days in the year and an increase in volumes of 4.28% in T&G compared to 2.84% in GM and 2.08% nationally.
- Achieving the revised position is still going to be dependent on the successful implementation and continued adherence to a number of initiatives implemented by the Medicines Management Team especially those designed to reduce the numbers of repeat prescriptions and those that will identify cheaper alternative items.
- The latest full month's data has shown encouraging signs that the revised position will be attainable. The latest data shows there was a national and GM reduction in prescribing costs of 1.15% and 3.4% respectively. A T&G reduction of 5.7% in the same period is promising but this improved performance needs to be replicated every month in order to ensure no additional pressure is created in later months.
- Some of this reduction may be attributable to centrally controlled price changes in Category M items which resulted in 52% of items being subject to a price increase and 48% being subject to a price reduction. This is indicative of one of the variables that continue to make accurately forecasting the prescribing position difficult and results in a situation where this particular cost centre will be subject to a degree of volatility that others are not.
- Any savings that can be achieved should be noted in the context of an average daily spend on prescribing of around £130-140k. The figures below show the actual spend each day in T&G on prescribing and show the improved performance for the most recent month for which data is available but it also highlights the volatility of how the spending varies from month to month. In particular it highlights the impact on spend if there is a peak similar to December 2015.



- Any future pressure on the position can be mitigated by sustained efforts to reduce volumes and control spend. Delivering savings from QIPP in excess of current predictions could even lead to a reduction in the total spend on prescribing. It is an area that remains in need of a high level of focus.

Tameside MBC

	Year to Date (M9)			Year End			Movement	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Adult Social Care & Early Intervention	31,270	32,173	(903)	41,995	43,199	(1,204)	(1,336)	132
Childrens Services, Strategy & Early Intervention	18,946	20,620	(1,674)	25,877	28,109	(2,232)	(1,914)	(318)
Public Health	1,720	1,775	(55)	1,400	1,473	(73)	(121)	48
TMBC Total	**51,936**	**54,568**	**(2,632)**	**69,272**	**72,781**	**(3,509)**	**(3,371)**	**(138)**

Overall the TMBC year end forecast position has deteriorated by £138k since period 8 increasing the projected year end variance to c.£3.5m, 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 (£0.6m), planned savings initiatives yet to be realised (£0.9m), additional minor variations (£0.2m).

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 M9 YTD position and projected outturn
- Acknowledge risk in relation to achieving balanced 2016/17 financial position

Tameside and Glossop Integrated Care NHS Foundation Trust

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	152,244	154,755	2,512	202,785	205,645	2,860	205,137	(508)
Expenditure	158,174	161,164	(2,989)	210,707	214,254	(3,547)	213,749	(505)
EBITDA	(5,931)	(6,408)	(478)	(7,922)	(8,609)	(687)	(8,609)	0
Net Deficit after Exceptional Costs	**(12,971)**	**(12,881)**	**90**	**(17,300)**	**(17,300)**	**0**	**(17,300)**	**0**

Financial Position

- For the 9 months to December 2016, the ICO is delivering a deficit of £12.9m, broadly on line with plan.
- The year end forecast is for the planned £17.3m deficit, and assumes the following;
  - Delivery of the £7.8m Efficiency savings target
  - Delivery of the Tameside and Glossop CCG block contract
  - Small over performance on all associate PbR contracts
  - Financial and performance criteria for receipt of £6.5m 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

- 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.

Key Information

- The Trust is appealing the reduction of STF funding relating to delivery of the A&E trajectory (c.£450k). If this is successful, the Trust's deficit will reduce by this amount.

The Financial Gap

Establishing the Financial Gap

- The current financial gap across the health and social care economy in Tameside & Glossop is estimated to be £70.2m by 2020/21.
- In 2016/17 the opening gap was £45.7m which consists of £13.5m CCG, £8m council and £24.2m ICO. Successful 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.
- Work is underway to identify future opportunities for savings and 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

- The 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				2017/18			
	R	A	G	Total	R	A	G	Total
PRIORITY 1 - Prescribing	0	0	0	**0**	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	0	553	**553**	0	486	523	**1,009**
PRIORITY 5 - Back Office Functions and Enabling Schemes	0	0	0	**0**	500	1,000	0	**1,500**
PRIORITY 6 - Governance	0	0	0	**0**	0	100	0	**100**
Other Schemes in progress/achieved:	R	A	G	Total	R	A	G	Total
Neighbourhoods	0	0	459	**459**	0	74	681	**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	0	500	**500**	500	59	500	**1,059**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,682	0	**1,682**
Technical Finance & Reserves	0	0	6,167	**6,167**	0	0	4,382	**4,382**
Other efficiencies	0	0	3,054	**3,054**	4,388	0	28	**4,416**
Grand Total:	0	0	12,164	**12,164**	**7,839**	**11,923**	**7,346**	**27,108**
Including adjustment for Optimum Bias:	-	-	12,164	**12,164**	784	5,961	7,346	**14,091**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								
QIPP Target				**13,500**				**23,900**
Savings still to find assuming application of optimism bias:				1,336				9,809
Other Actions to close the gap in 2016-17 **(to be confirmed)**				1,336				
Outstanding QIPP at close of 2016-17:				**0**				

- Since last month all schemes are currently showing as green but there is still a gap of £1.336m
- Several schemes have been identified (rates reimbursement and reprofiling of the transformation fund) which will cover the gap and it is expected that all these schemes will produce the full benefits identified by the end of month 10.
- A number of QIPP schemes for 2016/17 are non-recurrent so work continues to identify schemes for 2017/18.

Recurrent vs Non Recurrent	2016/17	2017/18
Recurrent Savings	**1,744**	**21,158**
Red	0	7,011
Amber	0	11,683
Green	1,744	2,464
Non Recurrent Savings	**10,419**	**5,950**
Red	0	828
Amber	0	240
Green	10,419	4,882
Total	**12,164**	**27,108**

- A more detailed breakdown of QIPP schemes is included as appendix A.

Closing the Financial Gap - TMBC

Scheme Detail	R	A	G	Total	Notes
Public Health - savings found			217	217	Planned reduction to the annual management fee payable to Active Tameside and additional incidental savings delivered within the service
Public Health - savings found			169	169	A reduction in the Community Services contract value has been agreed with Tameside ICFT
Public Health - additional resource (projected cost pressures)			49	49	
Public Health - reduction in estimated capital financing repayments (Active Tameside)			456	456	The capital financing figure in 16-17 has reduced due to a rephasing of works to reconfigure the Active Tameside estate
Public Health - negotiated reduction in Public Health Network subscription			48	48	
Public Health - savings still to find		442		442	.
Adult Social Care additional resource (projected cost pressures)			3,908	3,908	
Adult Social Care - saving found, reduction in Dowrie costs			101	101	
Adult Social Care - savings still to find	896			896	The Council is currently in the process of identifying further options to address the projected financial gap that is expected to arise during 2016/17. Updates will be reported within future monitoring reports.
Childrens Social Care - savings found			120	120	Reduction to inflationary increases that were projected to materialise during 2016/17.
Childrens Social Care - additional resource (projected cost pressures			1,215	1,215	
Childrens Social Care - savings still to find	379			379	
TOTAL	1,275	442	6,283	8,000	

Integrated Commissioning Fund 2016/17

	Year to Date (M9)			Year End			Movement	
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Description	Budget	Actual	Variance	Budget	Forecast	Variance	Previous Month	Movement in Month
Acute	148,541	148,290	251	197,343	197,575	(232)	121	(353)
Mental Health	21,694	21,688	6	28,993	29,018	(25)	(55)	30
Primary Care	61,535	62,313	(778)	81,655	82,754	(1,099)	(1,081)	(18)
Continuing Care	8,740	9,071	(331)	12,251	12,651	(400)	(386)	(14)
Community	20,560	20,571	(11)	27,493	27,511	(18)	39	(57)
Other	20,057	20,179	(122)	31,893	30,735	1,158	758	400
QIPP					1,336	(1,336)	(2,517)	1,181
CCG Running Costs	3,258	3,372	(114)	5,162	4,546	616	604	12
CCG Sub Total	**284,385**	**285,484**	**(1,099)**	**384,790**	**386,126**	**(1,336)**	**(2,517)**	**1,181**
Adult Social Care & Early Intervention	31,270	32,173	(903)	41,995	43,199	(1,204)	(1,336)	132
Childrens Services, Strategy & Early Intervention	18,946	20,620	(1,674)	25,877	28,109	(2,232)	(1,914)	(318)
Public Health	1,720	1,775	(55)	1,400	1,473	(73)	(121)	48
TMBC Sub Total *	**51,936**	**54,568**	**(2,632)**	**69,272**	**72,781**	**(3,509)**	**(3,371)**	**(138)**
GRAND TOTAL **	**336,321**	**340,052**	**(3,731)**	**454,062**	**458,907**	**(4,845)**	**(5,888)**	**1,043**

Better Care Fund

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 CCG	DCC/Other 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

Risk and Other Issues

- The main financial risks within ICF are listed below
- Detailed registers which include further information about the risk and mitigating actions are reviewed by the Audit Committee. Copies are available on request.

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

Continuing Health Care

- A full review is currently underway within the CCG to validate the current forecast. Once this has been completed a detailed review will be published if any significant variances to the forecast are identified.

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.

Section 2 - Care Together Economy Capital Financial Position

Tameside MBC

Scheme	Approved Capital Programme Total	Approved 2016/2017 Allocation	Expenditure to Month 9	Projected Expenditure to 31 March	2016/2017 Projected Outturn Variation	Scheme Comments
	£'000	£'000	£'000	£'000	£'000	
Childrens Services - In Borough Residential Prope	912	912	711	800	112	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	3,265	3,879	1,324	Active Dukinfield - The scheme is on budget with a confirmed opening date of 28th 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 - Adapta	1,978	1,978	905	1,500	478	
Total	23,158	8,093	4,881	6,179	1,914	

Appendix 1 - CCG QIPP Schemes

Summary of QIPP £'000s	2016/17 R	A	G	Total	2017/18 R	A	G	Total
PRIORITY 1 - Prescribing	0	0	0	**0**	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**	0	5,318	0	**5,318**
PRIORITY 4 - Single Commissioning Function Responsibilities	0	0	553	**553**	0	486	523	**1,009**
PRIORITY 5 - Back Office Functions and Enabling Schemes	0	0	0	**0**	0	1,000	0	**1,000**
PRIORITY 6 - Governance	0	0	0	**0**	0	100	0	**100**
Other Schemes in progress/achieved:	R	A	G	Total	R	A	G	Total
Neighbourhoods	0	0	459	**459**	0	74	681	**755**
Primary Care	0	0	698	**698**	0	312	1,000	**1,312**
Mental Health	0	0	232	**232**	0	0	232	**232**
Acute Services - Elective	0	0	500	**500**	0	0	500	**500**
Enabling Schemes to facilitate QIPP	0	0	0	**0**	0	1,682	0	**1,682**
Technical Finance & Reserves	0	0	6,167	**6,167**	0	0	4,382	**4,382**
Other efficiencies	0	0	3,054	**3,054**	6,740	0	616	**7,356**
Grand Total:	0	0	12,164	**12,164**	**7,863**	**11,864**	**7,934**	**27,661**
Including adjustment for Optimum Bias:	-	-	12,164	**12,164**	786	5,932	7,934	**14,652**
10% of red rated schemes will be realised								
50% of amber rated schemes will be realised								
100% of green rated schemes will be realised								
QIPP Target				**13,500**				**23,900**
Savings still to find assuming application of optimism bias:				1,336				9,248
Other Actions to close the gap in 2016-17 **(to be confirmed)**				1,336				
Outstanding QIPP at close of 2016-17:				**0**				

Recurrent vs Non Recurrent	2016/17	2017/18
Recurrent Savings	**1,744**	**22,598**
Red	0	7,863
Amber	0	11,683
Green	1,744	3,052
Non Recurrent Savings	**10,419**	**5,122**
Red	0	0
Amber	0	240
Green	10,419	4,882
Total	**12,164**	**27,720**

Scheme	Savings 2016/17	Savings 2017/18	RAG Rating 2016/17	RAG Rating 2017/18	Accountable Lead	SCMT/ICO	Supported by: Officer	Supported by: Clinical	Start Date	Notes	Reporting Governance	QIPP Category	NHS England Non ISFE Mapping		Link to Transformation Funding
PRIORITY SCHEMES - HIGH															
PRIORITY 1 - Prescribing															
Reverse 17/18 Growth - prescribing	0	1,123	N/A	R	Clare Watson	Clare Watson	Peter Howarth	Jamie Douglas Tina Greenhough	01-Apr-17			Prescribing	Transformational	Primary Care	No
Pharmacy repeat ordering	0	718	N/A	A	Clare Watson	Clare Watson	Peter Howarth	Jamie Douglas Tina Greenhough	10-Aug-16	CCG policy agreed by PRG August 2016 and implementation has commenced. Medicines Management Team and practice staff working hard to implement and some early signs of success are evident. However as detailed in the prescribing deep dive report presented to finance committee in December there are wider issues in prescribing which has resulted in significant increase in forecast. This forecast already makes some assumptions based on realisation of some QIPP, therefore it would be a double count to include again here.	Professional Reference Group	Prescribing	Transformational	Primary Care	No
DNP/ Grey / Red list	0	125	N/A	A	Brendan Ryan	Clare Watson/Claire Yarwood	Peter Howarth Tony Sivner	Jamie Douglas Tina Greenhough	06-Sep-16	Implementation of the 'Do Not Prescribe' (DNP) and Red list as per GMMMG will generate savings. Staff/ GP/Consultant adherence and vigilance is required. Individual MDT reviews may be necessary to effect these savings. This has been promoted and is discussed in practice visits. Dependent on member practice adherence to the CCG policy. See comment above about double count of QIPP in 16/17.	Care Together Programme Board	Prescribing	Transformational	Primary Care	Yes
Economy wide prescribing review projects (multiple) to ensure cost and quality effective prescribing practice	0	550	N/A	A	Brendan Ryan	Clare Watson/Claire Yarwood	Peter Howarth Tony Sivner	Jamie Douglas Tina Greenhough	01-Sep-16	Programme of medicines management QIPP initiatives led by CCG and ICO medicines management teams. 16/17 additional QIPP forecast reduced to zero in line with the comments above.	Care Together Programme Board	Prescribing	Transformational	Primary Care	Yes
Prescribing Total	**0**	**2,516**													
PRIORITY 2 - Effective Use of Resources / Prior Approval															
Effective Use of Resources/Prior Approval	0	1,500	N/A	A	Michelle Rothwell	Michelle Rothwell/ Trish Cavanagh	Ian Bromilow Elaine Richardson BI David Milner	Nav Riyaz (clinical lead for EUR)	31-Oct-16	Non-payment of un-authorised EUR procedures. Significant potential savings based on benchmarking data across GM. Requires GP adherence to relevant referral processes and EUR policies. CSU ready to upload summary guides and templates from 12th Dec, Draft paper waiting for final finance the proposal is for an internal interceptor or referrals through CSU plan to get to PRG Dec. Practice level data shared with neighbourhood leads and CBMs to encourage peer review and best practice sharing re referring. Discussion with lead commissioner regarding an Ophthalmology provider to assess any financial over charging and challenge activity	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
EUR/Prior Approval Total	**0**	**1,500**													
PRIORITY 3 - Demand Management															
Management of Outpatient Follow-up attendances	0	300	N/A	A	Peter Nuttall	Clare Watson	Elaine Richardson	Alison Lea Tim Hendra	15-Oct-16	ICO to lead review of follow up outpatients, and in this review to establish controls on the number of follow up attendances for all outpatient referrals, e.g. only a first and a single follow up would be allowed without prior approval. Some areas would need to be exceptions to this (e.g. fracture clinic, cancer etc). An economy wide task and finish group has been established to benchmark with other hospitals and identify the protocols for out patient follow ups and C2C referrals. Will identify specialty-specific issues and proposals and will include post-discharge follow ups, which is happening as part of the 17/18 contract negotiation process.	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
Year End Settlement with ICO	500	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Dec-16	Year end settlement which incorporates previous estimates arround EUR, C2C, OP follow-ups, primary care demand management which have all been reduced to zero for 2016/17 to be replaced with the benefit of the year end settlement	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
Introduce stringent controls on C2C referrals	0	100	N/A	A	Peter Nuttall	Clare Watson	Elaine Richardson Ian Bromilow	Alison Lea Tim Hendra	15-Oct-16	Controls to be introduced on C2C referrals, agreed between the ICO and single commission, and monitored via CCG/ICO contract management and planned care workstream of Care Together. Audit to be conducted on current adherence in ICO. An economy wide task and finish group to be set up to identify the new protocols for out patient follow ups and C2C referrals. This is being addressed as part of the 17/18 contract negotiation.	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
Discharge to assess	0	0	N/A	N/A	Pauline Jones	Michelle Rothwell	Elaine Richardson	Saif Ahmed Naveed Riyaz	01-Oct-16	Roll out by ICO should have been completed across all wards by end Nov. Need to ensure all potential patients managed through the process not just those who are going home. GM DTOC trajectory overriding focus and that will reduce LoS. Reducing LOS would enable us to make significant economy wide recurrent savings in 17/18 and beyond. Values not included as this is a critical enabler and the savings are included within other demand management areas.	Contracting & Performance Group	Acute Services - Elective & Urgent	Transformational	Acute	Yes
Primary Care demand management (OPFA)	0	658	N/A	A	Clare Watson	Clare Watson	Elaine Richardson Alison Lewin Tracey Simpson	Saif Ahmed Alison Lea Tim Hendra	28-Sep-16	Primary care demand to be managed via increased support to practices to analyse and revise referral patterns. Access to advice and guidance from secondary care, commissioning improvement scheme, risk stratification of high risk patients, and referral management (including referral interceptor) are key enablers. Ali Lea and Saif Ahmed to develop further proposals for primary care demand / referral management for presentation back to GB. Dermatology Interceptor going to PRG in Dec. Paper on reducing IVF cycles awaiting refreshed data then will go to PRG for April Implementation. Encouraging use of Advice and Guidance. Encouraging peer review of referrals.	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	Yes
	0	0	N/A	N/A	Clare Watson	Clare Watson	Elaine Richardson Tori O'Hare / Janna Rigby Alison Lewin	Saif Ahmed Alison Lea	28-Sep-16	Develop strict process for referral management for the 5 outlier practices - Ali Lea and Saif Ahmed to develop proposals for consideration at GB meeting. Calculation assumes 1 referral a day prevented for the 5 outlier practices for the remaining 6 months of the year.	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
Stop all elective and day case procedures Jan 17 - Mar 17	0	0	N/A	N/A	Clare Watson	Clare Watson	Elaine Richardson	Alison Lea	01-Jan-17	This was discussed at the Governing Body and it was agreed that further conversations to commence with the ICO on how to manage referrals.	Contracting & Performance Group	Acute Services - Elective	Transformational	Acute	No
Reverse all 17/18 growth - acute	0	3,925	N/A	A	Clare Watson	Clare Watson	Elaine Richardson	Alison Lea	01-Apr-17	As agreed in budget setting meeting. Reverse all activity growth - TFT £2789k, Associates £843k, other £291k	Professional Reference Group	Neighbourhoods	Transformational	Acute	No

Scheme	Savings		RAG Rating		Accountable Lead	SCMT/ICO	Supported by		Start Date	Notes	Reporting Governance	QIPP Category	NHS England Non ISFE Mapping		Link to Transformation Funding
	2016/17	2017/18	2016/17	2017/18			Officer	Clinical							
Reverse all 17/18 growth - continuing care	0	335	N/A	A	Michelle Rothwell	Michelle Rothwell	Jayne Wilkinson	Saif Ahmed Naveed Riyaz	01-Apr-17		Professional Reference Group	Other Efficiencies	Transformational	Acute	No
Demand Management Total	**500**	**5,318**													
PRIORITY 4 - Single Commissioning Function Responsibilities (Incorporting Running Costs review)															
Efficiency savings (admin budget)	419	264	G	G	Kathy Roe	Paul Pallister	David Milner Tracy Brennand	Tina Greenhough	31-Oct-16	Confirmed savings made in 16/17 from running costs budgets. Chiefly driven by no longer having to fund salary of Chief Operating Officer, but also audit fee charged, TFT B4 (HR), cross year benefit from 15/16. Further savings/slippage possible following budget holder review and in the event of any staff vacancies. SCMT will report back monthly to SCB on this area. Linked to urgent work regarding the strategic responsibilities of the single commissioning function and the ICO.	Single Commissioning Board and Care Together Programme Board	Other Efficiencies	Transactional	Other	No
	0	236	N/A	A											
Pay budgets - review of Interim staff and fixed term post	50	250	G	A	Kathy Roe	Paul Pallister	David Milner Tracy Brennand	Tina Greenhough	31-Oct-16	Restrict recruitment - essential business continuity/within economy. Figure presented is based on the assumption that none of the current vacancies in the CCG (excluding COO where saving already claimed) are frozen, giving part year effect in 16/17. No consideration to resilience in teams or continuation of essential service has been factored into this calculation. Review of all staff on interim contracts, which could potentially be brought to an end without the expense of redundancy/MARS. Total annual spend on interim staff within the CCG is £353k. Linked to urgent work regarding the strategic responsibilities of the single commissioning function and the ICO. Discussions are currently underway with Grant Thornton to potentially reclaim an element of VAT which has already paid by the CCG, but was jointly funded with the Local Authority.	Single Commissioning Board/CCG Governing Body	Other Efficiencies	Transactional	Other	No
	0		N/A												No
Review of Lay members/Clinical leads roles/programme	7	219	G	G	Steven Pleasant	Paul Pallister	Paul Pallister Tracy Brennand Graham Curtis	Alan Dow	28-Sep-16	CCG investment in lay members and advisors, and clinical members / leads have been reviewed to ensure in line with business priorities and benchmark against other CCGs. Proposals were discussed at Governing Body on 28th September 2016 and a decision taken to have 3 Lay Members going forward. The new arrangements will become effective from 1st January 2017. With regards to Clinical Leads it was agreed that there will be a reduction in Clinical Lead capacity with a phased implementation.	Single Commissioning Board/CCG Governing Body	Other Efficiencies	Transactional	Other	No
	44		G	G	Steven Pleasant	Paul Pallister	Paul Pallister Tracy Brennand Graham Curtis	Alan Dow	28-Sep-16	Saving captured as programme	Single Commissioning Board/CCG Governing Body	Other Efficiencies	Transactional	Other	No
Corporate costs printing, photocopiers, postage	33	40	G	G	Kathy Roe	Paul Pallister	David Milner Tracy Brennand	Tina Greenhough	15-Oct-16	Proportion of postage expenditure relates to NHSE (child health) - recharge arrangement now in place. Message to single commission staff to limit use of postal system to support efficiency programme.	Single Commissioning Board/CCG Governing Body	Other Efficiencies	Transactional	Other	No
SCF Total	**553**	**1,009**													
PRIORITY 5 - Back Office Functions and Enabling Schemes															
Implementation of economy wide IM&T strategy / model	0	500	N/A	A	Peter Nuttall	Kathy Roe	Colin Skoyles / GMSS Tracy Brennand	Richard Bircher	01-Jul-16	Rapid development and implementation of plans for healthy economy wide rationalisation of IM&T functions and commitments, including sharing of licences and support functions, bringing GP Practice IT in-house. Discussions are developing to incorporate the requirements of imminent CCG re-location.	Care Together Programme Board	Other Efficiencies	Transformational	Other	Yes
Implementation of economy wide estates strategy including rationalisation	0	500	N/A	A	Robin Monk	Clare Watson Gillian Parker	Dawn Scott Tracy Brennand		01-Oct-16	Implementation of plans for estates rationalisation in line with economy wide estates strategy	Care Together Programme Board	Other Efficiencies	Transformational	Other	Yes
Back Office / Enabling Schemes Total	**0**	**1,000**													
PRIORITY 6 - Governance															
Review and streamline the single commission, ICO and Care Together governance and decision making structures	0	100	N/A	A	Kathy Roe	Claire Yarwood / Sandra Stewart	Paul Pallister / Tom Neve / Robert Landon	Alan Dow	15-Oct-16	To become more efficient in making decisions where possible in order to release costs quicker. This would also release resource (people) to do more engagement with practices and ensure schemes are progressed quicker. This should also help release cash as well.	Single Commissioining Board and Care Together Programme Board	Other Efficiencies	Transformational	Other	No
Governance Total	**0**	**100**													
PRIORITY SCHEMES - MEDIUM - SUPPORTING SCHEMES / ALREADY ACHIEVED															
Neighbourhoods															
Recommissioning of wheelchair service	230	451	G	G	Clare Watson	Clare Watson	Ali Lewin	Richard Bircher	01-Apr-16	Contract for 2016-17 in place guaranteeing 16/17 saving. SCB approval 6/9/16 of revised costing model for 2017-18 to deliver recurrent savings. A procurement process is underway following SCB approval on 1st November 2016.	Professional Reference Group	Neighbourhoods	Transactional	Community	No
Reverse 17/18 Growth - community	0	74	N/A	A	Clare Watson	Clare Watson	Ali Lewin	Richard Bircher	01-Apr-17		Professional Reference Group	Neighbourhoods	Transformational	Community	No
Investment in ISCAN deferred	230	230	G	G	Clare Watson	Clare Watson	Alan Ford	Kay Phillips	01-Jun-16	Business case rejected at June PRG. Therefore money which was held in reserves is no longer required. Any further work in this area to be taken forward as a 'models of care' business case.	Professional Reference Group	Neighbourhoods	Transformational	Community	No
Neighbourhoods Total	**459**	**755**													
Primary Care															
Increase GP appointments to 15 minutes	0	0	N/A	N/A	Clare Watson	Clare Watson	Janna Rigby Tori O'Hare	Jamie Douglas Saif Ahmed Nav Riyaz	01-Oct-16	Mandated from April 2017. 15 min is considered a better time frame to hold effective consultations and allow for more detailed consultation hence there are less referrals made (National & International evidence).Close link to integrated neighbourhoods and extensivists model. This is an enabler to demand management.	Professional Reference Group	Primary Care	Transformational	Primary Care	No

Scheme	Savings		RAG Rating		Accountable Lead	SCMT/ICO	Supported by		Start Date	Notes	Reporting Governance	QIPP Category	NHS England Non ISFE Mapping		Link to Transformation Funding
	2016/17	2017/18	2016/17	2017/18			Officer	Clinical							
Review evaluation of Primary Care Quality Scheme discretionary spend	204	500	G	G	Michelle Rothwell	Michelle Rothwell	Janna Rigby Tori O'Hare	Jamie Douglas Joanna Bircher	01-Nov-16	Evaluation of 2015/16 scheme and proposals for 2017/18 to be discussed at September PRG (14/9/16). Feedback from GB to be taken into account in this discussion re the requirement for measureable / quantifiable outcomes and targets.	Professional Reference Group	Primary Care	Transformational	Primary Care	No
Review of commitments to Over 75 schemes	200	500	G	G	Clare Watson	Clare Watson	Janna Rigby Tori O'Hare	Jamie Douglas	01-Nov-16	CCG to review and evaluate the investment in Over 75 schemes. This will determine the future investment for this cohort of the population. This has now been agreed and the status changed to Green at £0.5m saving in 2017-18.	Professional Reference Group	Primary Care	Transformational	Primary Care	No
Primary Care IAT	294	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Dec-16		Finance & QIPP Group	N/A	N/A	N/A	No
Reverse 17/18 Growth - primary care	0	224	N/A	A	Clare Watson	Clare Watson	Janna Rigby Tori O'Hare	Jamie Douglas	01-Apr-17	Includes LES, OOH, PCIT, meds mgt, oxygen etc.	Professional Reference Group	Primary Care	Transformational	Primary Care	No
Review of current APMS contracts	0	88	N/A	A	Clare Watson	Clare Watson	Janna Rigby Tori O'Hare	Jamie Douglas	01-Apr-17	Proposals in development via the CCG Primary Care Joint Co-Commissioning Committee regarding an alternative model for the commissioning of primary care services currently delivered via the APMS contract. A paper is being prepared to take to a future PRG meeting. Recurrent savings of £150k with part year effect in 17/18.	Professional Reference Group	Primary Care	Transformational	Primary Care	No
Primary Care Total	**698**	**1,312**													
Mental Health															
RADAR	32	32	G	G	Clare Watson	Clare Watson	Chris Pimlott David Milner	Vinny Khunger Tina Greenhough	01-Apr-16	Money held in reserve in anticipation of additional spend with Greater Manchester West FT. No longer required.	Professional Reference Group	Mental Health	Transactional	MH	No
MH Safer Staffing	200	200	G	G	Clare Watson	Clare Watson	Chris Pimlott Julia Whittaker	Vinny Khunger Tina Greenhough	01-Sep-16	Business case rejected at September PRG. Funding was originally held in reserves in anticipation of approval, but released to reserves now decision has been made.	Professional Reference Group	Mental Health	Transformational	MH	No
Mental Health Total	**232**	**232**													
Acute Services - Elective															
Integrated Elective Services	500	500	G	G	Trish Cavanagh	Clare Watson	Elaine Richardson	Alison Lea	01-Apr-16	Bridging arrangements are in place with Care UK / GM Primary Eye Care for 2016/17, with fully integrated service in place for MSK, ENT & ophthalmology through the ICO from April 2017. Based on budgets in place as part of the bridging service, significant 16/17 in year savings are expected. This will be a minimum of £700k and based on current trajectories the savings could	Professional Reference Group	Acute Services - Elective	Transformational	Acute	Yes
Manage RTT Targets	0	0	N/A	N/A	Trish Cavanagh	Clare Watson	Elaine Richardson	Alison Lea	01-Sep-16	Manage OP activity at 92% performance for incompletes over all specialties in TFT and not over-achieve. Subject to TFT being able to respond quickly in alignment with consultant capacity plans.	Care Together Programme Board	Acute Services - Elective	Transformational	Acute	No
Minor Eye Condition Service	0	30	N/A	A	Clare Watson	Clare Watson	Elaine Richardson Julia Whittaker	Alison Lea	01-Sep-16	Optimise use of minor eye condition service - service now live by GM primary eyecare. New way of patients with urgent need. Evidence elsewhere suggests reduced A&E demand. This is an enabler to demand management.	Professional Reference Group	Acute Services - Elective	Transformational	Acute	No
Review of GP direct access diagnostic pathways (including AQP)	0	0	N/A	N/A	Clare Watson	Clare Watson	Elaine Richardson	Alison Lea	01-Oct-16	Analysis at local and GM level underway to understand the significant increase in spend over recent years in AQP with no corresponding reductions at acute providers. New service specifications (including protocols) are being developed for 2017-18. Proposals to be presented to PRG January 2017.	Professional Reference Group	Acute Services - Elective	Transformational	Acute	No
Review current audiology pathways (including AQP)	0	0	N/A	N/A	Clare Watson	Clare Watson	Elaine Richardson	Alison Lea	01-Sep-16	Specifications are being reviewed to understand the reasons for multiple referrals to audiology and ENT. Protocols will be developed to reduce unnecessary referrals.	Professional Reference Group	Acute Services - Elective	Transformational	Acute	No
Recommissioning of direct access Echo pathway	0	29	N/A	A	Trish Cavanagh	Clare Watson	Ian Bromilow Alison Lewin	Thomas Jones	01-Apr-17	Consultation currently underway which is likely to result in service of notice on Manor House Echo service (6 month notice period) as per previous agreement (in former PIQ Committee) and in line with contractual position.	Professional Reference Group	Acute Services - Elective	Transformational	Acute	No
Acute Services - Elective Total	**500**	**559**													
Enabling Schemes to facilitate QIPP															
Demand Management letter to associates	0	1,000	N/A	A	Clare Watson	Clare Watson	Ian Bromilow David Milner	Saif Ahmed Naveed Riyaz	01-Apr-17	Letter sent to all associate providers informing of our Care together schemes and warning that they should expect to see a reduction in demand which we anticipate will reduce 17/18 contracts by approximately 10%. Need to recognise that contracts will still be PbR, therefore realisation of benefits will be dependent upon all of the other actions discussed in this spreadsheet to reduce demand.	Professional Reference Group	Acute Services - Elective & Urgent	Transformational	Acute	Yes
Home IV Antibiotics	0	0	N/A	N/A	Trish Cavanagh	Michelle Rothwell	Alison Lewin	Richard Bircher	01-Jan-17	Subject to ICO internal business case to expand the current service to 7 days.	Professional Reference Group	Acute Services - Urgent	Transformational	Acute	Yes
Commissioning Improvement Scheme	0	0	N/A	N/A	Clare Watson	Clare Watson	Tori O'Hare	Alan Dow	01-Apr-16	GP led schemes to manage demand, reduce inappropriate referrals and ensure value for money. Practices may be eligible to receive a payment under the scheme in 2017/18 based on achievement at both individual practice and neighbourhood. Suggestion that we revisit the terms of this agreement to reduce the value of the 17/18 incentive payment available to help with the financial position.	Professional Reference Group	Acute Services - Elective & Urgent	Transformational	Acute	No
Communication / engagement with member practices and the public regarding agreed approaches to all referrals and QIPP schemes	0	0	N/A	N/A	Clare Watson	Clare Watson	Ali Lewin Elaine Richardson	Richard Bircher	01-Sep-16	No direct savings but key enabler to ensure member practice engagement, involvement and adherence to financial recovery plan proposals	Single Commissioning Board	Other Efficiencies	Transformational	Other	No
Increase at pace and scale the officer and clinical peer support to outlier GP Practices	0	0	N/A	N/A	Clare Watson	Clare Watson	Ali Lewin Tracey Simpson	Saif Ahmed Naveed Riyaz Andy Hershon Asad Ali Alan Dow	01-Aug-16	Using data from month 5, we have now identified 11 Practices who are an outlier by >5% from their unified budget. A programme of increased supporrt is being rolled out to these Practices and all Practices have received a complete data pack. Progress to date from this review has demonstrated that we have 18 Practices now on budget or under-spent and 32 Practices have shown improvement between months 4 and 5.	Professional Reference Group	Primary Care	Transformational	Primary Care	No

Scheme	Savings		RAG Rating		Accountable Lead	SCMT/ICO	Supported by		Start Date	Notes	Reporting Governance	QIPP Category	NHS England Non ISFE Mapping		Link to Transformation Funding
	2016/17	2017/18	2016/17	2017/18			Officer	Clinical							
Achievement of QPP	0	240	N/A	A	Michelle Rothwell	Michelle Rothwell	Alison Lewin	Alison Lea Joanna Bircher	01-Mar-17	Robust systems are in place for monitoring QPP in 2016-17 with named commissioning leads assigned to each QP measure. These leads, supported by BI, will provide a quarterly update on the position of achieving the QP target and describe any mitigating actions being taken where QP are not on target. The Nursing &Quality Directorate will hold bi monthly meetings with lead commissioners, BI and finance to monitor progress against QP scheme and report to Director of Nursing and Quality. The value rated as Green in 2017-18 reflects an area where performance to date in 2016-17 means there is confidence in this value having been achieved.	Quality Committee	Acute Services - Elective	Transformational	Acute	No
Reverse all growth - other	0	442	N/A	A	Kathy Roe	Kathy Roe Claire Yarwood	Elaine Richardon Alison Lewin David Milner	TBC	01-Apr-17	other' directorate. includes patient transport, 111, AQP, estates, safeguarding, programme staffing etc.		Other Efficiencies	Transformational	Other	No
Community DVT Clinic	0	0	N/A	N/A	Trish Cavanagh	Clare Watson	Alison Lewin	Saif Ahmed Thomas Jones	01-Jan-17	Proposal is establishment of Community DVT Clinic to undertake DVT ultrasound scans. To take forward via Urgent Care workstream but requires investment. Discussions have commenced with ICO re a different approach to their delivery of an existing service by the vascular team and an update will be provided by the ICO.	Professional Reference Group	Acute Services - Urgent	Transformational	Acute	Yes
Right Care	0	0	N/A	N/A	Trish Cavanagh	Michelle Rothwell	Ali Lewin Tracey Simpson BI Team	Richard Bircher Jamie Douglas	01-Oct-16	Fully explore Right Care programmes where T&G are deemed an outlier. Total savings potential of £22,115k identified in the 2016 refresh from Right Care. Many of the savings areas within this are already captured by other transformational plans we are implementing, but Right Care does present some new areas of opportunity we can exploit. For example we are currently reviewing Gastrointestinal services where Right Care suggests savings of £2,024k may be possible. The total savings target in this area is set at a level which is ambitious, but also ensure no double count against the wider Care Together programme. Provider need to deliver a service which is compatible with right care, which includes changing GP referral behaviour. A meeting was held at the CCG on 7th November and a team is attending the NW Right Care event on the 25th November including clinical representation.	Professional Reference Group	Acute Services - Elective & Urgent	Transformational	Acute	Yes
Ensure economy wide working on any proposals where changes in financial model will occur - ensure CT-FEW involved in / aware of ALL proposals	0	0	N/A	N/A	Kathy Roe	Kathy Roe Claire Yarwood	Elaine Richardon Alison Lewin David Milner	TBC	01-Oct-16	New ways of working between provider & commissioner to ensure that all projects, both commissioner and provider originated promote joint working and economy wide savings.	Professional Reference Group	Acute Services - Elective	Transformational	Acute	No
Development of Single Commission contract register	0	0	N/A	N/A	Clare Watson	Clare Watson	Ian Bromilow Trevor Tench	TBC	01-Aug-16	Development of register of all contracts held by the single commission, to include financial and contractual term detail, to support the SC to review current contractual obligations, be aware of contractual commitments when developing plans for financial recovery / QIPP, and identify opportunities for redesign / recommissioning	Professional Reference Group	Other Efficiencies	Transformational	Other	No
Enabling Schemes for QIPP Total	**0**	**1,682**													
Technical Finance & Reserves															
Non Recurrent Funding	1,000	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Aug-16	Release non recurrent funds which are currently uncommitted toward addressing QIPP challenge	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Risk Reserve	443	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Aug-16	Release risk reserve toward addressing QIPP challenge	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
GM Strategic levy	64	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Aug-16	Double count identified following detailed review of reserves. IAT actioned, but funding not taken out of reserves	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
CATs Reserve	176	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Aug-16	April invoices already funded from recurrent budgets, therefore non recurrent reserve held for 3 month bridging period not required.	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Personal Health Budgets	150	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner Michelle Rothwell	N/A	01-Aug-16	£150k held in reserves to pay for personal health budgets. No actual spend between April & August. Therefore half of the reserve released to QIPP in August as a result of slippage. Remaining £75k released to QIPP in January as still no sign of spend in year. A reserve of £50k has been created in 17/18 in relation to this.	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
CHC over accrual in 2015/16	1,983	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner Michelle Rothwell	N/A	01-Aug-16	Value of benefit in 15/16 now confirmed. Detailed review of 16/17 forecast now undertaken so confidence in releasing this value to QIPP.	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Independent Sector activity	350		G	N/A	Clare Watson	Clare Watson	Tracey Simpson David Milner	N/A	01-Aug-16	Tameside FT have been subcontracting a significant number of patients (mainly T&O) to the private sector for treatment to help with RTT targets. The FT are being charged tariff for this, but are also incurring costs and carrying risk in relation to these patients. During contract setting we agreed it would be sensible to remove this activity from the TFT contract and for the CCG to contract directly with the independent sector. As a result of this £841k was taken out of the Tameside contract and moved to reserves. The CCG's M4 position included £300k of overperformance, therefore a double count against the reserve. We anticipate that the spend on IS providers will continue to increase as the increased number of direct referrals starts to convert into chargeable activity. Therefore the £841k reserve has transferred into IS budgets and forecast to plan hence releasing the £300k double count to QIPP.	Professional Reference Group	Other Efficiencies	Transactional	Other	No
MRI scans (subject to TFT £1.2m from TMBC)	229	0	G	N/A	Clare Watson	Clare Watson	Tracey Simpson David Milner	N/A	01-Aug-16	Similar arrangement to above about moving diagnostic imaging to independent sector. £594k originally on reserves in relation to this. Diagnostics are paid from the same IS budgets above and following transfer of funding we believe budget should be sufficient on the assumption referral patterns do not change significantly. To be prudent, £228k held in reserves as a potential contingency in this area, but release to QIPP.	Professional Reference Group	Other Efficiencies	Transactional	Other	No
Release 0.5% contingency	0	1,908	N/A	G	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Apr-17		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Release half of the 1% 'uncommitted'	0	1,908	N/A	G	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Apr-17		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No

CCG Financial Recovery Schemes

Scheme	Savings		RAG Rating		Accountable Lead	SCMT/ICO	Supported by		Start Date	Notes	Reporting Governance	QIPP Category	NHS England Non ISFE Mapping		Link to Transformation Funding
	2016/17	2017/18	2016/17	2017/18			Officer	Clinical							
Release residual non recurrent spend	0	566	N/A	G	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Apr-17		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Release IM&T Reserve	17		G	N/A							Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Underspend against GM Levy	289	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01//12/16		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Double count against Levy	228	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01//12/16		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Winter Funding	429	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01//12/16		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
GM Strategic Levy	669	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01//12/16		Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Double count on MH allocation	141	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Aug-16	Double count identified following detailed review of reserves. Eating disorders reserve which is already included in budgets.	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Technical Finance & Reserves Total	**6,167**	**4,382**													
Other Efficiencies															
Efficiency Savings: Programme Budgets	409	0	G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	01-Apr-16	Individual budget holder review meetings already held as part of budget setting process. Therefore all of the obvious savings have already been captured. However further reviews to identify slippage and savings will be held in year. Green Schemes include £137k cross year benefits, £77k calderstones, £66k SBC cross year, £110k secondary care cross year	Finance & QIPP Group	Other Efficiencies	Transformational	Other	No
Potential change to GPIT rates following CFOs	220		G	N/A	Kathy Roe	Kathy Roe	Tracey Simpson David Milner	N/A	15-Oct-16	Total CCG contribution across GM to reduce from £18.6m to £15m. Confirmed CCG benefit as a result of this.	Finance & QIPP Group	Other Efficiencies	Transactional	Other	No
Review of employee related schemes where there are more cost-effective alternatives available	0	28	N/A	G	Paul Pallister	Kathy Roe	Tracey Simpson Tracy Brennand	N/A	01-Apr-17	This includes programmes where there are alternatives readily available in the Council and therefore these costs can be saved if notice is served to cease the programme within the CCG. This comprises: Employee Assistance Scheme (£1k), Investors in People (£18k) and Leadership Academy (£9k).		Other Efficiencies	Transformational	Other	No
Other schemes - inspired by best practice in other CCG recovery plans	0	0	N/A	N/A	TBC	TBC	QIPP Project Team	TBC	14-Oct-16	We are in the process of reviewing recovery plans from other CCG's (both from within GM and from further afield), to identify best practice and good ideas which are suitable for implementation in Tameside & Glossop. Options currently being discussed: Advice and Guidance clinics for gynaecology, IVF, Dicharge pathways for dementia, review of transport services, End of life rapid response.	Finance & QIPP Group	Other Efficiencies	Transformational	Other	No
Use of 1% Contingency	1,899	0	G	N/A	Kathy Roe	Kathy Roe	Kathy Roe	N/A	09-Sep-16	In compliance with NHSE business rules	Finance & QIPP Group	N/A	N/A	N/A	No
CCG share of the HRG4+ adjustment	0	588	N/A	G	Kathy Roe	Kathy Roe	Kathy Roe	N/A	01-Apr-17		N/A	N/A	N/A	N/A	No
Phase 2 QIPP Schemes	0	6,740	N/A	R	Kathy Roe	Kathy Roe	Kathy Roe	N/A	01-Apr-17	Phase 2 QIPP schemes	N/A	N/A	N/A	N/A	No
Care Together Programme: Uncommitted funds	527	0	G	N/A	Kathy Roe	Kathy Roe	Kathy Roe	N/A	08-Sep-16	Internally funded transformation fund from non recurrent funds. This had been earmarked to support the Care Together programme on a non recurrent basis however as an action of last resort to achieve financial balance in 2016-17, the uncommitted element of this can be released for this purpose.	Care Together Programme Board	N/A	N/A	N/A	No
Other Efficiencies Total	**3,054**	**7,356**													
Grand Total	**12,164**	**27,720**													
SAVINGS TARGET	**13,500**	**22,485**													
OTHER POTENTIAL ACTIONS TO CLOSE GAP - TO BE CONFIRMED															

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Reporting Member / Officer of Single Commissioning Board	Angela Hardman Executive Director, Public Health and Performance
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – GOVERNING BODY PERFORMANCE UPDATE**
Report Summary:	This paper provides the Single Commissioning Board with a draft quality and performance report for comment. This report has been reviewed by the Quality and Performance Assurance group on the 1 February 2017. 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 November 2016. The format of this report will include elements on quality from the Nursing and Quality directorate. As this report evolves. This report also includes Adult Social Care indicators. This evolving report will align with the other Greater Manchester Health and Social Care Partnership and national dashboard reports. The following have been highlighted as exceptions: • Diagnostic standard improving but still failing the standard. • A&E Standards were failed at THFT. • Ambulance response times were not met at a local or at North West level. • Improving Access To Psychological Therapies (IAPT) performance for Aceess and Recovery remain a challenge • 111 Performance against KPIs. • MRSA. Attached for information 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. • For those indicators where we are deemed to be in the lowest quartile performance we seek the Board's view on how these should be reported as exceptions within the performance and quality report.

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.
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)**	As the systems restructures and different parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all parts to account and understanding best where to focus resources and oversight. This report and framework continues to be developed to achieve this.
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, Public Health:

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. 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 other Greater Manchester Health and Social Care Partnership 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 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. CONTENTS – QUALITY AND PERFORMANCE REPORT

2.1 NHS Tameside & Glossop CCG: NHS Constitution Indicators (November 2016).

2.2 Adult Social services indicators. (Quarter 2 16/17). These will be further expanded on in future iterations of this report.

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

- Diagnostic standard improving but still failing the standard.
- A&E Standards were failed at THFT.
- Ambulance response times were not met at a local or at North West level.
- Improving Access To Psychological Therapies (IAPT) performance for Access and Recovery remain a challenge
- 111 Performance against KPIs
- MRSA Bacteraemia

The exception reports in future reports will evolve as clarity is provided on the comparators.

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

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

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

2.6 There are a number of indicators where the CCG is deemed to be in the lowest performance quartile nationally. We seek the Board's view on how these should be reported as exceptions within the performance and quality report. These indicators have been highlighted in light orange on the dashboard and are as follows:

Better Health

- People with diabetes diagnosed less than a year who attend a structured education course;
- Utilisation of the NHS e-referral service to enable choice at first routine elective referral;
- People with a long-term condition feeling supported to manage their condition(s);
- Inequality in emergency admissions for urgent care sensitive conditions;
- Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions;
- Quality of life of carers.

Better Care

- One-year survival from all cancers;
- Proportion of people with a learning disability on the GP register receiving an annual health check;
- Choices in maternity services;
- Emergency admissions for urgent care sensitive conditions;
- Delayed transfers of care per 100,000 population;
- Population use of hospital beds following emergency admission;
- Management of long term conditions.

Sustainability

- Digital interactions between primary and secondary care.

3. KEY HEADLINES

3.1 Below are the key headlines from the quality and performance dashboard.

Referrals

3.2 Although GP referrals have increased this month compared to last month they have continued to decrease overall and have decreased compared to the same period last year. Other referrals have slightly increased compared to last month and have also increased compared to the same period last year. YTD GP referrals have decreased by 8% compared to the same period last year and other referrals have decreased by 0.6% compared to the same period last year for referrals at T&G ICFT. Referrals to all providers have decreased by 5% compared to the same period last year and other referrals have decreased by 2.9%.

18 Weeks RTT Incomplete Pathways

3.3 Performance continues to be above the national standard of 92%, currently achieving 92.7% during November. The specialties failing are Urology 89.88%, Trauma and Orthopaedics 90.39%, Neurology 90.91%, Plastic Surgery 82.78% and Cardiothoracic Surgery 91.38%. There were no patients waiting longer than 52 weeks during November.

Diagnostics 6+ week waiters

3.4 This month the CCG failed to achieve the 1% standard with a 1.29% performance. Of the 61 breaches 30 occurred at Central Manchester (echocardiography, flexi sigmoidoscopy, gastroscopy and MRI). 22 at T&G ICFT (audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS). 8 at NWCATs (audiology assessments and MRI) and 1 at Pennine Acute (gastroscopy). Central Manchester performance is due to an ongoing issue with endoscopy which GM are aware of. T&G ICFT performance is primarily due to audiology struggling with capacity.

A&E waits Total Time with 4 Hours at T&G ICFT

3.5 The A&E performance for November was 86.58% which is below the target of 95% which is ranked third in GM. The current performance is not on target to achieve the 90% for Quarter 3. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. Integrated Assessment Unit (IAU) and Ambulatory Emergency Care (AEC) are used as escalation capacity at times of pressure and this then increases traffic through A&E as the capacity to accept direct admissions are reduced.

3.6 **Ambulance Response Times Across NWAS area**

In November the North West position (which we are measured against) was not achieved against the standards. Locally we also did not achieve any of the standards. Increases in

activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

111

3.7 The North West NHS 111 service is performance managed against a range of KPIs reported as follows for November:

- Calls Answered (95% in 60 seconds) = 67.47%
- Calls abandoned (<5%) = 6.88%
- Warm transfer (75%) = 34.96%
- Call back in 10 minutes (75%) = 36.04%

The benchmarking data shows that the North West NHS 111 service was ranked 42nd out 42 for both calls answered in 60 seconds (67%) and calls transferred to clinical advisor (12%). This is compared to Bristol which is the highest ranked for calls answered in 60 seconds (98%) and North Central London for calls transferred to clinical advisor (33%).

Looking at the dispositions we are also ranked 42nd out of 42 for % recommended home care (3%) compared to the highest ranked provider North Central London (14%). Percentage recommended for dental/pharmacy (2%) we are ranked 41st out 42 compared to the highest ranked provider, York and Humber (12%).

In November 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.

Cancer

3.8 All of the cancer indicators achieved the standard during November.

Improving Access to Psychological Therapies

3.9 Performance continues to be above the Quarterly Standard for the IAPT access rate (75%) achieving 3.92% during Quarter 2. However, the Quarter 2 performance for IAPT recovery rate remains below the standard at 46.00%. In terms of IAPT waiting times the Quarter 2 performance is above the standard against the 18 week standard (95%) which was reported as 98.6%. The Quarter 2 performance for the 6 week wait standard (75%) was reported as 73.4%.

3.10 **Healthcare Associated Infections**

Clostridium Difficile: The number of reported cases during November was below plan. Tameside & Glossop CCG had a total of 6 reported cases of clostridium difficile against a monthly plan of 8 cases. For the month of November this places Tameside and Glossop CCG 2 cases under plan. Of the 6 reported cases, 5 were apportioned to the acute (3 at Tameside Hospital FT, 1 at Central Manchester FT and 1 at Christie Hospital FT) and 1 to the non-acute. To date (April to November 2016) Tameside and Glossop CCG had a total of 57 cases of clostridium difficile against a year to date plan of 69 cases. This places Tameside and Glossop CCG 12 cases under plan. Of the 51 reported cases, 30 were apportioned to the acute (24 at THFT, 2 at Central Manchester FT, 2 at Christie Hospital FT, 1 at The Royal Orthopaedic Hospital FT, 1 at Stockport FT) and 27 to the non-acute. In regards to the 2016/17 financial year, Tameside and Glossop CCG have reported 57 cases of clostridium difficile against an annual plan of 97 cases. This currently places the CCG 40 cases under plan with 4 months of the financial year remaining.

MRSA: In November 2016 Tameside and Glossop CCG have reported 0 cases of MRSA against a plan of zero tolerance. To date (April 2016 to November 2016) Tameside and Glossop CCG have reported 6 cases of MRSA against a plan of zero tolerance. Breakdown includes 4 acute cases (1 at Tameside Hospital FT, 2 at Central Manchester, 1 at South Manchester FT) and 2 non acute cases.

Mixed Sex Accommodation

3.11 There continues to be good performance against the Mixed Sex Accommodation standard with no MSA breaches reported in November for Tameside and Glossop CCG patients.

Dementia

3.12 We continue to perform well against the estimated diagnosis rate for people aged 65+ for November which was 74.4% against the 66.7% standard.

Adult Social Care Indicators

3.13 Performance in Adult Social Care is supported by the Adult Social Care Outcomes Framework (ASCOF). The framework contains nationally published qualitative and quantitative indicators. The qualitative indicators are informed by the completion of an annual national survey of a selection of service users and a biannual survey of a selection of Carers- both surveys are administered locally.

It is widely recognised that the quantitative indicators in the ASCOF do not adequately represent the service delivery of Adult Social Care, therefore in response, data sets have been developed regionally and locally in order to provide performance data that supports service planning and decision making for Adult Social Care in Tameside.

4. CONSIDERATIONS OF THE QUALITY AND PERFORMANCE ASSURANCE GROUP

4.1 Following the meeting of the Quality and Performance Assurance Group on the 1 February 2017 members made the following comments for consideration.

4.2 One care home provider recently inspected by the CGC has raised some concerns. Senior contract and quality officers have subsequently met with the providers in advance of the publication of the report to discuss action plans. The Quality and Performance Assurance Group are therefore assured on the monitoring of those action plans.

4.3 Following CQC inspection on Pennine care Foundation Trust the Quality and Performance Assurance Group were presented with a brief of the CQC report and have requested continuous feedback from the improvement board and sight of the action plan that will be monitored by that improvement board.

5. RECOMMENDATIONS

5.1 As set out on the front of the report.

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Key Messages

Positive trends

18 Weeks RTT Incomplete Pathways: Performance continues to be above the national standard of 92%, currently achieving 92.7% during November.
18 Weeks RTT 52+ Week Waits: There were no patients waiting longer than 52 weeks during November.
Cancer: All of the cancer indicators achieved standard during November.
IAPT Access Rate: Performance continues to be above the Quarterly standard (3.75%) achieving 3.92% during Quarter 2.
IAPT Waiting Times: Quarter 2 performance is above standard for 18 week waiting times and 18 week waits is reported as 98.6% (Standard 95%)
Healthcare Associated Infections Clostridium Difficile: The number of reported cases during November (6) was below plan.
Mixed Sex Accommodation: There were no MSA breaches reported in November for Tameside and Glossop CCG patients.
Dementia: Estimated diagnosis rate for people aged 65+ for November was 74.4% against the 66.7% standard.
Referrals: Although GP referrals have increased this month compared to last month they have continued to decrease overall and have decreased compared to the same period last year. Other referrals have slightly increased compared to last month and have also increased compared to the same period last year.

Challenges

Please note a more detailed exception report is available for each of these indicators later in this report.

A&E Waits Total Time Within 4 Hours At T&G ICFT: November performance at Tameside And Glossop Integrated Care NHS FT (T&GICFT) is below the 95% target, at 86.6%. A total of 7,029 patients attended A&E in the month, of which 943 did not leave the department within 4 hours.
Diagnostics 6+ Week Waiters: Performance was higher (worse than) the national standard of 1.00%, currently achieving 1.29% during November.
Ambulance Response Times Across NWAS Area: Performance against all three response times across the North West Ambulance Service (NWAS) area are worse than the national standards in November. Responses to Red1 and Red2 calls within 8 minutes were below the 75% standard, at 62.8% and 60.4%, respectively. Responses to all Red calls within 19 minutes were also below the 95% standard, at 86.8%.
Healthcare Associated Infections MRSA: There have been 6 reported cases of MRSA during the year. No cases reported in the month of November.
111: The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Nov:- Calls Answered (95% in 60 seconds) = 67.47%- Calls abandoned (<5%) = 6.88%- Warm transfer (75%) = 34.96%Call back in 10 minutes (75%) = 36.04%
IAPT Recovery Rate: Quarter 2 performance was below the standard (50%) achieving 46.00%.
IAPT Waiting Times: Quarter 2 performance is below the standard for 6 week waiting times. IAPT 6 week waits is reported as 73.4% (standard 75%).

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

Key: H=Higher L=Lower <> =N/A

Better Health

Description	Indicator	F	Level	Better is...	Threshold	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	Nov-16	Exceptions	GM	England	Trend
	Utilisation of the NHS e-referral service to enable choice at first routine elective referral	M	T&G CCG	H								11.8%	11.6%	11.2%	11.1%	11.6%	10.4%	10.7%	10.0%				
	Number of women Smoking at Delivery.	Q	T&G CCG	L	England	14.4%		16.1%			15.8%	13.6%			16.9%						11.9% (Q1)	10.20%	
	Personal health budgets	Q	T&G CCG	H				4.0				4.0			4.1						11 (Q1)	11 (Q1)	
	Percentage of deaths which take place in hospital	Q	T&G CCG	<>				50.7%				47.6%			49.0%						50% (Q4 15/16)	47% (Q4 15/16)	
	Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q	T&G CCG	L				1475														929	
	Inequality in emergency admissions for urgent care sensitive conditions	Q	T&G CCG	L				3269														2359	
	Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	Q	T&G CCG	<>											1.1							1.1	
	Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care	Q	T&G CCG	<>																			
	Injuries from falls in people aged 65 and over	A	T&G CCG	L						2116												2014	

Description	Indicator		Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Exceptions	GM	England	Trend
	Percentage of children aged 10-11 classified as overweight or obese	A	T&G CCG	L						33.3%	34.1%			34.6% FY 14/15	33.2% FY 14/15	
	Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	A	T&G CCG	H							46.8%			41.8% FY 14/15	39.8% FY 14/15	
	People with diabetes diagnosed less than a year who attend a structured education course	A	T&G CCG	H							0.0%			1.9% FY 14/15	5.7% FY 14/15	
	People with a long-term condition feeling supported to manage their condition(s)	A	T&G CCG	H				66.6%	63.9%	62.9%	62.4%	61.4%			64.30%	
	Quality of life of carers	A	T&G CCG	H				80.4%	80.7%	77.70%	80.00%	77.5%		90.5% (2015)	80.0% (2016)	

Key: H=Higher L=Lower <> =N/A

Better Care

Description	Indicator	F	Level	Better is...	Threshold	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	Nov-16	Exceptions	GM	England	Trend
Cancer 2 Week Wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	M	T&G CCG	H	93%	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%	97.5%		96.90%	95.16%	
	Maximum two week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	M	T&G CCG	H	93%	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%	100.0%		96.30%	96.05%	
Cancer 31 Day Wait	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	M	T&G CCG	H	96%	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%	98.2%		97.80%	97.22%	
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	M	T&G CCG	H	94%	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%	100.0%		96.60%	94.54%	
	Maximum 31 day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	M	T&G CCG	H	98%	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%	100.0%	Breach due to deferred treatment in Jan-16.	99.60%	99.51%	
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	M	T&G CCG	H	94%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100%	97.72%	
Cancer 62 Day Wait	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	M	T&G CCG	H	85%	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%	90.4%	There were 10 breaches out of a total of 39 seen in Sept 16.	88.30%	82.10%	
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	M	T&G CCG	H	90%	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%	92.9%		90.00%	92.47%	
	Maximum 62 day wait for first treatment following a consultants decision to upgrade the priority of the patients (all cancer)	M	T&G CCG	H	85%	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%	94.4%	For Sept 16 there were 13 patients treated with 6 being treated over the target	86.50%	89.65%	
18 Weeks RTT	Patients on incomplete non emergency pathways (yet to start treatment)	M	T&G CCG	H	92%	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%	92.7%	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%.	92.30%	90.05%	
	Patients waiting 52+ weeks on an incomplete pathway	M	T&G CCG	L	Zero Tolerance	0	1	0	2	0	12	1	0	1	1	1	0	1	0	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	M	T&G CCG	L	1%	2.4%	2.5%	2.68%	1.83%	2.88%	2.17%	2.55%	1.55%	2.36%	1.70%	1.20%	1.24%	1.34%	1.29%	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.	1.50%	1.10%	
Dementia	Estimated diagnosis rate for people aged 65+	M	CCG	H	66.70%	68.90%	68.90%	70.30%	71.60%	71.10%		69.60%	69.80%	70.50%	70.3%	71.3%	72.8%	75.3%	74.4%		77.50%	68.00%	
A&E < 4 Hours	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - THFT	M	THFT	H	95%	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%	86.6%	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.	86.00%	88.40%	
	Delayed transfers of care per 100,000 population	M	T&G CCG	L												21.2					16.3	14.1	

	People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	M		H					0.0%	11.1%		33.3%	45.5%	62.1%	65.4%							78.0%	72.00%	
	Achievement of milestones in the delivery of an integrated urgent care service	M		H												4								
IAPT-Improving Access to psychological services	Access	Q	T&G CCG	H	3.75%	4.30%		4.41%		4.3%		3.95%			3.92%								4.00%	
	Recovery	Q	T&G CCG	H	50%	44.00%		40.14%		40.0%		45.75%			46.00%							47.50%	48.89%	
	Waiting times less than 6 weeks	Q	T&G CCG	H	75%	52.60%		60.14%		56.3%		62.75%			73.40%							79.30%	84.82%	
	Waiting times less than 18 weeks	Q	T&G CCG	H	95%	89.61%		90.54%		90.4%		91.50%			98.60%							95.40%	97.47%	
	Reliance on specialist inpatient care for people with a learning disability and/or autism	Q		L				65				62										62 (Q1)	58 (Q1)	
	Emergency admissions for urgent care sensitive conditions	Q		L				3269															2359	
	Population use of hospital beds following emergency admission	Q		L				1.3															1.0	
	Management of long term conditions	Q		L				1276															795 Q4 15/16	
	People eligible for standard NHS Continuing Healthcare	Q		H								63.9										53.5	46.0	

Description	Indicator		Level	Better is...	Threshold	2009	2010	2011	2012	2013	2014	2015	Exceptions	GM	England	Trend
	Cancers diagnosed at early stage	A	T&G CCG	H					44.1	43.7	44.2			48.90%	50.70%	
	One-year survival from all cancers	A	T&G CCG	H		64.9	65.7	66.6	67.6	67.6				69.50%	70.20%	
	Cancer patient experience	A	T&G CCG	H							9.1	8.7		9 (2014)	8.9 (2014)	
	Women's experience of maternity services	A	T&G CCG	H								77.6			79.7	
	Choices in maternity services	A	T&G CCG	H								61.4%				

Description	Indicator		Level	Better is...	Threshold	09/10	10/11	11/12	12/13	13/14	14/15	15/16	Exceptions	GM	England	Trend
	Neonatal mortality and stillbirths	A	T&G CCG	L			5.9	5.1	6.4	7.8	7.8			8.0 fy 14/15	7.8 FY 14/15	
	Dementia Care Planning and Post-Diagnostic Support	A	T&G CCG	H							79.4%			79.6% FY 14/15	77.0% FY 14/15	
	Patient experience of GP services	A	T&G CCG	H				85.6%	85.7%	83.4%	81.2%	83.2%		85.40%	83.20%	
	Proportion of people with a learning disability on the GP register receiving an annual health check	A	T&G CCG	H						44.6%	34.0%			47.5% FY 13/14	47.0% FY 14/15	

Description	Indicator		Level	Better is...	Threshold	2010	2011	2012	2013	2014	2015	2016	Exceptions	GM	England	Trend
	Primary care workforce	A	T&G CCG	H							0.9	1.0			1.0	

Key: H=Higher L=Lower <> =N/A

Better Care - Adult Social Care

Description	Indicator	F	Level	Better is...	Threshold	3rd Quarter 2015-16			4th Quarter 2015-16 Out-turn			1st Quarter 2016-17			2nd Quarter 2016-17			Exceptions			
						Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16		GM	England *	Trend
ASCOF 1C - Proportion of people using social care who receive self-directed support, and those receiving direct payments.	**Part 1a - % of service users who receive self directed support**	Q	LA	H	86.9	97.80%			97.77%			97.59%			97.51%			Cumulative year to date performance reported	-	86.9	
	Part 1b - % of carers who receive self directed support	Q	LA	H	77.7	92.89%			91.10%			99.57%			99.79%			Cumulative year to date performance reported	-	77.7	
	Part 2a - % of service users who are in receipt of direct payments	Q	LA	H	28.1	16.38%			15.43%			14.91%			14.74%			Cumulative year to date performance reported	-	28.1	
	Part 2b - % of carers who are in receipt of direct payments	Q	LA	H	67.4	91.38%			74.63%			77.87%			73.43%			Cumulative year to date performance reported	-	67.4	
ASCOF 2A - Permanent admissions to residential and nursing care homes, per 100,000 population.	**Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64**	Q	LA	L	13.3	9.69 (13 Admissions)			11.92 (16 Admissions)			1.49 (2 Admissions)			2.98 (4 Admissions)			Cumulative year to date performance reported	-	13.3	
	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	Q	LA	L	628.2	481.61 (182 Admissions)			643.03 (243 Admissions)			153.87 (59 Admissions)			307.75 (118 Admissions)			Cumulative year to date performance reported	-	628.2	
	Total number of permanent admissions to residential and nursing care homes aged 18+	Q	LA	H	-	195			259			61			122			Cumulative year to date performance reported	-	-	
ASCOF 2B - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/ rehabilitation services.	**Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital**	Q	LA	H	82.7	-			86.44			-			-			Based on a sample period of discharges from hospital between October - December each year.	-	82.7	
	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital compared against the HES data (hospital episode stats)	Q	LA	H	2.9	-			4.02			-			-			Based on a sample period of discharges from hospital between October - December each year.	-	2.9	
Early Help	**Number of people supported outside the Social Care System with prevention based services.**	Q	LA	H	-	8609			8503			8406			8308			Cumulative year to date performance reported	-	-	
Helped To Live At Home	**Number of people helped to live at home and remain independent with support from Adult Services in community based services**	Q	LA	H	-	2945			2971			3027			3000			Cumulative year to date performance reported	-	-	
Early Help - Re-ablement Services	**% of people completing re-ablement who leave with either no package or a reduced package of care.**	Q	LA	H	-	90.29%			90.40%			85.98%			87.76%			Cumulative year to date performance reported	-	-	
REVIEWS D40 - Proportion of service users with a completed review in the financial year	**Service users needs change and frequent reviews ensure that they receive services which are suitable for their needs, and that LA's can utilise resources in the most efficient and appropriate way.**	Q	LA	H	-	60.07%			72.78%			22.39%			41.09%			Cumulative year to date performance reported	-	-	

* Rag ratings are based on quarter on quarter and year on year comparisons.
England data is 15/16.

Key: H=Higher L=Lower <> =N/A

Sustainability

Description	Indicator	F	Level	Better is...	Threshold	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	Nov-16	Exceptions	GM	England	Trend
Referrals	GP Referrals-Total	M	T&G CCG	L		5532	5116	5180	5723	5636	67180	6018	5494	5724	5359	5142	5310	5086	5192	Variance from Monthly plan			
	Other referrals- Total	M	T&G CCG	L		2715	2694	2670	2871	2837	34656	2904	2748	2730	2751	2853	2786	3060	3085	Variance from Monthly plan			
	GP referrals- T&G ICFT	M	T&G CCG	L		4088	3804	3817	4242	4129	48782	4088	3971	4053	3766	3452	3611	3566	3673	Variance from previous year			
	Other referrals - T&G ICFT	M	T&G CCG	L		1375	1418	1419	1639	1540	19274	1640	1428	1521	1637	1670	1612	1836	1854	Variance from previous year			
Activity	Outpatient Fist Attend	M	T&G CCG	L	Plan	7169	6561	6591	6698	6554	80783	6852	7137	7441	6755	6903	7205	7265	7606	Variance from Monthly plan			
	Elective Inpatients	M	T&G CCG	L	Plan	2986	2642	2799	2898	2717	34015	2799	2890	3022	2871	2876	2915	2956	3201	Variance from Monthly Plan			
	Non-Elective Admissions	M	T&G CCG	L	Plan	2462	2562	2407	2372	2636	28906	2361	2409	2314	2267	2336	2244	2337	2431	Variance from Monthly Plan			
	In-year financial performance	Q		H																			
	Outcomes in areas with identified scope for improvement	Q		H																		58.30%	
	Digital interactions between primary and secondary care	Q		H											52.6								
	Local strategic estates plan (SEP) in place	A		H								Yes											
	Financial plan	A		H								AMBER											

Key: H=Higher L=Lower <> =N/A

Well Led

Description	Indicator	F	Level	Better is...	Threshold	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	Nov-16	Exceptions	GM	England	Trend
	Quality of CCG leadership	Q		H																			
Description	**Indicator**		**Level**	**Better is...**	**Threshold**	**2009**		**2010**		**2011**		**2012**		**2013**		**2014**		**2015**		**Exceptions**	**GM**	**England**	**Trend**
	Staff engagement index	A		H														3.9				3.8	
	Progress against workforce race equality standard	A		L														0.3				0.2	
Description	**Indicator**		**Level**	**Better is...**	**Threshold**	**09/10**		**10/11**		**11/12**		**12/13**		**13/14**		**14/15**		**15/16**		**Exceptions**	**GM**	**England**	**Trend**
	Effectiveness of working relationships in the local system	A		H														66.9					

Indicates the lowest performance quartile nationally.

Key: H=Higher L=Lower <> =N/A

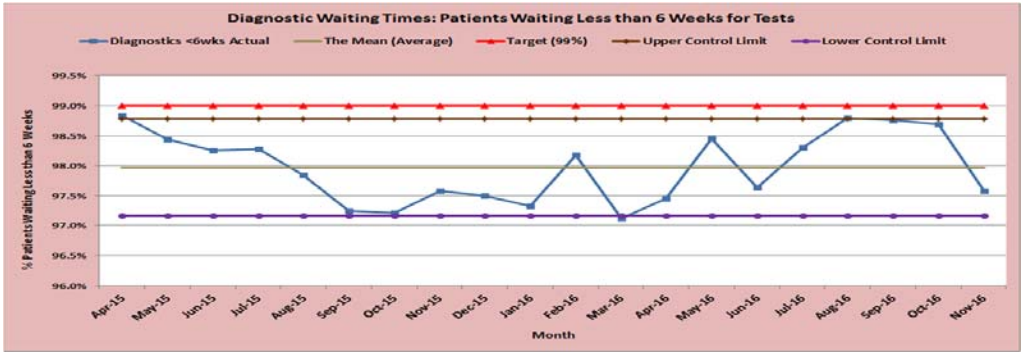
Other Indicators

Description	Indicator	F	Level	Better is...	Threshold	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	Nov-16	Exceptions	GM	England	Trend
Mixed Sex Accommodation	MSA Breach Rate	M	T&G CCG	L	0	0	0	0	0	0	0	0	0	0.1	0.2	0	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	Q	THFT	L	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	Q	T&G CCG	H	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%	
	Other Indicators																						
Other Indicators	Avoidable admissions- People		T&G CCG	L		5.58%	-14.25%	14.22%	14.95%	29.21%													
	Avoidable admissions-Cost		T&G CCG	L		39.92%	41.00%	12.51%	15.90%	-2.92%													
	Re admissions		T&G CCG	L																			
	Average LOS	M	T&G CCG	L									5.38	5.22	5.00	4.20							
	DTOCS (Patients)	M	LA	L		39	19	43	42	37		38	49	37	47	42	47	71	52				
	DTOCS (Patients)	M	Trust	L		33	16	43	36	25		26	38	25	32	29	38	61	45				
	Other Indicators-111																						
111 KPIs	Calls answered (60 Seconds)	M	NW	H	95.00%		55.00%	56.00%	58.00%	49.00%		80.00%	85.00%	90.00%	83.0%	90.0%	89.0%	71.4%	67.5%			88.50%	
	Calls abandoned	M	NW	L	<5%		15.00%	16.00%	15.00%	23.00%		6.00%	4.00%	2.00%	4.0%	2.0%	2.0%	6.4%	6.9%			2.40%	
	Warm Transfer	M	NW	H	75%		38.0%	39.0%	38.0%	31.0%		35.0%	33.0%	32.0%	33.0%	35.0%	36.0%	33.2%	35.0%			36.10%	
	Call back in 20 mins	M	NW	H	75%		36.00%	32.00%	34.00%	32.00%		39.00%	41.00%	40.00%	38.0%	39.0%	34.0%	34.7%	36.0%			38.20%	
	Ambulance																						
Ambulance	Red 1 < 8 Minutes (75% Target)	M	T&G CCG	H	75.00%	70.40%	76.60%	54.50%	67.00%	73.20%		81.50%	71.10%	69.50%	75.6%	66.7%	65.9%	68.3%	60.4%	High levels of demand and lengthening turn around times.	63.00%	67.30%	
	Red 2 < 8 Minutes (75% Target)	M	T&G CCG	H	75%	61.60%	65.30%	60.90%	55.80%	68.30%		64.90%	58.00%	63.10%	58.60%	65.80%	60.00%	60.48%	54.76%	High levels of demand and lengthening turn around times.	57.10%	62.90%	
	All Reds <19 Minutes (95% Target)	M	T&G CCG	H	95%	90.20%	91.2%	89.1%	87.9%	92.3%		90.7%	89.9%	91.1%	89.9%	91.0%	89.1%	86.4%	83.1%	High levels of demand and lengthening turn around times.		90.40%	
	Red 1 < 8 Minutes (75% Target)	M	NWAS	H	75%	70.40%	78.5%	69.3%	70.5%	74.8%		76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%	62.8%	High levels of demand and lengthening turn around times.	63.00%	67.30%	
	Red 2 < 8 Minutes (75% Target)	M	NWAS	H	75%	68.50%	69.5%	63.5%	61.1%	70.4%		67.5%	66.3%	66.2%	62.7%	65.3%	61.8%	63.0%	60.4%	High levels of demand and lengthening turn around times.	57.10%	62.90%	
	All Reds <19 Minutes (95% Target)	M	NWAS	H	95%	92.00%	92.70%	89.90%	88.10%	92.60%		92.00%	91.50%	91.50%	89.8%	91.1%	89.0%	88.2%	86.8%	High levels of demand and lengthening turn around times.		90.40%	
	Quality																						
Quality	Clostridium Difficile-Whole Health Economy	M		L	Plan	4	1	4	5	3	71	4	7	3	9	10	5	13	6			1120	
	Clostridium Difficile-Acute	M		L	Plan	1	0	1	4	0	29	2	2	2	4	5	2	8	5			399	
	Clostridium Difficile-Non-Acute	M		L	Plan	3	1	3	1	3	42	2	5	1	5	5	3	5	1			718	
	MRSA-Whole Health Economy	M		L	0	1	2	0	0	1	8	0	0	2	1	3	0	0	0		4	66	
	MRSA-Acute	M		L	0	0	1	0	0	0	3	0	0	2	0	2	0	0	0			29	
	MRSA-Non Acute	M		L	0	1	1	0	0	1	5	0	0	0	1	1	0	0	0			37	

Exception Report

Tameside & Glossop CCG- January

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



Key Risks and Issues:

As a CCG
This month the CCG failed to achieve the 1% standard with a 1.29% performance.
Of the 61 breaches 30 occurred at Central Manchester (echocardiography, flexi sigmoidoscopy, gastroscopy and MRI). 22 at T&G ICFT (audiology assessments, colonoscopy, CT scans, gastroscopy and NOUS). 8 at NWCATs (audiology assessments and MRI) and 1 at Pennine Acute (gastroscopy).

Central Manchester performance is due to an ongoing issue with endoscopy which GM are aware of.
T&G ICFT performance is primarily due to audiology struggling with capacity.

As lead Commissioner.
T&G ICFT as a provider are achieving the standard.

Actions:

The Lead commissioner for CMFT has been asked to inform us when performance will come in line
T&G ICFT Information Team are working with the Audiology business manager to understand what action is needed to resolve the audiology waits.
Practices are being encouraged to book NWCATS Direct Access MRI through E-referral which would reduce booking delays.

Operational and Financial implications:

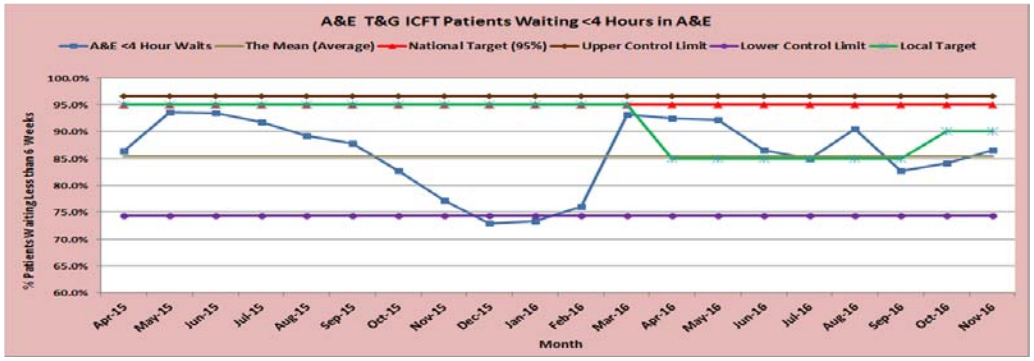
Failure of the standard will negatively impact on the CCG assurance rating. The CCG can Levey penalties through contract with those providers who fail the target.

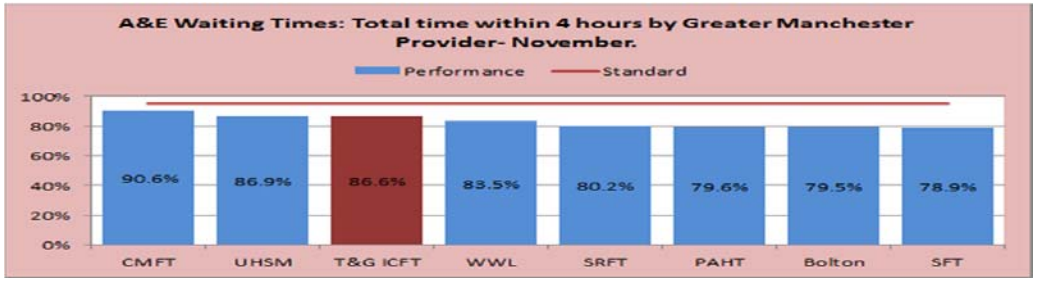
Diagnostics Waiting Times Patients Waiting > 6 Weeks by GM CCG

	Nov-16			
CCG	**Waiting > 6 Weeks**	**Total Waiting List**	**Performance**	**Standard**
NHS Central Manchester CCG	153	3180	4.8%	1%
NHS North Manchester CCG	68	3266	2.1%	1%
NHS South Manchester CCG	44	2618	1.7%	1%
NHS Trafford CCG	50	5204	1.6%	1%
NHS Oldham	61	3931	1.6%	1%
NHS Bury CCG	49	3644	1.3%	1%
NHS Bolton CCG	47	3604	1.3%	1%
NHS Heywood Middleton & Rochdale CCG	56	4309	1.3%	1%
NHS Tameside and Glossop CCG	61	4730	1.3%	1%
NHS Salford CCG	54	4389	1.2%	1%
NHS Wigan Borough CCG	50	5720	0.9%	1%
NHS Stockport CCG	44	5278	0.8%	1%

Unvalidated -Next month FORECAST

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





Key Risks and Issues:
The A&E performance for November was 86.58% which is below the target of 95%. The current performance is not on target to achieve the 90% for Quarter 3. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There are still medical cover and specialty delays when teams are in Theatres . Acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. IAU and AEC are used as escalation capacity at times of pressure and this then increases traffic through A&E as the capacity to accept direct admissions are reduced.

The level of acute beds occupied by people who should have been discharged is higher than it should be which reduces Medical bed capacity.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.

Actions:
Actions include:
- Weekly urgent Care Exec focus on the Delayed Discharges to address capacity issues and prioritising discharges. Additional staffing in IUCT will support the wider roll out of Discharge to Assess building on the excellence seen in discharging people home for assessment. Additional capacity has been funded in the Community bed base.
- T&G ICFT internal Silver Command model operational when required
- Ward Liaison Officers operational to support effective patient flow
- Escalation beds are closed as quickly as possible to release IAU and AEC capacity and the old Critical care area is being opened to deliver the Ambulatory Care service.
- Using Fracture Clinic at peak times to assist with managing the minors work stream. the trust are also working with Salford ED to identify improved model for minors
- Staffing capacity is being flexed to support times of peak activity

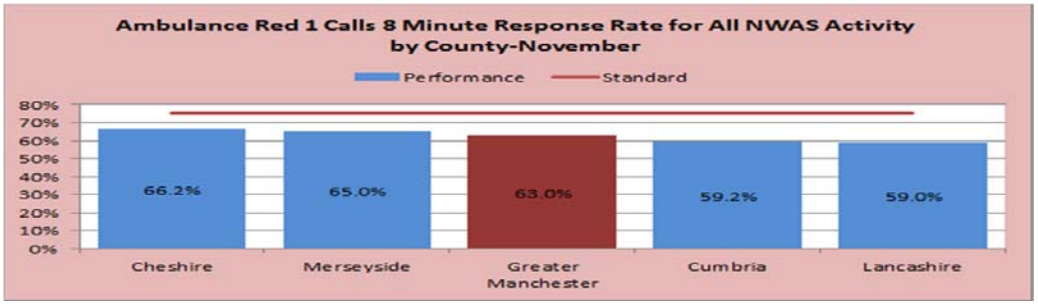
Operational and Financial implications:
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

The failure of this target will impact on the CCGs ability to obtain the

Next month FORECAST

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

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



Ambulance Red 1 Calls 8 Minute Response Rate for All NWAS Activity by CCG

	Nov-16			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS Central Manchester CCG	36	50	72.0%	75%
NHS Wigan Borough CCG	76	113	67.3%	75%
NHS Stockport CCG	60	90	66.7%	75%
NHS North Manchester CCG	93	140	66.2%	75%
NHS Bolton CCG	73	112	65.2%	75%
NHS Oldham	56	86	65.1%	75%
NHS Bury CCG	41	63	64.5%	75%
NHS Salford CCG	70	114	61.6%	75%
NHS South Manchester CCG	33	54	61.1%	75%
NHS Tameside and Glossop CCG	59	97	60.4%	75%
NHS Heywood Middleton & Rochdale CCG	40	78	50.6%	75%
NHS Trafford CCG	29	59	49.2%	75%

Key Risks and Issues:

In November the north west position (which we are measured against) was 62.8.% however locally we only achieved 60.4% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Unvalidated next month FORECAST

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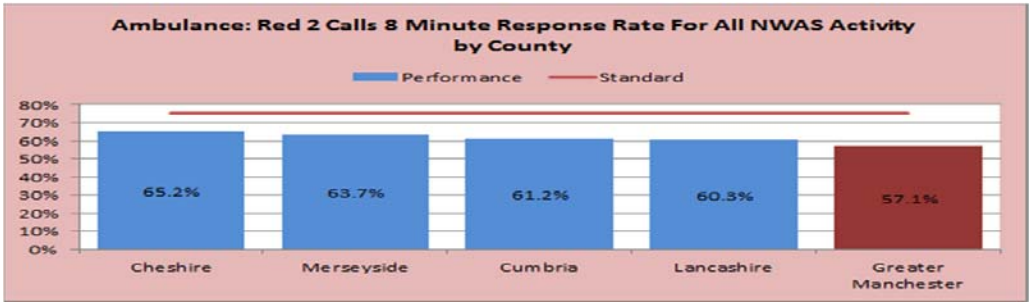
Ambulance performance- | **Lead Officer: Elaine Richardson** | **Lead Director:** Clare Watson | **Governance: A&E Delivery Board**



Ambulance: Red 2 Calls 8 Minute Response Rate For All NWAS Activity by CCG

	Nov-16			
CCG	**<8 Mins**	**Total**	**Performance**	**Standard**
NHS South Manchester CCG	805	1250	64.4%	75%
NHS Central Manchester CCG	708	1131	62.6%	75%
NHS Bury CCG	640	1066	60.1%	75%
NHS North Manchester CCG	926	1543	60.0%	75%
NHS Bolton CCG	951	1622	58.7%	75%
NHS Wigan Borough CCG	1059	1808	58.6%	75%
NHS Oldham	825	1491	55.3%	75%
NHS Heywood Middleton & Rochdale CCG	728	1320	55.2%	75%
NHS Tameside and Glossop CCG	816	1490	54.8%	75%
NHS Salford CCG	757	1394	54.3%	75%
NHS Stockport CCG	871	1651	52.8%	75%
NHS Trafford CCG	561	1132	49.6%	75%

Key Risks and Issues:

In November the north west position (which we are measured against) was 60.4% however locally we only achieved 54.76 Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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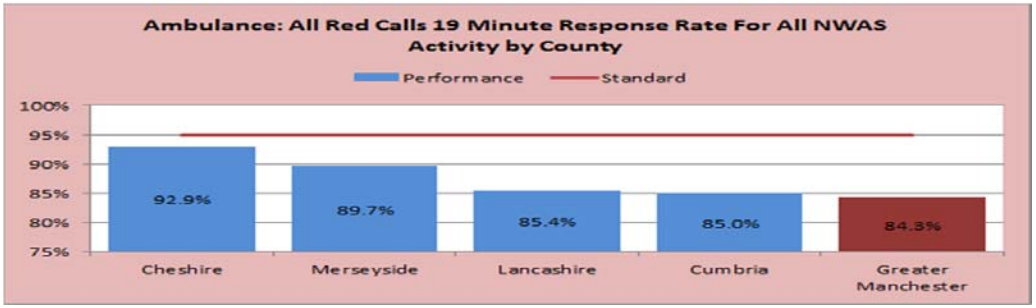
Ambulance performance- | **Lead Officer: Elaine Richardson** | **Lead Director:** Clare Watson | **Governance: A&E Delivery Board**



Ambulance: All Red Calls 19 Minute Response Rate For All NWAS Activity by CCG

	Nov-16			
CCG	**<19 Mins**	**Total**	**Performance**	**Standard**
NHS South Manchester CCG	1155	1304	88.5%	95%
NHS Central Manchester CCG	1034	1181	87.6%	95%
NHS Stockport CCG	1491	1741	85.6%	95%
NHS Salford CCG	1281	1508	84.9%	95%
NHS North Manchester CCG	1425	1683	84.7%	95%
NHS Bolton CCG	1468	1734	84.7%	95%
NHS Wigan Borough CCG	1623	1921	84.5%	95%
NHS Oldham	1312	1577	83.2%	95%
NHS Tameside and Glossop CCG	1318	1587	83.1%	95%
NHS Heywood Middleton & Rochdale CCG	1149	1398	82.2%	95%
NHS Bury CCG	921	1129	81.6%	95%
NHS Trafford CCG	961	1191	80.7%	95%

Key Risks and Issues:

In November the north west position (which we are measured against) was 86.8% however locally we only achieved 83.1% Increases in activity have placed a lot of pressure on NWAS and ambulances have experienced delays in handovers at acutes which together have impacted on its ability to achieve the standards.

Actions:

Blackpool CCG have agreed to support NWAS in implementation of its remedial action plan.

NWAS have agreed the following actions including :

Working with Health Care Professionals to ensure ambulances are dispatched appropriate to priority of need e.g. non urgent used when suitable.
Working with identified care homes that are high users of 999.
Working with acute trusts with handover delays to identify opportunities to reduce them.
An additional 700 hours added to the Urgent Care Desk to support decision making process and reduce activity to ED.
Additional areas of support are also being identified including working more closely with 111.

The Contracting and Strategic Partnership Board will maintain scrutiny on NWAS to ensure agreed actions are implemented.

Locally a hospital ambulance liaison officer and a community specialist paramedic are in place to support effective use and turnaround of ambulances.

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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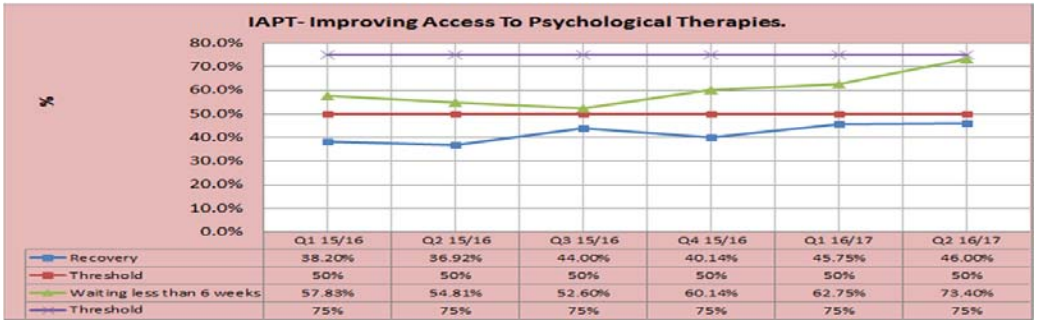
Improving Access To Psychological Therapies (IAPT)- **Lead Officer: Pat McKelvey** **Lead Director:** Clare Watson **Governance: Contracts**



	IAPT Recovery Rate	
Greater Manchester CCG	Rolling Quarter Ending Sep 2016	Plan (50%)
NHS TRAFFORD CCG	55.05%	50.00%
NHS WIGAN BOROUGH CCG	51.18%	50.00%
NHS BOLTON CCG	50.98%	50.00%
NHS BURY CCG	50.90%	50.00%
NHS STOCKPORT CCG	48.65%	50.00%
NHS TAMESIDE AND GLOSSOP CCG	46.04%	50.00%
NHS SALFORD CCG	44.67%	50.00%
NHS OLDHAM CCG	44.30%	50.00%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	41.43%	50.00%
NHS SOUTH MANCHESTER CCG	41.10%	50.00%
NHS NORTH MANCHESTER CCG	33.75%	50.00%
NHS CENTRAL MANCHESTER CCG	31.71%	50.00%

	IAPT Completing Treatment <6 Weeks	
Greater Manchester CCG	Rolling Quarter Ending Sep 2016	Plan (75%)
NHS WIGAN BOROUGH CCG	100.00%	75.00%
NHS OLDHAM CCG	89.00%	75.00%
NHS TRAFFORD CCG	83.00%	75.00%
NHS BOLTON CCG	83.00%	75.00%
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	82.00%	75.00%
NHS SALFORD CCG	81.00%	75.00%
NHS TAMESIDE AND GLOSSOP CCG	78.00%	75.00%
NHS STOCKPORT CCG	78.00%	75.00%
NHS BURY CCG	77.00%	75.00%
NHS NORTH MANCHESTER CCG	57.00%	75.00%
NHS CENTRAL MANCHESTER CCG	46.00%	75.00%
NHS SOUTH MANCHESTER CCG	44.00%	75.00%

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) Reduction of time taken for initial triage 3) Increased roll-out of step 3 groups

Operational and Financial implications:

Failure of the standard will negatively impact on the CCG assurance rating. The achievement of the standards may need additional investment notably to achieve the expected expansion of the service by 2020.

Unvalidated next QTR FORECAST

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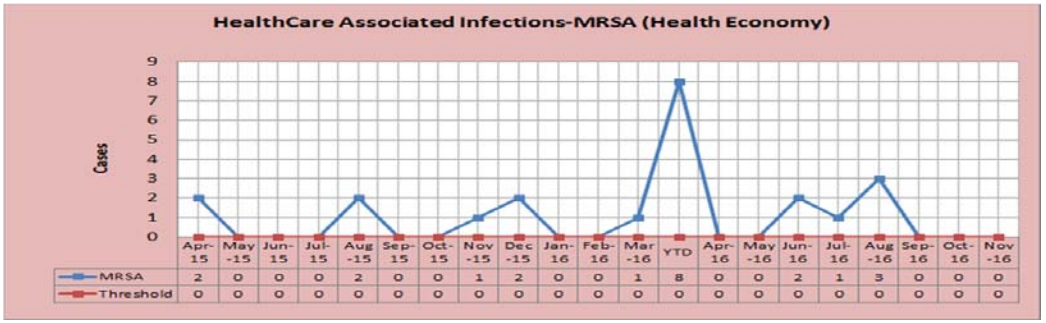
MRSA- **Lead Officer: Lynn Jackson** **Lead Director:** Michelle Walsh **Governance: Contracts**



Key Risks and Issues:

There were no reported cases in November.
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.

Operational and Financial implications:
The CCG can Levey penalties through contract with those providers who fail the target.

Greater Manchester CCGs MRSA

Organisation Name	Code	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Total
NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	01D	0	0	0	0	0	0	0	0	**0**
NHS BURY CCG	00V	0	0	1	0	0	0	0	0	**1**
NHS CENTRAL MANCHESTER CCG	00W	0	0	0	0	0	0	0	1	**1**
NHS SOUTH MANCHESTER CCG	01N	1	0	0	0	0	0	0	0	**1**
NHS TRAFFORD CCG	02A	0	0	0	0	0	0	0	1	**1**
NHS WIGAN BOROUGH CCG	02H	0	0	0	0	0	0	0	1	**1**
NHS OLDHAM CCG	00Y	1	0	0	0	1	1	0	1	**4**
NHS SALFORD CCG	01G	1	0	0	2	0	0	1	0	**4**
NHS STOCKPORT CCG	01W	1	1	1	0	0	0	0	0	**3**
NHS NORTH MANCHESTER CCG	01M	1	2	0	0	0	1	0	2	**6**
NHS TAMESIDE AND GLOSSOP CCG	01Y	0	0	2	1	3	0	0	0	**6**
NHS BOLTON CCG	00T	0	1	0	2	3	1	3	1	**11**
Total		**5**	**4**	**4**	**5**	**7**	**3**	**4**	**7**	**39**

Next month FORECAST

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111- **Lead Officer: Elaine Richardson** **Lead Director:** Clare Watson **Governance: Contracts**

Indicators - access & quality		NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
Calls per month per 1,000 people		22.7	18	Isle of Wight	45.9	South East Coast	6.1
Calls per month via 111 per 1,000 people		22.7	16	Isle of Wight	45.7	South East Coast	6.1
Of all calls offered, % abandoned after at least 30 seconds[1]		7%	1	NW inc. Blackpool	7%	Milton Keynes	0%
Of calls answered, % in 60 seconds		67%	42	Bristol	98%	NW inc. Blackpool	67%
Of calls answered, % triaged		90%	16	Luton	124%	Bedfordshire	67%
Of answered calls, % transferred to clinical advisor		12%	42	North Central London	33%	NW inc. Blackpool	12%
Of transferred calls, % live transferred		50%	9	Isle of Wight	82%	York & Humber	10%
Average NHS 111 live transfer time[1]		00:00:07					
Average warm transfer time		NCA					
Of calls answered, % passed for call back		11%	33	Cornwall	20%	Isle of Wight	1%
Of call backs, % within 10 minutes		36%	20	Cambridge and Peterborough	74%	Leicestershire and Rutland	9%
Average episode length		00:15:08					

Dispositions as a proportion of all calls triaged	T&G CCG	NW inc. Blackpool	Scoring out of 42 Areas: NW inc. Blackpool	Highest		Lowest	
111 dispositions: % Ambulance dispatches	15%	15%	8	Devon	20%	North Essex	10%
111 dispositions: % Recommended to attend A&E	8%	8%	28	East London and City	14%	South East Coast	5%
Recommended to attend primary and community care	57%	57%	37	Berkshire	66%	North Central London	39%
Of which - % Recommended to contact primary and community care		43%	22	Banes & Wiltshire	45%	North Central London	30%
- % Recommended to speak to primary and community care		12%	28	Cambridge and Peterborough	19%	North Central London	5%
- % Recommended to dental / pharmacy		2%	41	York & Humber	12%	Devon	1%
111 dispositions: % Recommended to attend other service	2%	2%	30	Nottinghamshire	9%	Banes & Wiltshire	1%
111 dispositions: % Not recommended to attend other service	19%	18%	5	North Central London	31%	Mainland SHIP	8%
Of which - % Given health information		4%	1	NW inc. Blackpool	4%	Somerset	0%
- % Recommended home care		3%	42	North Central London	14%	NW inc. Blackpool	3%
- % Recommended non clinical		10%	7	South East London	27%	Cambridge and Peterborough	3%

Key Risks and Issues:

The North West NHS 111 service is performance managed against a range of KPIs reported as follows for Nov:
- Calls Answered (95% in 60 seconds) = 67.47%
- Calls abandoned (<5%) = 6.88%
- Warm transfer (75%) = 34.96%
Call back in 10 minutes (75%) = 36.04%

In November 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.

Actions:

NWAS has agreed a further remedial action plan with commissioners.
NWAS has continued to deploy all available staff, and is actively managing staff absence and attrition in order to best meet the service needs.
Recruitment and training has been carried out to deliver new staff into operations during December and January.
A range of process changes are being implemented this includes patients using telephone key pads to identify the most appropriate call handler e.g. call regarding children automatically go to a nurse and issues such as coughs and colds receive self care and advise.
Greater Manchester is working with NWAS and Out Of Hours providers to implement the clinical assessment service that will help ensure A&E and primary care dispositions are correct.

Operational and Financial implications:

Poor patient experience could impact on willingness to use the service and increase A&E and primary care presentations.
Contract penalties applied by lead commissioner (Blackpool CCG).

Unvalidated next month FORECAST

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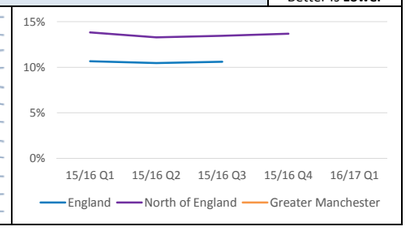
Better Health

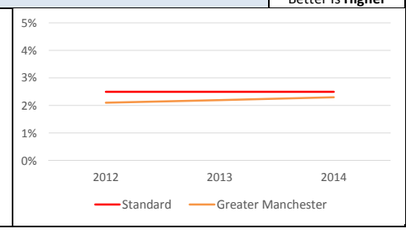
Fewer GM Babies Will Have a Low Birth Weight Resulting in Better Outcomes For The Baby & Less Costs To The Health System

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

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



Low Birth Weight of Term Babies — Better Is **Higher**



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

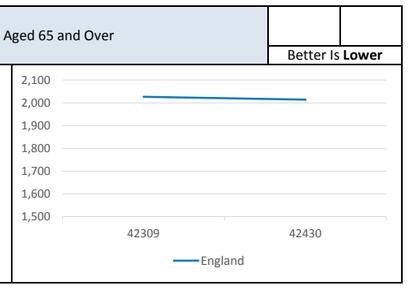
Percentage of Children Aged 10-11 Classified as Overweight or Obese — Better Is **Lower**

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

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**

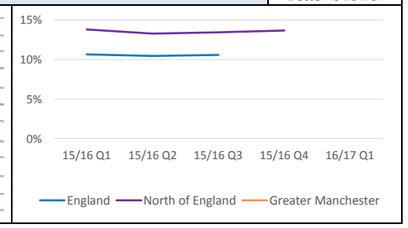
Bolton	1,626
Bury	2,005
Central	2,846
HMR	2,351
North	3,052
Oldham	2,319
Salford	3,220
South	2,761
Stockport	2,649
T&G	2,116
Trafford	2,203
Wigan	2,693



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

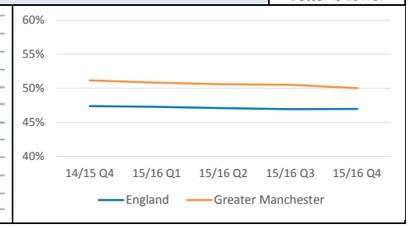
Maternal Smoking at Delivery — Better Is **Lower**

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



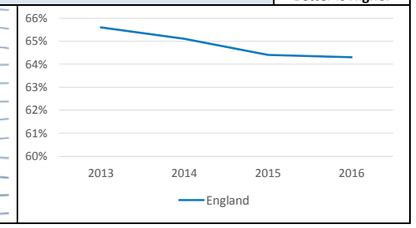
Percentage Of Deaths Which Take Place In Hospital — Better Is **Lower**

Bury	46.6%
HMR	46.4%
Oldham	47.0%
Bolton	46.5%
Stockport	48.9%
T&G	50.7%
Salford	49.1%
Wigan	52.1%
South	52.8%
North	53.9%
Central	53.2%
Trafford	57.2%



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

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

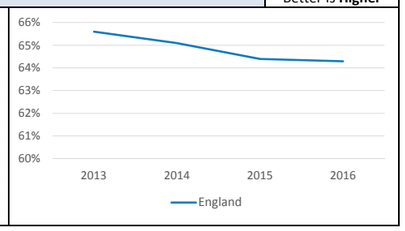


Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

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

Better Is **Higher**

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

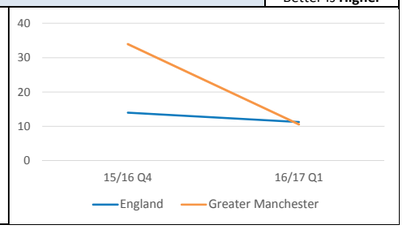


(Placeholder TBC)

Personal Health Budgets Per 100,000 Population

Better Is **Higher**

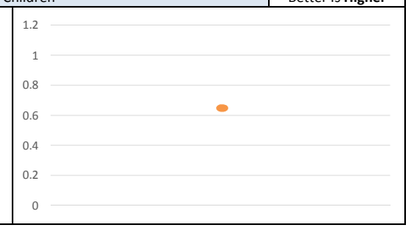
Bolton	6
Bury	5
Central	23
HMR	8
North	24
Oldham	3
Salford	0
South	27
Stockport	12
T&G	4
Trafford	3
Wigan	19



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

Better Is **Higher**

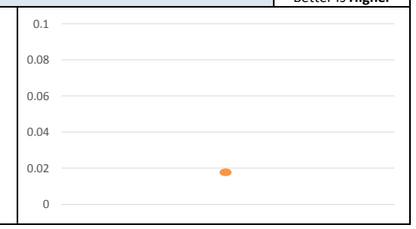
Bolton	38.7%
Bury	0.0%
Central	32.7%
HMR	0.0%
North	38.1%
Oldham	38.2%
Salford	44.0%
South	41.6%
Stockport	46.6%
T&G	46.8%
Bury	0.0%
HMR	0.0%



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

Better Is **Higher**

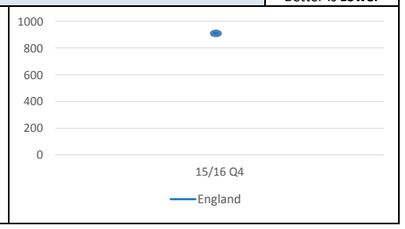
Bolton	0.1%
Bury	0.0%
Central	0.0%
HMR	0.0%
North	2.5%
Oldham	0.8%
Salford	1.0%
South	0.6%
Stockport	1.6%
T&G	0.0%
Bury	0.0%
HMR	0.0%



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**

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

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

Better Is **Lower**

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

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

Better Is **Lower**

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

Medicine Optimisation (Placeholder)

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

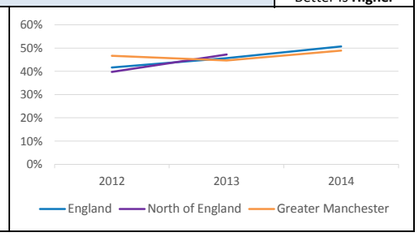
Better Care

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

Cancers Diagnosed at Early Stage

Better Is **Higher**

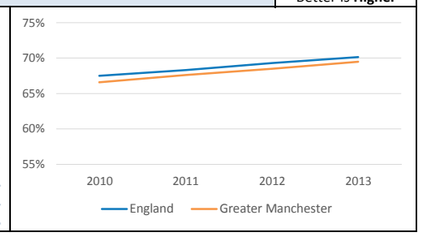
Trafford	47.3%
Stockport	50.8%
Bolton	51.5%
Oldham	49.4%
HMR	50.1%
Wigan	51.7%
South	47.2%
T&G	44.2%
Bury	53.7%
North	48.2%
Central	37.4%
Salford	46.3%



One-Year Survival From All Cancers

Better Is **Higher**

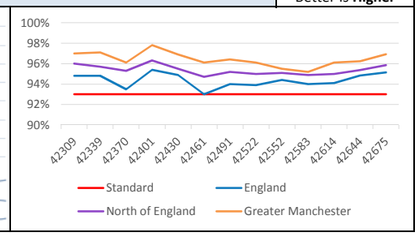
Stockport	72.3%
Trafford	72.0%
Bury	70.7%
Central	70.1%
South	69.9%
Wigan	69.5%
Bolton	69.2%
HMR	69.1%
Salford	68.8%
Oldham	67.9%
T&G	67.6%
North	66.9%



People Referred By Their GP With Suspected Cancer Within Two Weeks

Better Is **Higher**

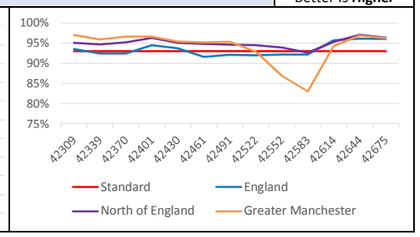
Bolton	98.9%
Wigan	98.1%
Stockport	98.1%
Salford	95.4%
South	95.6%
T&G	97.5%
North	97.0%
HMR	97.1%
Oldham	97.7%
Bury	97.6%
Central	92.6%
Trafford	94.7%



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

Better Is **Higher**

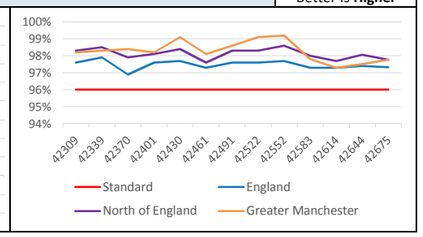
Stockport	97.9%
T&G	100.0%
Oldham	98.3%
HMR	100.0%
Wigan	95.3%
Bolton	96.6%
Central	91.7%
Trafford	97.5%
Salford	95.9%
Bury	97.0%
South	87.7%
North	97.3%



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

Better Is **Higher**

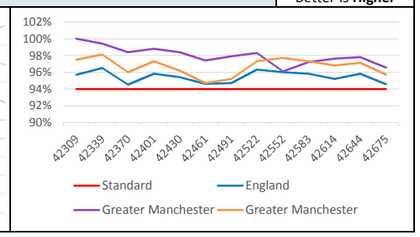
Stockport	98.7%
Central	94.6%
T&G	98.2%
Oldham	98.6%
Wigan	98.7%
North	100.0%
Bury	95.5%
HMR	97.3%
Salford	100.0%
Trafford	93.4%
Bolton	97.0%
South	100.0%



People Receiving Subsequent Cancer Treatments - Surgery Within 31 Days

Better Is **Higher**

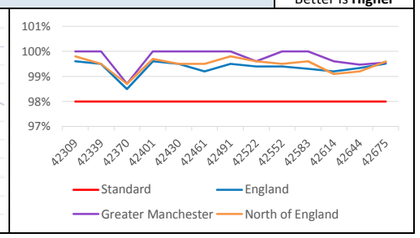
Stockport	93.8%
Salford	100.0%
North	100.0%
Bury	89.5%
South	100.0%
Central	80.0%
Trafford	95.0%
HMR	100.0%
Oldham	100.0%
Wigan	100.0%
T&G	100.0%
Bolton	100.0%



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

Better Is **Higher**

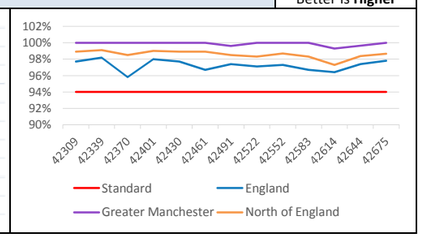
Stockport	100.0%
Bolton	100.0%
Trafford	100.0%
Bury	100.0%
Salford	100.0%
Central	87.5%
T&G	100.0%
HMR	100.0%
Wigan	100.0%
North	100.0%
Oldham	100.0%
South	100.0%



People Receiving Subsequent Cancer Treatments - Radiotherapy Within 31 Days

Better Is **Higher**

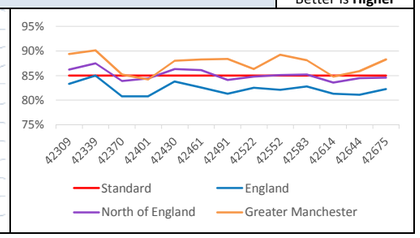
South	100.0%
Wigan	100.0%
T&G	100.0%
Bury	100.0%
Salford	100.0%
Central	100.0%
Stockport	100.0%
HMR	100.0%
Trafford	100.0%
North	100.0%
Bolton	100.0%
Oldham	100.0%



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

Better Is **Higher**

Central	77.8%
Bury	85.7%
Stockport	95.2%
South	95.0%
Bolton	94.5%
Wigan	92.2%
Trafford	79.2%
HMR	80.0%
Oldham	85.7%
Salford	85.3%
T&G	90.6%
North	92.6%

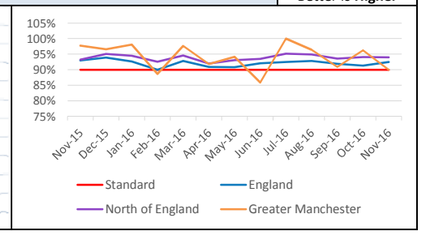


Decreased Variation In Quality Of Care Health Outcomes Across GM Localities

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

Better Is **Higher**

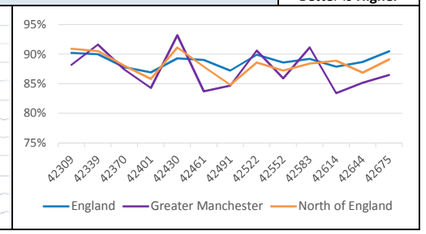
South	80.0%
T&G	92.9%
Stockport	100.0%
North	69.2%
Trafford	100.0%
Salford	88.9%
Bolton	100.0%
HMR	100.0%
Central	75.0%
Wigan	100.0%
Bury	100.0%
Oldham	66.7%



62-Day Wait For Treatment Following A Consultant Upgrade

Better Is **Higher**

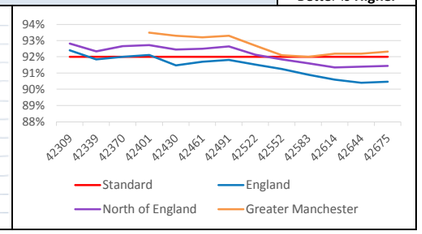
Central	100.0%
South	100.0%
North	100.0%
Trafford	87.5%
Bury	100.0%
Wigan	85.4%
Salford	84.2%
HMR	87.5%
Bolton	88.9%
Oldham	75.0%
Stockport	76.5%
T&G	94.4%



Patients Waiting 18 Weeks Or Less From Referral To Hospital Treatment

Better Is **Higher**

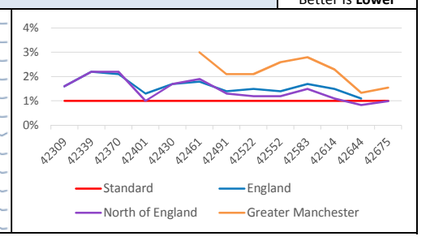
Wigan	95.1%
Oldham	93.7%
Salford	93.2%
Bolton	93.3%
HMR	93.1%
North	91.5%
T&G	92.6%
Central	92.1%
Bury	92.7%
Stockport	92.4%
Trafford	88.5%
South	87.8%



Diagnostics Test Waiting Times

Better Is **Lower**

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



Improved Patient/Carer Experience Of Care And Increased Patient Empowerment

Primary Care Access (Placeholder)

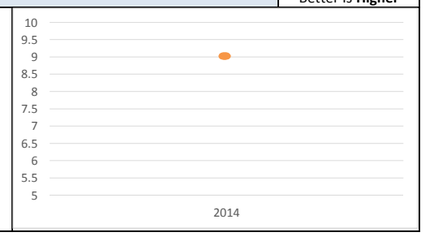
Better Is **Higher**

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

Cancer Patient Experience

Better Is **Higher**

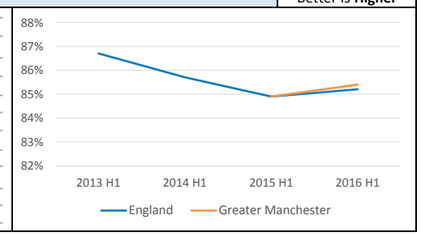
Bolton	9.0
Bury	9.2
Central	8.1
HMR	8.9
North	8.6
Oldham	8.5
Salford	9.4
South	8.7
Stockport	9.2
T&G	9.1
Trafford	9.1
Wigan	9.1



Patient Experience Of GP Services

Better Is **Higher**

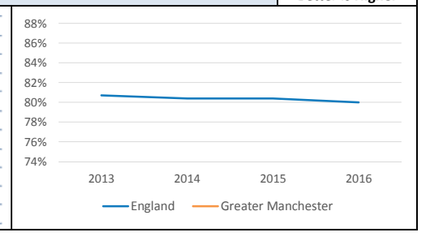
Bolton	87.2%
Bury	86.9%
Central	81.8%
HMR	82.3%
North	81.5%
Oldham	84.7%
Salford	85.3%
South	84.0%
Stockport	88.9%
T&G	83.2%
Trafford	86.5%
Wigan	88.2%



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

Better Is **Higher**

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

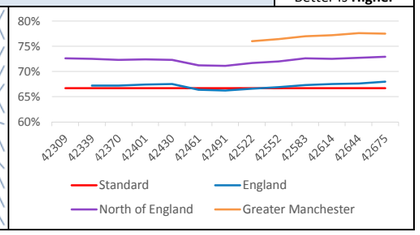


Improved Outcomes For People With Learning Disabilities/Mental Health Needs

Estimated Diagnosis Rate For People With Dementia

Better Is **Higher**

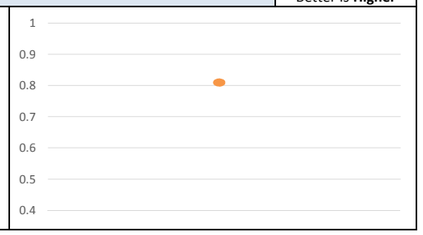
Wigan	97.6%
North	92.3%
Bury	92.5%
HMR	86.7%
Bolton	81.8%
Central	78.6%
Trafford	70.8%
Oldham	70.8%
Stockport	69.4%
T&G	67.8%
Salford	66.4%
South	63.6%



Dementia Care Planning and Post-Diagnostic Support

Better Is **Higher**

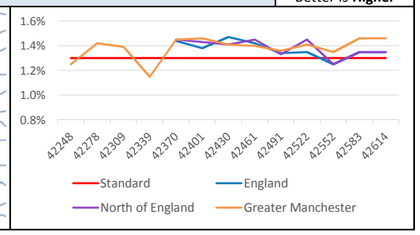
Bolton	80.1%
Bury	82.7%
Central	83.2%
HMR	76.2%
North	75.7%
Oldham	78.3%
Salford	81.4%
South	77.2%
Stockport	82.9%
T&G	79.4%
Trafford	77.7%
Wigan	77.9%



Improving Access to Psychological Therapies Access Rate

Better Is **Higher**

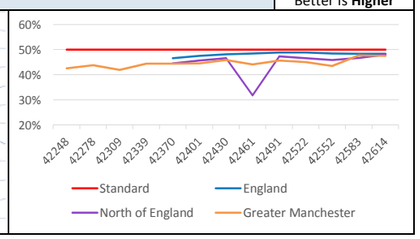
Salford	1.88%
Oldham	1.99%
Wigan	1.54%
Bolton	1.16%
T&G	1.35%
Stockport	1.37%
South	1.11%
North	1.37%
Trafford	1.00%
Bury	1.38%
HMR	1.53%
Central	1.17%



Improving Access to Psychological Therapies Recovery Rate

Better Is **Higher**

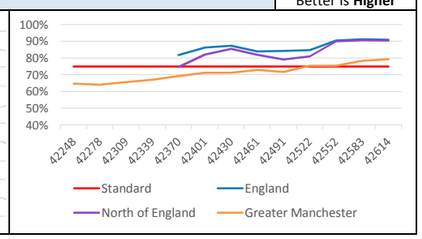
Trafford	53.8%
Bury	50.0%
Bolton	51.8%
Wigan	54.3%
T&G	50.0%
Salford	46.2%
Oldham	43.1%
South	37.5%
Stockport	52.0%
HMR	43.6%
North	36.7%
Central	33.3%



Improving Access to Psychological Therapies Seen Within 6 Weeks

Better Is **Higher**

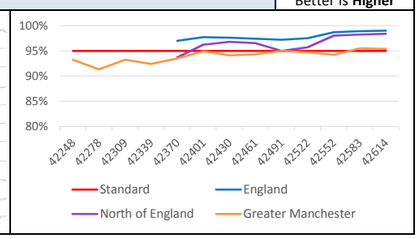
Wigan	100.0%
Trafford	83.3%
Bolton	83.1%
Oldham	89.7%
HMR	82.5%
Salford	80.6%
T&G	78.8%
South	45.5%
Bury	76.8%
Stockport	77.4%
Central	45.7%
North	56.7%



Improving Access to Psychological Therapies Seen Within 18 Weeks

Better Is **Higher**

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



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

Better Is **Higher**

Bolton	86.0%
Bury	100.0%
Central	97.2%
HMR	75.8%
North	100.0%
Oldham	57.1%
Salford	90.0%
South	57.7%
Stockport	66.7%
T&G	65.4%
Trafford	71.8%
Wigan	70.0%

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

Better Is **Lower**

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

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

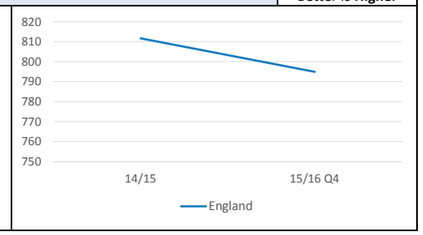
Better Is **Lower**

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**

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



Out Of Area Placements For Acute Mental Inpatient Care - Transformation

Better Is **Higher**

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

Children And Young People's Mental Health Services Transformation

Better Is **Higher**

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

Crisis Care And Liaison Mental Health Services Transformation

Better Is **Higher**

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

Decreased Need For Hospital Services With More Community Support

Population Use Of Hospital Beds Following Emergency Admission

Better Is **Lower**

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

Emergency Admissions For Urgent Care Sensitive Conditions

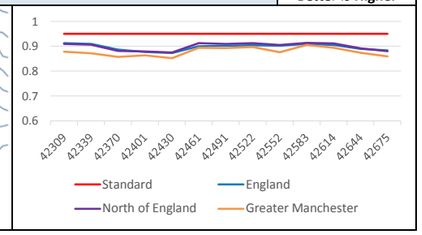
Better Is **Lower**

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

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

Better Is **Higher**

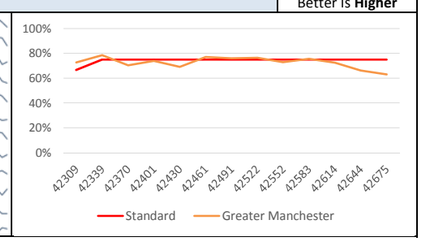
UHSM NHS	86.9%
CM NHS FT	90.6%
WWL NHS	83.5%
Salford Roy	80.2%
Bolton NHS	79.5%
Pennine Ac	79.6%
Tameside N	86.6%
Stockport N	78.9%



Ambulance in Red 1 in 8 mins

Better Is **Higher**

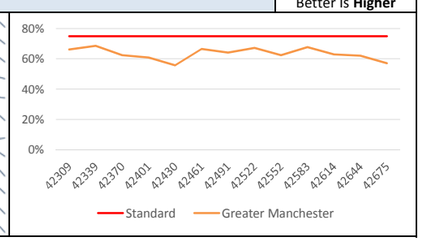
South	61.1%
North	66.2%
Bolton	65.2%
Salford	61.6%
Oldham	65.1%
Central	72.0%
HMR	50.6%
Wigan	67.3%
T&G	60.4%
Stockport	66.7%
Trafford	49.2%
Bury	64.5%



Ambulance in Red 2 in 8 mins

Better Is **Higher**

South	64.4%
North	60.0%
Bolton	58.7%
Central	54.3%
Bury	55.3%
HMR	62.6%
Wigan	55.2%
Oldham	58.6%
Salford	54.8%
T&G	52.8%
Trafford	49.6%
Stockport	60.1%

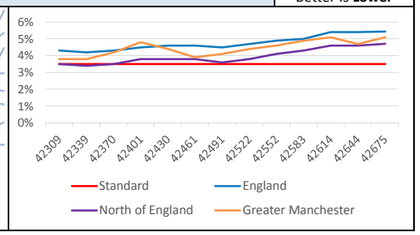


Improved Transition Of Care Across Health And Social Care

Delayed Transfers of Care - Bed Days

Better Is **Lower**

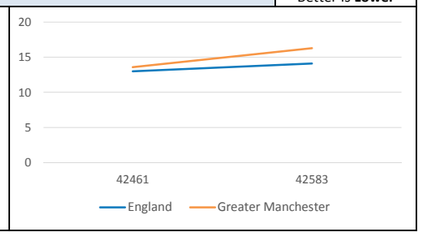
WWL NHS	0.4%
Pennine Ac	1.9%
Salford Roy	5.8%
CM NHS FT	3.1%
Bolton NHS	7.1%
Tameside N	10.8%
UHSM NHS	12.8%
Stockport N	9.4%



Delayed Transfers of Care per 100,000 Population

Better Is **Lower**

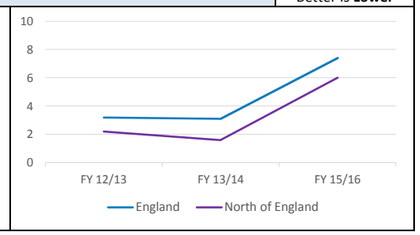
Bolton	15.5
Bury	8.1
Central	22.0
HMR	9.2
North	19.4
Oldham	3.4
Salford	5.7
South	19.0
Stockport	30.6
T&G	21.2
Trafford	36.9
Wigan	5.3



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

Better Is **Lower**

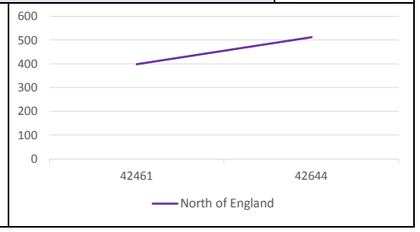
Bolton	4.4
Bury	5.5
Central	7.5
HMR	4.6
North	7.5
Oldham	2.3
Salford	4.2
South	7.5
Stockport	3.6
T&G	6.4
Trafford	14.5
Wigan	4.9



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

Better Is **Lower**

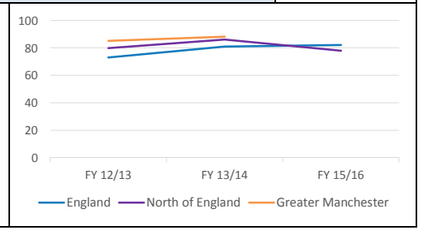
Bolton	496.0
Bury	297.0
Central	473.0
HMR	99.0
North	473.0
Oldham	214.0
Salford	175.0
South	473.0
Stockport	963.0
T&G	1065.0
Trafford	989.0
Wigan	178.0



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

Better Is **Lower**

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



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

Better Is **Lower**

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

Percentage Of People Aged 65+ Discharged Direct To Residential Care

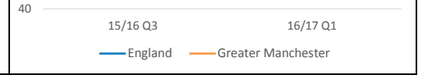
Better Is **Lower**

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

People Eligible For Standard NHS Continuing Healthcare

Better Is **Higher**

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

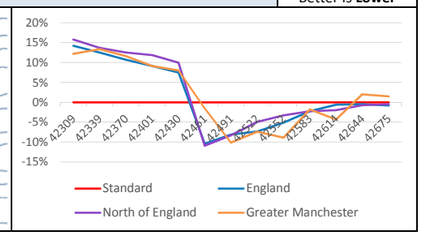


Placeholder TBC

C.Difficile (Ytd Var To Plan)

Better Is **Lower**

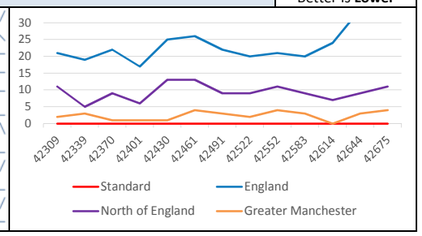
Salford	-22.4%
Trafford	-23.8%
T&G	-17.4%
Oldham	-19.0%
South	0.0%
Bolton	-3.8%
North	11.5%
Wigan	23.6%
HMR	9.1%
Bury	25.0%
Central	37.0%
Stockport	38.0%



MRSA

Better Is **Lower**

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



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

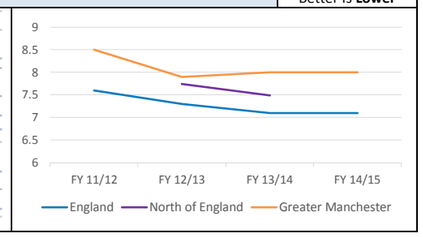
Better Is **Higher**

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**

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



Primary Care Workforce

Better Is **Higher**

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

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

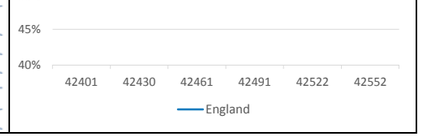
Better Is **Higher**

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

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

Better Is **Higher**

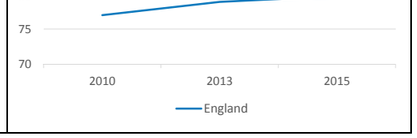
Bolton	103.9%
Bury	78.3%
Central	45.2%
HMR	61.7%
North	70.0%
Oldham	98.1%
Salford	88.2%
South	71.6%
Stockport	57.6%
T&G	11.1%
Trafford	62.2%
Wigan	55.2%



Women's Experience Of Maternity Services

Better Is **Higher**

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



Choices In Maternity Services

Better Is **Higher**

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

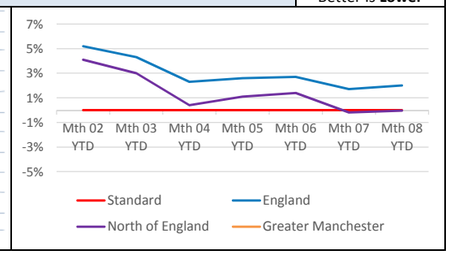
Sustainability

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**

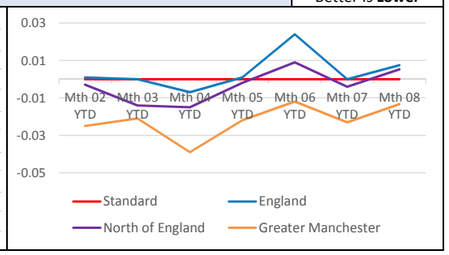
T&G	-4.2%
Salford	-4.7%
Bury	1.3%
Stockport	-2.2%
Trafford	-4.1%
North	-6.4%
Oldham	3.1%
Central	-4.3%
HMR	1.2%
Wigan	4.6%
South	-0.8%
Bolton	13.6%



Activity V Plan: Total OP Attends (Specific Acute)

Better Is **Lower**

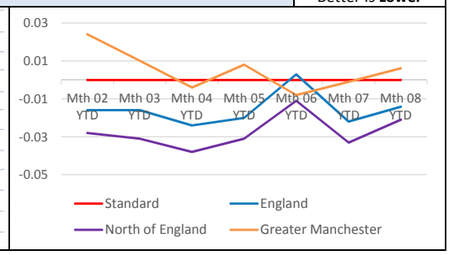
Trafford	-5.0%
Bury	-0.4%
South	-4.4%
Salford	2.2%
Stockport	-2.5%
Oldham	-5.6%
Wigan	6.5%
T&G	-8.6%
North	1.2%
Central	-3.5%
HMR	1.8%
Bolton	1.9%



Activity V Plan: Total Elective Spells (Specific Acute)

Better Is **Lower**

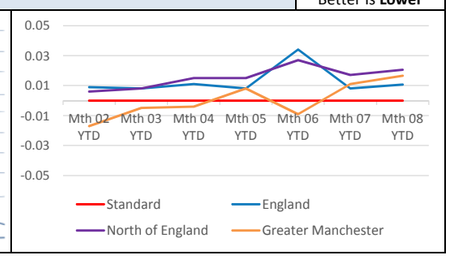
HMR	-2.8%
Oldham	-5.7%
T&G	-12.3%
South	1.0%
North	-3.5%
Trafford	3.4%
Stockport	5.6%
Wigan	3.1%
Bury	1.4%
Bolton	5.7%
Salford	4.4%
Central	9.2%



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

Better Is **Lower**

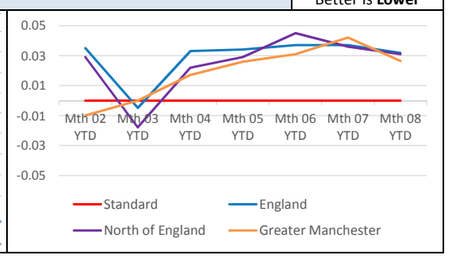
Oldham	0.2%
North	-2.7%
Stockport	-2.2%
HMR	5.0%
T&G	-3.5%
Wigan	7.9%
Central	1.4%
Bury	5.0%
Bolton	2.0%
Trafford	-1.0%
Salford	4.7%
South	6.2%



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

Better Is **Lower**

Wigan	-1.6%
HMR	2.6%
Bolton	9.1%
North	0.7%
Salford	4.3%
T&G	1.5%
Oldham	3.0%
South	1.2%
Bury	3.5%
Stockport	1.6%
Trafford	4.4%
Central	4.0%



Digital Interactions Between Primary And Secondary Care

Better Is **Higher**

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

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**

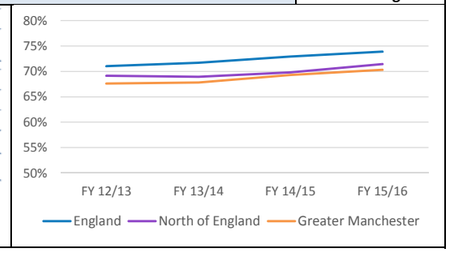
Bolton
Bury
Central
HMR
North
Oldham
Salford
South
Stockport
T&G
Trafford
Wigan

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**

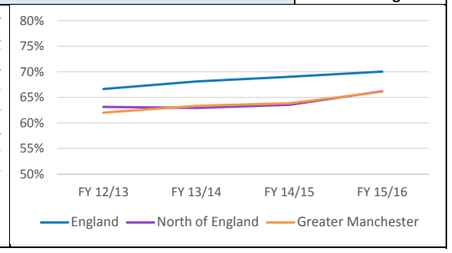
Stockport	77.9%
Trafford	79.0%
Bury	70.6%
Wigan	76.9%
Tameside	71.2%
Bolton	70.0%
Oldham	67.0%
Salford	69.2%
Rochdale	63.0%



Employment Rate, Resident Population Aged 50-64

Better Is **Higher**

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



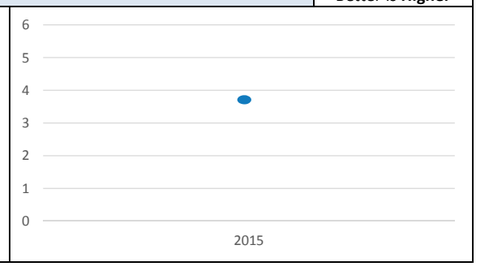
Well Led

Placeholder TBC

Staff Engagement Index

Better Is **Higher**

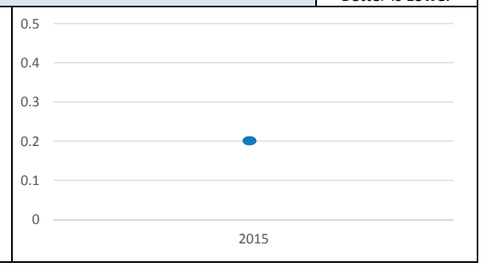
Bolton	3.9
Bury	3.7
Central	3.9
HMR	3.7
North	3.8
Oldham	3.7
Salford	3.8
South	3.8
Stockport	3.8
T&G	3.9
Trafford	3.8
Wigan	4.0



Progress Against Workforce Race Equality Standard

Better Is **Lower**

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



Effectiveness Of Working Relationships In The Local System

Better Is **Higher**

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

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 Governance (Placeholder)

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

Select a CCG

3	1. 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

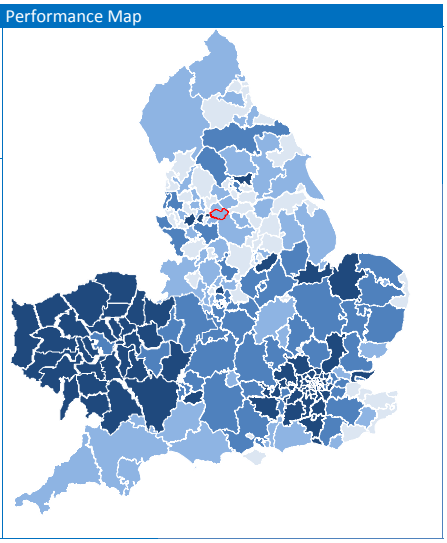
The 10 closest CCGs to NHS Tameside and Glossop CCG

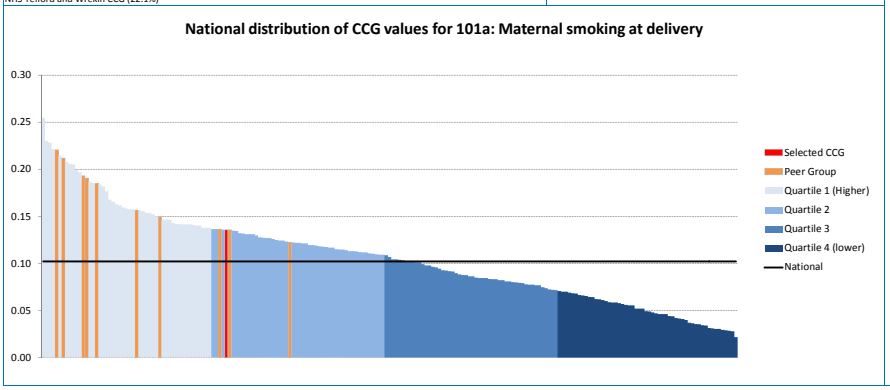
NHS Rotherham CCG (19.1%)
NHS Stoke on Trent CCG (18.5%)
NHS Bury CCG (12.3%)
NHS Wakefield CCG (19.3%)
NHS Hartlepool and Stockton-on-Tees CCG (13.6%)
NHS Barnsley CCG (15.7%)
NHS St Helens CCG (13.6%)
NHS Halton CCG (15.0%)
NHS South Tees CCG (21.2%)
NHS Telford and Wrekin CCG (22.1%)

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	

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**ROLE OF STRATEGIC COMMISSIONING – TAMESIDE AND GLOSSOP STRATEGIC COMMISSIONING FUNCTION – WHAT WILL THE SYSTEM LOOK LIKE IN 2020**
Report Summary:	Our Care Together vision is to create an Integrated Care Foundation Trust which provides care (acute, community, personal health/wellbeing, mental health, all age social care and wider 3rd sector) for our total population. It will be commissioned and contracted for by the Single Commission, which brings together the commissioning responsibilities of the NHS Tameside and Glossop and Tameside MBC. The Care Together Programme is a joint venture between commissioner and provider, and therefore all parties must work together to achieve our collective vision.
Recommendations:	Members are asked to support the following recommendations to be made to the constituent bodies of the SCB: • Single Commission's proposed strategic commissioning role/portfolio; • Single Commission's proposed long stop commissioning dates and movement of services and contracts to Tameside and Glossop Integrated Care Foundation Trust; • Formal due diligence and governance processes to ensure the safe transfer of services and contracts, including a series of local checkpoints to assure the system's readiness; • Development of a 'System Health Framework' to manage the transformational change; • Clinical Leadership role developments; • Proposals for staff transition across the system.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	It is essential that an adequate and robust due diligence timescale is allocated and facilitated prior to the transfer of associated services. It should also be recognised that approval will be required from each constituent partner organisation and that the requirements of external regulatory bodies will need to be acknowledged. Additional due diligence of the related support function responsibilities will also be necessary. The associated risks will need to be clearly identified and should be recognised within the evolving financial principles agreement aligned to the 2017/2018 Integrated Care Foundation Trust contract. In addition it is essential that the profiling of any external funding allocated to the Economy (e.g. Greater Manchester Health and Social Care Partnership Transformation Funding) is recognised and aligned to the service transfer timescales within the report. An evaluation of any further resource allocations necessary to support the transfer of services will also be required and included within the due diligence process as appropriate.

Legal Implications: **(Authorised by the Borough Solicitor)**	The report sets out the vision that the system is seeking to deliver. A detailed implementation plan will be required to deliver that vision. The report recognises that there is a need to ensure appropriate advice is sought at the appropriate time to mitigate against the risk of challenge and ensure legal compliance with procurement, employment law and NHS framework. Work needs to take place re the potential for clinical conflicts of interest. Importantly there needs to be and clear democratic sign off, oversight and accountability. It is not possible for any statutory organisation to delegate its responsibilities. However, it can allow for another organisation to discharge them on its behalf. To do this it mist be satisfied as to the risks, controls and assurance measures in place as ultimately it will be held accountable for matters it may not directly manage.
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?	The Care Together Programme as a joint venture between commissioner and provider to achieve our collective vision set out in the Locality Plan.
How do proposals align with the Commissioning Strategy?	This aligns with the Commissioning Strategy in defining the role of strategic commissioning.
Recommendations / views of the Professional Reference Group:	PRG were supportive of the report and accepted the proposals set out within the report.
Public and Patient Implications:	Public engagement and formal statutory consultation of service change will require leadership across the system, led by the Single Commissioning Function. There is a framework in place for ensuring that commissioning decisions are made based on sound evidence of need and impact.
Quality Implications:	Whilst there is no direct quality implications of commissioned services. Due regard will be required on the Single Commissioning Function gaining assurance on quality.
How do the proposals help to reduce health inequalities?	The transformed integration system aims to collectively raise the healthy life expectations of our population. This gives joint responsibility to the Single Commissioning Function and the Integrated Care Foundation Trust for reducing inequalities, and improving outcomes and expectations.
What are the Equality and Diversity implications?	Commissioning decisions will need to take due regard to any Equality and Diversity implications and all proposals will need to include the completion of an Equality Impact Assessment (EIA).
What are the safeguarding implications?	Commissioning decisions will need to take due regard to any safeguarding implications and to provide evidence in their proposals.
What are the Information Governance implications? Has a privacy impact assessment been	A privacy impact assessment is not required. Due regard will be given to information governance responsibilities and adhered to at all times.

conducted?

Risk Management: Risks will be managed through clear process and documentation.

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

Clare Watson, Director of Commissioning:

 Telephone: 0161 304

 e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 Our Care Together vision is to create an Integrated Care Foundation Trust, which provides care (acute, community, personal health/wellbeing, mental health, all age social care and wider 3rd sector) for our total population. It will be commissioned and contracted for by the Single Commission, which brings together the commissioning responsibilities of the NHS Tameside and Glossop and Tameside MBC. The Care Together Programme is a joint venture between commissioner and provider, and therefore all parties must work together to achieve our collective vision.

1.2 The partners need the transformed integrated system to collectively raise the healthy life expectations for our population. Through an action focused programme of delivery, with clear and measurable strategically commissioned outcomes within neighbourhoods, the system needs to enable the public's health and improved wellbeing to take primacy. This gives joint responsibility to the Single Commission and Integrated Care Foundation Hospital for reducing inequalities, and improving outcomes and expectations.

1.3 Below are a proposed timeframe for the Single Commission's strategic commissioning intentions and long stop dates for achieving these. This means the delegation/transfer of responsibilities between the Single Commission and Integrated Care Foundation Hospital. The commissioning and contracting journey means a sharing of skills and expertise between the Single Commission and Integrated Care Foundation Hospital to enable this to happen.

1.4 To achieve this, the Integrated Care Foundation Hospital will need to take on some current functions of the Single Commission to deliver the movement of provision arrangements into the Integrated Care Foundation Hospital. This may move the Integrated Care Foundation Hospital to an Accountable Care Foundation Trust, or at least create an Accountable Care integrated system.

2. STRATEGIC COMMISSIONING INTENTIONS

2.1 Provisional long stop dates

Service Area	Apr-16	Apr-17	Sep-17	Oct-17	Apr-18	Apr-19	Apr-20
Community Service	Community services to Integrated Care Foundation Hospital						
Mental Health		Pennine Care bi-lateral (T&GICFT working in an aligned way)			LD services	Pennine Care and all other MH contracts	
Social Care				Adult Social Care*			Children's Social Care and wider C&F contracts **
Primary Care		Some prescribing budgets (tbc, but likely to be community services)	Urgent PC offer aligned to Integrated Care Foundation Hospital (could	Smaller prescribing budgets aligned with LCSs GP	IN GP discretionary services/ contracts	GP discretionary services/ contracts Wider FHS contracts	

			include WIC and other UPC discretionary spend	Prescribing budgets			
3rd Sector				3rd sector contracts to align with adult social care transfer. A 'pact' would need to be agreed so that 3rd sector providers are protected in line with social value developments			
Public Health				PH contracts as key part of Healthy Neighbourhood model			
Integrated Acute		Increase and change in activity in line with GM developments/ HT	Increase and change in activity in line with GM developments/HT	Increase and change in activity in line with GM developments/ HT	Increase and change in activity in line with GM developments/HT	Integrated Care Foundation Hospital takes on prime provider status of integrated elective pathways, including IS providers	

* Adult Social Care – the October 2017 timescale is our ambition, but is subject to further work and due diligence, therefore there may be some slippage. This may also mean that the timeframe for public health and third sector contracts and services transfer are also deferred.

**Children's Social Care and wider children & families contracts and services - will need further discussion to consider alternative commissioner - provider options.

2.2 Project Executives and commissioning leads for the transfer of commissioned services and contracts are:

Mental Health / Learning Disabilities	Clare Watson & Pat McKelvey
Adult Social Care	Steph Butterworth & Sandra Whitehead
Primary Care	Clare Watson, Peter Howarth (prescribing) & Janna Rigby
3rd Sector	Clare Watson & Alison Lewin
Public Health	Angela Hardman & Debbie Watson
Integrated Acute	Clare Watson & Elaine Richardson

Community services Clare Watson and Alison Lewin (already TSC'd, but requires commissioning assurance)

2.3 Formal due diligence and governance processes will be established to ensure the safe transfer of services and contracts. Additionally, the Single Commission will design a series of checkpoints aligned to the 'most capable provider' framework to assure the Single Commission and Integrated Care Foundation Hospital Boards of the system's readiness for

this transformation. This would include agreement of 'conditions' of any service and staff transfer.

3. SINGLE COMMISSION STRATEGIC COMMISSIONING ROLE

3.1 In parallel to Tameside and Glossop Integrated Care Foundation Hospital taking on, over an agree timescale, the provision of all the services in the table above, the **Single Commission's strategic commissioning role will be**:

- Place based Public Sector Reform commissioner, including **all** health and care services outcomes and quality assurance, including commissioning of other providers, for example mental health. In addition to Tameside and Glossop Integrated Care Foundation Hospital's outcomes, the Single Commission strategic commissioning portfolio will extend to the residual responsibilities within People, i.e. communities, education, and areas of commissioning within Place, incl. economic development, transport and a single estates function. It would also look to expand to include employment/work and the criminal justice.

  This would support the wider Public Sector Reform type agenda discussed at the Health and Wellbeing Board development day, and move the Single Commission towards a total place based agenda.

- Primary Care as per legislation for a Level 3 delegated commissioner and contractor. There will be a variety of options for primary care and how GPs initially work as part of the integrated neighbourhood teams. Over time it is likely that this will include not only GP contracts, but all 4 family health service contractor groups.

  The Single Commission will lead and facilitate these discussions as part of its commissioning and contracting role, involving Tameside and Glossop Integrated Care Foundation Hospital, and support the transition into a population based offer for primary care within the Integrated Neighbourhoods, jointly responsible for achieving the outcomes commissioned.

- Acute and tertiary services on a South East Sector or GM basis, in line with GM devolution, NW and/or national developments

- An intelligent and supportive partner of the Integrated Care Foundation Hospital. This means staff within the Single Commission providing experience, capacity and expertise to the Accountable Care integrated system, working with and/or alongside the Integrated Care Foundation Hospital. Therefore staff would be transferred, seconded and/or TUPE'd into the Integrated Care Foundation Hospital to enable this transformation.

3.2 Developing an Accountable Care integrated system is not about one organisation taking primacy over the other, but a true partnership, where all skills and experience are seen as equal. There needs to be a phase of transitionary/fixed term roles to bring additional capacity into the system.

3.3 To deliver this, the two organisations should develop a **'System Health Framework'** to manage the transformational change.

3.4 This would form part of any extended due diligence for each contract, but with a real focus on **culture, capacity and capability of the delegating and receiver organisations**.

4. CLINICAL LEADERSHIP

4.1 Further discussion is required about the role of clinical leadership within the Single Commission. If, as is being proposed, Tameside and Glossop Integrated Care Foundation Hospital wants to build the capacity within the Healthy Neighbourhoods and begin a more productive and proactive relationship with primary care, then the function of the Clinical Neighbourhood leadership needs agreement.

4.2 The Single Commission will determine what clinical leadership capacity it needs and what level of executive influence and authority this will have. This is closely aligned to the governance of the Single Commission and the scheme of delegation regarding decision making and system clinical leadership at a locality and GM/NW level, representing the Single Commission in all fora and taking charge of co-ordinating all clinical commissioning. There is an opportunity to learn from and align the clinical and political roles and decision making powers within the Single Commission.

NB Work needs to take place re the potential for clinical conflicts of interest.

5. T&GICFT LEAD PROVIDER ROLE

5.1 Tameside and Glossop Integrated Care Foundation Hospital will take on the lead provider role for the Tameside and Glossop health and care economy. This does not mean all services will be provided by Tameside and Glossop Integrated Care Foundation Hospital, but that it will co-ordinate and manage the complete range of integrated care pathways, including prevention, ongoing care and episodic treatment.

5.2 To do so, it will work in partnership with third party providers, from a range of sectors, to deliver care to contract outcomes agreed with the Single Commission. It will therefore take on, in some part, a role, currently managed by the Single Commission, in “commissioning” services – through a variety of mechanisms such as sub-contracting, grant-based partnership agreements etc.

5.3 Advice from the GM Partnership suggests that we need to ensure that we have a legal framework within which we transfer commissioning budgets and accountabilities.

5.4 To ensure that Tameside and Glossop Integrated Care Foundation Hospital has the necessary skills and capacity to carry out such functions, it is proposed that staff in related roles in the Single Commission will transfer to Tameside and Glossop Integrated Care Foundation Hospital where the functions they perform transfer to facilitate and support the delivery of our Care Together vision. Some suggestions are detailed below in Section 7.

6. PROCUREMENT & CONSULTATION

6.1 There are still a number of key issues to explore in order to ensure the system meets its ambitions, yet is kept safe.

6.2 The issue of procurement ranges from the long stop commissioning intentions with contracts, services and budgets moving into Tameside and Glossop Integrated Care Foundation Hospital without testing the market, to any sub-contracting, grant partnering proposed via the provider. Expert external advice may be required to ensure we protect ourselves from challenge.

6.3 It is also essential to protect certain organisations, particularly the 3rd sector providers. We are therefore proposing a 'pact' is developed in keeping with local and GM social value principles. There is great value in working with our community and independent providers, and this has been a key focus of the Healthy Lives, now integrated within the Healthy Neighbourhood work, so we are keen to develop this further. This principle of building capacity and capability with the 3rd sector holds good for other work streams, such as the elective redesign work, which was supported through PIQ (now PRG) from a commissioning perspective.

6.4 Public engagement and formal statutory consultation of service change will require leadership across the system, led by the Single Commission.

7. STAFF TRANSITION

Single Commission into Integrated Care Foundation Hospital (To be complete by end of Q3 2017/18)

7.1 As part of the proposed timescale, in Section 2 above, we need to agree the movement of some staff from the Single Commission to Tameside and Glossop Integrated Care Foundation Hospital to enable it to meet its strategic objectives and deliver the outcomes the Single Commission will set as part of its strategic commissioning ambitions.

7.2 We need to agree the phasing and transition timetable which matches the ambitions of our commissioning intentions. Before staff move, there needs to be a formal 'handover' programme, with full staff engagement in a new set of values within the Tameside and Glossop Integrated Care Foundation Hospital as the business model changes with the arrival of the new services, contracts and staff groups.

7.3 There will be an expectation that new structures and support programme are published in Quarter 4 2016/17 before any staff are transferred from the Single Commission to the Tameside and Glossop Integrated Care Foundation Hospital to ensure equity of opportunities for all.

7.4 Full engagement and consultation is required.

7.5 Staff wte and budgetary details to be confirmed. By the end of Q3 2017/18, in line with the transfer and alignment of contracts and services:

- Medicine management;
- Individualised Commissioning;

- Safeguarding;
- Home care and care home commissioners;
- Business Intelligence;
- Integrated Intelligence;
- IM&T/IM&T projects;
- GP IT Services;
- Operational commissioning officers of transferred services;
- Some quality monitoring and finance;
- Communications & Public Relations.

NB Following discussions with GM Partnership/NHSE, the Accountable Officer of the CCG (on behalf of the Single Commission) will retain accountability for any functions delegated to Tameside and Glossop Integrated Care Foundation Hospital. Processes must be put into place to ensure transparency and risk management of any function that Tameside and Glossop Integrated Care Foundation Hospital manages on behalf of the system.

Non Tameside MBC Single Commission into Single Commission (to be completed by end Q4 2016/17)

7.6 As the Single Commission is to take on all Tameside MBC's commissioning responsibilities, the staff and operational and strategic governance that currently sit outside of the Single Commission need to formally be aligned to its agenda. Structures, roles, responsibilities and portfolios will be reviewed and realigned within the new executive team to take account of this and of the transfer of functions to Tameside and Glossop Integrated Care Foundation Hospital.

7.7 A new Single Commission executive and management structure has been established, with no separate management team meetings for either partner of the Single Commission.

8. NEXT STEPS

8.1 Subject to approval through the Care Together and Single Commission's governance processes, a detailed programme plan, including risks, will be developed in early 2017. This will ensure momentum for the programme is maintained, and that system assurances are achieved.

8.2 The proposed Senior Responsible Officer for this work is Clare Watson, supported by Alison Lewin, working with Jess Williams and the Programme Support Office.

8.3 Subject to agreement, staff engagement (and consultation) will be required.

9. RECOMMENDATIONS

9.1 As set out on the front of the report.

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Officer of Single Commissioning Board:	Clare Watson, Director of Commissioning
Subject:	**CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH LOCAL TRANSFORMATION PLAN (Local Transformation Plan) UPDATE**
Report Summary:	The Tameside and Glossop Local Transformation Plan (Local Transformation Plan) was finalised in October 2015 and assured at the end of 2015/16 through NHS England bespoke process, with a view to align it in 2016/17 with mainstream Clinical Commissioning Group planning and assurances cycles. However, the Government and national public interest surrounding children and young people's Mental Health sees that robust assurance and audit remains in place. Our Local Transformation Plan has been in place for a year and it is required to be refreshed to reflect local progress and further ambitions at the end of 2016. The refresh of the Local Transformation Plans is seen by NSH England as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed.
Recommendations:	The Single Commissioning Board is: • Asked to note the contents of this report, and to authorise Single Commission Officers and Clinical Leads to continue to take relevant steps, make decisions, and to progress arrangements to further the elements discussed through the report. • Recommended to support the approval of the Local Transformation Plan refresh and finance plans for deliverables for 2017- 2020. • Asked to support aligning Local Transformation Plan with GM approaches where populations and needs require; thus delivering efficiencies • Asked to note the national context and building national pressures and assurance measures to increase spending on CAMHS and ensure the publication of the Local Transformation Plan Update.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	This is connected to the externally funding Local Transformation Plan allocation which is ring-fenced and must be spent in line with the original business case to LPT. If we do not spend in line with the externally approved objectives, the funding would be withdrawn. Therefore, finance support this business case with both the income and associated expenditure covered by the S75 agreement.
Legal Implications: **(Authorised by the Borough Solicitor)**	The report seeks Single Commissioning Board support and approval to spend the allocation given to CCG from NHS England for the continued delivery of the Local Transformation Plan on the elements outlined under 8.2 and Table 1: Local Transformation

	Plan Funding and Recommendation Allocation. Where funding is ring-fenced for a specific purpose, care needs to be taken to ensure any terms and conditions attached to the funding are adhered to.
How do proposals align with Health & Wellbeing Strategy?	Developing Well – there is a need to identify opportunities in relation to improving our commissioning and delivery systems to achieve better outcomes for children and young people with respect to emotional wellbeing and mental health, and review the whole system from prevention to specialist services to make sure we are providing better outcomes through: • Providing clear pathways • Providing a clear plan of how CYP emotional wellbeing and mental health needs will be met. • Producing strategy that will provide targeted awareness and improve identification
How do proposals align with Locality Plan?	The Local Transformation Plan is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention) • Community development • Enabling self-care • Locality based services • Urgent integrated care services
How do proposals align with the Commissioning Strategy?	The Local Transformation Plan contributes to the Commissioning Strategy by: • Patients and communities being empowered to care for themselves and to work together to support local health and wellbeing • Technology enabled access to information, advice & care • Locality based integrated teams of multi skilled health and social care professionals using integrated case management and care co-ordination • Identification and support of "at risk" people • High Quality Primary Care working through new models • Fewer overnight stays in hospital and more community based urgent care
Recommendations / views of the Professional Reference Group:	PRG noted the contents and recommends that the Single Commissioning Board ratifies the approval of the recommendations.
Public and Patient Implications:	The update and refresh of our Local Transformation Plan has been developed through consultation and engagement – including the voice of the child and those who care for them. The Local Transformation Plan will deliver improved experiences and outcomes for those CYP and families needing support.
Quality Implications:	A quality impact assessment has been completed and is attached.

How do the proposals help to reduce health inequalities?	The Local Transformation Plan and refresh seeks to reduce health inequalities, target the resources to where most needed and ensure services are accessible to all.
What are the Equality and Diversity implications?	It is not anticipated that the proposal will have a negative effect on any of the protected characteristic group(s) within the Equality Act. An Equality Impact assessment has been completed and is attached.
What are the safeguarding implications?	Strengthening of current provision and systems
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. NHS providers, GP Practices and neighbourhood teams would have IG policies in place and they would be expected to adhere to these.
Risk Management:	By implementing and adhering to the Local Transformation Plan and aligning with GM approaches it is expected that there would be an increase in CYP accessing services, support and treatment.
Access to Information :	The background papers relating to this report can be inspected by contacting: Alan Ford, Commissioning Business Manager for Children, Young People & Families Telephone: 07500 980612 e-mail: alan.ford4@nhs.net

1. BACKGROUND

1.1. Future in Mind was published in March 2015, setting out a series of proposals to implement whole system transformation leading to improved outcomes for children and young people with mental health problems. The report emphasised the need for joined up provision and commissioning. These proposals were endorsed by the Five Year Forward View for Mental Health published earlier this year (February 2016).

1.2. NHS England (NHSE) agreed that access to the new funds for children and young people's mental health announced in the Autumn Statement 2014 and Spring Budget 2015 would follow the development of Local Transformation Plans (LTPs) that were required to describe how the national ambition could be translated and delivered locally.

1.3. LTPs for Children and Young People's Mental Health and Wellbeing, led by Clinical Commissioning Groups (CCGs) require active engagement with all stakeholders, need to be transparent and are publicly available. The plans included detail how local areas are using the new resources given to CCGs to deliver extra capacity and capability.

1.4. The Tameside and Glossop Local Transformation Plan was finalised in October 2015 and assured at the end of 2015/16 through NHSE bespoke process, with a view to align in 2016/17 with mainstream CCG planning and assurances cycles. However, the Government and national public interest surrounding children and young people's Mental Health ensures that robust assurance and auditing remains in place; with additional scrutiny from Greater Manchester Health and Social Care Partnership.

2. INTRODUCTION

2.1. The LTPs are 'living' documents that need to be refreshed as required and delivered through action plans for the 5 year life span of the programme. In support of this at the start of 2016 CCGs were advised of rising baseline funding for the next five years for implementing Future in Mind and the Five Year Forward View for Mental Health; providing the assurance and confidence for commissioning of increased resources to improve capacity and capability of LTPs.

2.2. Our Local Transformation Plan has been in place for a year and it is required to be refreshed to reflect local progress and further ambitions at the end of 2016. The refresh of the LTPs is seen by NSHE as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed. At the same time LTPs should be seen as part of the Sustainability and Transformation Plans (STPs).

2.3. A national review by Education Policy Institute's Mental Health Commission of all LTPs notes that although our plan was assured there were areas for improvement in relation to Transparency, Governance, Involving Children and Young People (CYP) and Ambition. In providing the following update on our Local Transformation Plan these areas have been addressed.

3. TRANSPARENCY AND GOVERNANCE

3.1. The Tameside and Glossop Local Transformation Plan 2015-2020, established key baseline information and needs utilising a variety of data (provided by numerous key sources, including Tameside Public Health, Providers and the National Child and Maternal Intelligence Network (ChiMat). Our Workforce development plans have delivered a training ladder for children and young people practitioners, regardless of the setting or employer, which is hosted by Tameside Safeguarding Children Board (LSCB). All information from the base line Local Transformation Plan been updated this year where available including workforce

establishment, activity and stakeholder feedback. The Local Transformation Plan update and refresh outlines the progress to date along with further challenges and next set of priorities for the current system. In our approach access and waiting times, cross system outcomes measures and inpatient provision from Specialist Commissioners (NSHE) have been analysed. Our approach remains situated within a triangulated methodology applying activity data, outcome findings and needs analysis underpinned by stakeholder feedback. This approach continues to shape our priorities that remain aligned to the government report 'Future in Mind' and the Five Year Forward View for Mental Health.

3.2. To implement our Local Transformation Plan, Tameside and Glossop established a formal management structure with a Transformation Programme Board (Children and Young People's Emotional Wellbeing and Mental Health Board), which meets bi monthly. The board is made up of senior managers across Commissioning, NHS health providers, third sector providers, Action Together, Schools setting, Tameside Metropolitan Borough Council Children's Social Care, Tameside Youth Offending to name a few. The work of the board in delivering the Local Transformation Plan is driven by subgroups that have been created and align with the quadrants and domains of the new model of care - Thrive (Getting Advice, Getting Help, Getting More Help and Getting Risk Support). Governance documentation including terms of reference, risk register, highlight reporting templates, subgroup leads and subgroup priorities are in place. Each subgroup has agreed to a number of overall high level objectives and key tasks within an agreed action plan with timelines (Gantt Charts), which are overseen by the board to manage interdependencies and to ensure that the focus remains on making a real difference for children and young people across Tameside and Glossop.

3.3. Transparency and governance surrounding the refresh of our Local Transformation Plan has been strengthened within the developing alignment of the Greater Manchester (GM) Mental Health Strategy. Tameside and Glossop CCG chair the GM Future in Minds Delivery group, a consortium of all 12 GM CCGs/10 Local Authorities with representation from the Strategic Clinical Network, NHSE Specialised Commissioning and Public Health.

3.4. Greater Manchester is now working towards a whole system approach to the delivery of mental health and well-being services that support the holistic needs of the individual and their families, living in their communities. This will bring together and draw on all parts of the public sector, focus on community, early intervention and the development of resilience. In this context, it is worth noting that six of the thirty two strategic initiatives identified with the GM Mental Health Strategy relate to children and young people. Mental Health has also been identified as a key priority area within the review of Children's Services currently underway across GM.

3.5. Tameside and Glossop, in meeting the challenges of these times and those ahead has moved to a Single Commission Board (SCB), integrating Tameside MBC Local authority Commissioning, Tameside MBC Public Health and Tameside and Glossop Clinical Commissioning Group. The Local Transformation Plan will receive executive oversight from multiple perspectives at a locality level through Single Commissioning Board and the Tameside Health and Wellbeing Board as well as at a Greater Manchester Health and Social Care Partnership level.

4. INVOLVEMENT OF CHILDREN AND YOUNG PEOPLE

4.1. Tameside and Glossop has – and will continue to - undertake a variety of engagement activities with children and young people to inform the development of its Local Transformation Plan. A full chapter of our Local Transformation Plan is dedicated to the Voice of the Child and provides full details of all engagement activity. Following on and building on the initial CYP review of our Emotional Health and Well-being services carried out in 2015 we are developing working relations with Tameside Youth Council / Youth Fora. In

this, children and young people have reviewed and developed all priorities going forward; establishing a set of priorities from the voice of the child.

4.2. The voices of local children and young people have provided a set of quality standards, which are seen as the right of any child or young person who maybe experiencing emotional wellbeing and/or mental health issues. The 'I' statements as they have become to be known, are now embedded in children and young people's Emotional Wellbeing and Mental Health services specification KPIs and grant agreements across the system.

Figure 1: The Voice of the Child I statements

The Voice of the Child	
1.	I should be listened to, given time to tell my story and feel like what I say matters.
2.	I want my situation to be treated sensitively and I should be respected and not feel judged.
3.	I want the professionals that I come into contact with to be kind and understanding and realise that I need to trust them if they are going to help me.
4.	I should always be made to feel safe and supported so that I can express myself in a safe environment.
5.	I should be treated equally and as an individual and be able to shape my own goals with my worker.
6.	I want my friends, family and those close to me to understand the issues so that we can support each other.
7.	I want clear and up to date detailed information about the services that I can access.
8.	I want to get the right type of help, when things first start to be a problem, at the right time in the right place and without having to wait until things get worse.
9.	I want to feel that services are shaped around my needs and not the other way round, but I also want to know that I am not alone in how I am feeling.
10.	I want my support to feel consistent and easy to find my way around, especially if I need to see different people and services.

4.3. More widely, our commissioned services have now embedded and utilised the Experience of Service Questionnaire (ESQ) as one of the core Routine Outcomes Measures (ROM) that evaluates children and young people and their carer's satisfaction with services. The findings of this are being used to improve services and delivery. The ESQ comes in three versions: the parent/carer, the child version for children aged 9-11, and the young person version for children aged 12-18. The application of this ROM has been embedded within the cross system – and CAMHS – outcome framework.

5. LEVEL OF AMBITION

5.1. As detailed above, our Local Transformation Plan has been structured in line with the five priority areas set out in Future in Minds and the Forward View for Mental Health. By 2020/21, there is an expectation of significant expansion in access to high-quality mental health care for children and young people. At least 70,000 additional children and young people each year nationally will receive evidence-based treatment – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those with diagnosable mental health conditions.

5.2. Our ambition is for a children and young people's emotional wellbeing and mental health system that is truly personalised, joined up, supports all children and young people to stay well and provides the very best support and care when and where they need it. For children, young people and those who care for them, this means we will put them at the heart of all what we do to ensure better outcomes and experiences that meet their needs.

5.3. We are working collectively to create an integrated system where every child and young person in Tameside and Glossop receives the best, consistent, care and support; delivered as locally as possible - in our communities - with services designed in a joined up way so that they are seamless. This has – and still - requires us to establish a comprehensive system wide approach to providing support and care and an array of new and/or refreshed seamless pathways.

5.4. Our ambition requires the following aims to be achieved/embedded:

- To improve access and partnership working to bring about an integrated whole system approach to promoting emotional well-being and resilience and meeting the emotional wellbeing and mental health needs of children and young people.
- To ensure children, young people and families have:
    - Access to timely and appropriate information and support from pregnancy to adulthood;
    - Clearly signposted routes to support, including specialist CAMHS;
    - An 'open door' into a system of joined up support that holds a 'no wrong door' approach, which is easy to navigate;
    - Clear understanding of the service(s) offer (what support should be received and what the expected outcomes are);
    - Timely access to this support that is as close to home as possible.

5.5. We have learnt that our aims to improve access and partnership working through an integrated whole system approach to meeting the emotional and mental health needs of children and young people hold a number of inherent challenges. We know that delivering better coordinated care and support centred on the child or young person's needs is challenging and there are barriers at multiple levels. As such, to maximise success we are aligning and driving changes at Greater Manchester Level through processes noted earlier.

5.6. This is a five year programme of change and our successes to date should be viewed as the start of a longer planning process with subsequent year on year updated action plans to follow; ensuring a phased approach that addresses not just system changes, but also develops the culture for sustainability and learning.

5.7. Our Local Transformation Plan is extremely ambitious both in its desire to effectively implement the recommendations set out in Future in Mind but also changes the model of care for CAMHS to the Thrive model (see **Appendix A**), fully incorporating universal, community and voluntary sector provision, and also the pace and volume of supporting activity required to make this happen. Our plan includes a mix of redesign, underpinned by the transformational restructure of our specialist Healthy Young Minds (CAMHS) service, and additional investment to increase capacity in specific pathways and services such as Eating Disorders and Neurodevelopmental conditions (ADHD and ASC). Details of all investment areas are provided in the finance section.

5.8. While last year's nationally mandated priority was for the design, development and delivery of extended specialist Eating Disorder Teams for children and young people (which we have delivered), this year's focus is on ensuring 'Better Crisis Care support'.

6. WHERE ARE WE NOW (NOVEMBER 2016 UPDATE)

6.1. Utilising its local transformation funding, Tameside and Glossop has invested in new early intervention and prevention services as well as expanding capacity within its CAMHS (renamed and branded Healthy Young Minds) service to ensure that CYP receive the right level of support in a timely manner; aid recovery and prevent escalation to specialist services. Our specialist CAMHS workforce has been uplifted from 23.7 FTE in 2014/15 to 32.5 FTE in 2016/17 (a 37% increase on base line year). Both public and third sector services have been uplifted, providing accessible services in meeting need – an array of new pathways have been developed and implemented for children and young people with mild and moderate mental health issues.

6.2. The Local Transformation Plan has helped to deliver an increase in the number of CYP receiving high quality treatment. In 2014-15 (baseline) there were 2045 referrals to CAMHS of which 1,184 were accepted. In 2015/16 those referrals accepted by the service had increased to 1,438 – an increase of over 21% more children and young people accessing treatment. Indications for 2016/17 suggest this trend will continue. Although evidence shows more children and young people are now accessing treatment, the reduction in waiting times previously gained, is under threat by the increased numbers accessing treatment. As of the 31 October 2016 only 72.3 % of children and young people were seen within the 12 weeks and 97.9% seen within 18 weeks. Reducing waiting times remains a Local Transformation Plan key priority for 2017 and beyond.

6.3. Tameside and Glossop hold a comprehensive service directory which is updated and maintained by the Getting Help (Coping) Work stream. This includes a wide variety of community and voluntary sector providers who are vital to the delivery of a comprehensive CYP mental health system offer. A mapping exercise of all mental health provision available across Tameside and Glossop has been undertaken and will be shared with GPs so that they are able to effectively signpost children and young people to the most appropriate service. At a GM level work is to be undertaken during 2017/18 to identify mental health leads within GP practices that are trained in mental health and well-being.

6.4. We have also invested in the development of a local training ladder and a programme of e-learning and face to face training informed by an initial workforce competency audit. The training ladder will be hosted by Tameside Safeguarding Children's Board from April 2017, where it will have a cross cutting impact on all organisation's and services working with children and young people.

6.5. Healthy Young Minds (CAMHS) has been working to improve the support available between referral and first appointment through the development of a waiting times initiative, which includes embedding Third sector providers within the core offer. In addition a new, user friendly, interactive and informative website has been launched. Work on the website has included reviewing and including a range of applications for young people, self-help information and links to social media such as Twitter. This work has been completed and the new website (http://healthyyoungmindspennine.nhs.uk/) went live in June 2016. The website now has a range of quality assured self-help information, links to local and national resources NHS applications approved by young people.

6.6. Tameside and Glossop was selected in 2016 as a national pilot site by Department for Education and NHS England to test the named CAMHS school link scheme expressed in Future in Minds. Early evidence shows a shift in referrals to CAMHS, with GP referrals reducing and schools direct referrals increasing and the overall number of inappropriate referrals declining. There is still further work to be undertaken with schools to incorporate self-care for non-service users as part of a whole school approach to mental health – and expanding the CAMHS school link to more schools.

6.7. The transformational restructure of our specialist CAMHS service renamed and branded Healthy Young Minds incorporates dedicated resource for School Liaison, Looked after Children (LAC), Neurodevelopmental conditions and those children and young people involved in the criminal justice system. In addition there has been the creation a new Community Eating Disorders service that went live on 4 July 2016. As such a large focus of the Local Transformation Plan has been the identification and support of CYP "at risk" of mental health problems and increasing access to children and young people's mental health services.

6.8. The new innovative Community Eating Disorders Service (CEDS) launched in Tameside and Glossop is being rolled out in a phased approach with the next phases being key deliverables in 2017/18.

6.9. The CEDS provides dedicated care and support to children and young people (up to their 18th birthday) with an eating disorder. It also offers advice and support to families and carers. The service accepts new referrals for young people aged 16 to 18 years. New referrals for young people under 16 years must be directed to the existing core CAMHS (Healthy Young Minds Service), in the usual way.

6.10 The CEDS is also being delivered and jointly commissioned by Stockport, Trafford, Oldham, Heywood, Middleton and Rochdale (HMR) and Bury. It is commissioned by the clinical commissioning group in each borough. Rather than being a standalone service, the CEDS is part of the core community-based CAMHS Healthy Young Minds Service in each borough. The new service is delivered by two teams with dedicated venues:

- South Team: covering Tameside and Glossop, Stockport and Trafford
- North Team: covering Bury, HMR and Oldham

6.10. Through the Local Transformation Plan and the work of the board and subgroups the early priorities that were established have been delivered or initiated (*see **Appendix B** for the initial early Local Transformation Plan 2015-2017 Priorities*). The following provides high level highlights on the developments under the Local Transformation Plan that have been achieved:

- Reviewed access pathways for specialist CAMHS that has led to developing new Mood Disorder, Vulnerable Groups and Conduct Disorder pathways and ways of working;
- Worked with NHSE and the Department for Education to pilot and test the CAMHS school link model - providing training programme within 14 schools and ensuring a named CAMHS practitioner for each of the school that has a mental health lead (champion) within its setting;
- Implemented a children and young people's mental health outcomes framework that has been developed and agreed with the voice of the child ;
- Implemented and developing a cross system outcome reporting framework that enables national benchmarking with other services ;
- Placed accessible expert knowledge of children and young people's mental health across the system; particularly placing them where children and young people are deemed most vulnerable (LAC, Youth Offending);
- Ensured that all GPs have a named CAMHS Consultant to improve communication and access between Primary Care and CAMHS;
- Placed the third sector within the management and delivery of the NHS CAMHS service to enable a joined up offer between statutory and voluntary services;
- Strengthened the Third Sector offer for children and young people's emotional wellbeing and mental health;
- Delivered a new Integrated Parent Infant Mental Health Pathway in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health;

- Established a pathway for families with high needs, such as those within the child protection system and care leavers;
- Delivered a Neurodevelopmental Umbrella pathway for children and young people where there are queries or concerns about difficulties in the following areas: Attention, concentration, impulsivity and hyperactivity (ADHD and ASC).
- Developed and implemented a children and young people's mental health workforce training ladder for all practitioners working with children and young people, and
- Established a new Community Eating Disorder service that meets new waiting time standards that treatment should start within a maximum of 4 weeks from first contact with a designated healthcare professional for routine cases and within 1 week for urgent cases.

7. 2017 PRIORITIES AND BEYOND

7.1. The NHS Operational Planning and Contracting Guidance 2017-2019 has set out three national mandates for CCGs:

- To increase access to high quality mental health services for an additional 70,000 children and young people per year. As such local transformation plans need to deliver expanding access to children and young people's services by 7% in real terms in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19).
- To deliver community eating disorder teams for children and young people to meet access and waiting time standards.
- To increase access to evidence-based specialist perinatal mental health care.

7.2. Going forward we ae committed to the continued rollout and embedding of the Thrive Model for CAMHS across a whole system approach to improving access to information, guidance, advice and high quality treatment. In 2017, the Thrive model (i-Thrive) is to be applied to the whole of GM to help deliver improved access and reduced waiting times and help deliver the need efficiencies (more people seen within the resource envelope).

7.3. Our learning in Tameside and Glossop as an early adopter of the Thrive model will be shared with GM. In return, the application of Thrive on the large GM population conurbation will help to tackle and support the system wide changes (governance, accountability and information) required to deliver the fidelity of the model and deliver/optimise service and pathway structures.

7.4. In addition to our commitment to the new model of care a multitude of priorities have developed to be taken forward in 2017 (for further details see **Appendix C**).

7.5. As part the mandate to increase access to high quality mental health services for children and young people, CCG are required to commission 24/7 urgent and emergency mental health services that can effectively meet the needs of diverse communities, and ensure submission of data for the baseline audit in 2017.

7.6. ***Crisis Care:*** One of the pillars (strategic golden threads) in the GM Mental Health and Wellbeing Strategy is to improve access, which is responsive and holds clear arrangements that connect people to the support they need at the right time. Under this, an early priority has been established to introduce access to 24:7 Mental Health provision and 7 Day Community Provision for children and young people. To deliver this priority, a whole system approach is required that includes bringing together commissioning, simplifies the provider system, includes involvement from the independent and third sector and holds children and young people and those who care for them at the heart of change.

7.7. In addition to the GM strategy the national Five Year Forward View for Mental Health (2016) sets out a number of priorities for change over the next five years, including: Supporting

people experiencing a mental health crisis – by 2020/21 expand crisis resolution and home treatment teams to ensure 24:7 community-based mental health crisis response is available.

7.8. Across GM it is acknowledged there is a lack of community out of hours, 24:7 crisis care services for children and young people. As such the CCG should align and support the GM aim to stabilise 24:7 specialist CAMHS on call and that by January 2018 we will have developed and implemented a 24/7 crisis care support pathway for children and young people providing easy access to services that are responsive and provide appropriate help across all of GM.

7.9. The aim of this transformational change is to reduce duplication and make more efficient use of available resources to achieve better outcomes including a vision for integrated leadership, commissioning and delivery. There is a real opportunity to use the collective intelligence, experience and resources across GM to develop a crisis care pathway for children and young people that is innovative, accessible and effective supported by extended community provision across 7 days to provide wraparound crisis prevention help.

7.10. To deliver our aim GM-wide integrated mental health crisis prevention, assessment and support pathways for children and young people which are available 7 days per week are being developed.

7.11. Work has commenced through the GM Children and Young Peoples Mental Health Board to review current provision from a range of perspectives; to scope best practice across the region and beyond; to consult widely with all stakeholders; and to connect with associated transformational processes e.g. GM Crisis Concordat, Mental health Liaison Strategy, Local Transformation Plans, Children's Services review, Youth Justice Review and NHSE CAMHS Tier 4 and Secure Procurement review.

7.12. The next stage is to co-produce and articulate a multi-agency and single system response that maps onto the Thrive model for CAMHS; developing an emotional well-being and mental health service for children, young people and those who care for them that is supported by locality wraparound services and provision that seeks to prevent a journey of escalation and/or increasing severity and complexity. The key principles of the emerging pathway are described below:

- *GETTING ADVICE (COPING*) - Prevention services across localities that are available 7 days a week through accessible range of mediums and in a range of settings.
- *GETTING HELP* - Early Intervention and improved and timely access to support for a young person in distress. Aimed at reducing risk and enhancing early interventions. This evidence based approach will be underpinned by enhanced training and support for multi-agency teams who may be first responders or who are already engaged with the young person.
- *GETTING MORE HELP* - Follow up and prevention of future crises through effective multi agency care planning, improved access to evidence informed interventions and increased delivery of help in community settings including a young person's home.
- *GETTING RISK (INTENSIVE) SUPPORT* – A flexible crisis response with access to risk assessment, advice and support 24:7 from a confident and well trained multi agency workforce with access to appropriate hospital and community based places of safety and/or intensive home treatment teams who can support young people in crisis in their own homes.

7.13. As part of the finance plan outlined in Section 8 there is a need for the CCG/SCB to invest and support the GM Crisis Care approach in order to improve health outcomes for young people across our locality and GM, which seeks to reduce the requirement for acute and long term care.

7.14. The GM offer will be underpinned by current best practice providing a range of options for young people in crisis, meeting their immediate needs effectively. It will reduce the use of A&E as a first response to crises and reduce the use of paediatric wards while awaiting assessment.

7.15. ***Eating Disorders***: Following the successful launch and implementation of the CEDS, 2017 sees the continued development through phased incremental expansion.

7.16. During phase two the CEDS plans are to:

- Continue to provide urgent home-based treatment for young people aged under 16 years. This includes interventions such as meal time support.
- Begin to offer enhanced planned home-based treatment for young people aged under 16 years.
- Begin to deliver support sessions and workshops to young people aged 14 years and above – along with their families and carers, where appropriate. This will focus on topics such as body image, self-esteem, parental support, mindfulness and relaxation.
- Offer bespoke training to those who work with or care for young people. This will be done in partnership with national eating disorder charity B-eat
- Establish an eating disorders champion in each borough's core Healthy Young Minds (HYM) Service. This will enable the HYM and CEDS staff to better work together to support the different needs of young people.
- Continue to develop a central hub for the north team and the south team (see 6.10 above for boroughs covered by each team). The hubs will offer drop-in support sessions, as well as appointments. A number of 'spoke clinics' will also be offered across each borough - throughout Tameside and Glossop
- Offer seven day triage of new referrals for 16 to 18 year olds
- Launch the new hubs for the north and south teams (it is hoped that the south hub covering Tameside and Glossop that is located in Stockport will be open January 2017)
- Further develop close working arrangements with a range of support services from the third sector in each borough and further afield

7.17. ***Perinatal Mental Health Care:*** it is clear that parental mental health prenatally, postnatally and throughout childhood also has a significant impact on a child's outcomes, wellbeing and mental health. An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves.

7.18. Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90% of parents on their caseload have mental health problems, alcohol or substance misuse issues.

7.19. The argument for intervening early and maximising the impact of change in the first 1001 days of a baby's life is a compelling one in light of the significant impact mental health needs have on parents, their children and the wider health and social care economy. Pathways need to be joined up from Perinatal through and into early years (0-5 yrs).The highly acclaimed Tameside and Glossop Early Attachment Service (EAS) is recognised across GM in providing the community 'blue print' for services that is evidence based.

7.20. Through the Local Transformation Plan the Parent Infant Mental Health pathway has been reviewed in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health and remodel and mapped to Thrive. The service continues to develop through the Local Transformation Plan with the new Vulnerable Families post, which represents a new formal partnership between EAS and Children's Social Care.

7.21. The Vulnerable Families post focuses on Care Leavers (CLs) as parents or potential parents. The new partnership and the work of the post aims to offer various ports of entry to engage and support CLs and also manage risk differently, to prevent a 'revolving door' so that Child Protection is not the only response. The initiative involves a combination of (a) offering all

CLs relationship focussed workshops (New Beginnings), (b) specialist inter-agency staff training, and (c) targeted therapeutic support where appropriate. The formal partnership enables sharing expertise and knowledge, to enable to better meet the needs of CLs and improve their future opportunities in life.

8. 2017-2020 FINANCE PLAN

8.1. The assurance of the Local Transformation Plan has ensured additional money for the CCG to support delivery and redesign of children and young people's mental health provision. The refresh of the LTPs – and its publication - is seen by NSHE as the evidence that progress is being made, that the funding is being spent as intended and will provide evidence on how services are being transformed.

8.2. The table below outlines the NHSE funding received by the CCG to assist in the delivery of the Local Transformation Plan and the recommend programme to take forward till 2020.

Table 1: Local Transformation Plan Funding and Recommend Allocation

T&G Local Transformation Plan Funding	**2017/18**	**2018/19**	**2019/20**
NHS Tameside and Glossop CCG Local Transformation Plan Income			
Community Eating Disorders (CED)	141,000		
Local Transformation Funding	418,000		
Total Local Transformation Plan Income	559,000	559,000	559,000
Potential Expenditure		Continuation of 2017/18 scheme till 31.03.2020	
Core Programme:			
Community Eating Disorders (PCFT)	141,000		
Perinatal Care (Therapeutic Social Worker 1 FTE - EAS / PCFT)	40,000		
Improving Access (Waiting Times Initiative & Vulnerable Groups - 42nd St)	17,500		
Neurodevelopment Umbrella Clinics (Paeds Consultant Clinics - TGICFT)	27,000		
Neurodevelopment Nurse Specialist (AfC B7 Neuro Nurse Specialist - PCFT)	51,575		
Neurodevelopment Umbrella Coordinator (AfC B4 - PCFT)	*27,175*		
LAC Psychology (AfC B8a Psychologist - PCFT)	60,237		
LAC MH Post (AfC B6 PCFT)	43,772		
YOS Forensic & Transition (AfC B7 RMN - PCFT)	51,575		
HYM (CAMHS) Neighbourhood Link Post (inc School Link & Training PCFT)	43,772		
Schools CAMHS Link Project Management (Thomas Ashton Schl)	3,393		
CYP/Service User For a (Action Together)	3,000		
GM CAMHS Programmes (GM i-Thrive, GM Crisis Care, GM 24/7 on call)	49,000		
Total Expenditure	**559,000**	**559,000**	**550,000**
Balance	**0**	**0**	**0**

8.3. NHSE recognising the pressures, which are faced by localities in transforming their services, have reviewed and reprioritised spending on nationally-led programmes and identified an additional £25 million which is being made available for CCGs in 2016/17. This further funding is in addition to the already allocated monies to CCGs for children and young people's mental health in 2016/17 – outlined above. It brings forward the expected uplift in baseline funding to meet the published level of new monies in 2017/18 (£170 million) one year early, whilst also providing additional non-recurrent funding to support transformation this year.

8.4. As with all allocations of new money, it is critical that CCGs are able to demonstrate the impact of this investment. It is expected that these funds will support CCGs to accelerate their plans and undertake additional activities this year to drive down average waiting times for treatment, and reduce both backlogs of children and young people on waiting lists and length of stay for those in inpatient care. In order to secure release of the full additional funding, CCGs will be asked to provide details of how they intend to improve average waiting times for treatment by March 2017. It is also expected that this funding will:

- Support CCGs to continue to invest in training existing staff through the children and young people's IAPT training programme, including sending new staff through the training courses; and
- Accelerate plans to pump-prime crisis, liaison and home treatment interventions suitable for under 18s, with the goal of minimising inappropriate admissions to in-patient, paediatric or adult mental health wards.

8.5. CCGs are free to pool this funding across a wider geography – such as Great Manchester or a cluster of CCGs - to support activity linked to local transformation plans for children and young people's mental health (LTPs). Table 2 below outlines the additional non-recurrent funding being received in year 2016/17 in two tranches (end of October 2016 and January 2017) and its recommend allocation.

Table 2: Local Transformation Plan Additional Non-Recurrent in-Year (2016/17) Funding & Recommend Allocation

T&G Additional Non Recurrent Funding	**2016/17**
NHS Tameside & Glossop CCG additional non recurrent Local Transformation Plan Income	
First Tranche October 2016	
Second Tranche January 2017	
Total Non-Recurrent Income	117,000
Potential Expenditure	
Non Recurrent Programme:	
T&G Local Waiting Times Initiatives	21,000
T&G CYP IAPT	22,500
GM 24/7 specialist CAMHS on-call access (£10.2k per 100,000 pop)	16,000
GM Pump Priming of GM Crisis Care and GM i-Thrive	32,000
GM CYP RAID (6 month pilot)	19,500
GM CAMHS Future In Minds Programme Support	6,000
Total Expenditure	**117,000**

9. IDENTIFIED RISK

9.1. During our year of implementing the Local Transformation Plan the following risks have emerged that need to be continually monitored and mitigated.

- The funding allocation of the Local Transformation Plan beyond 2016/17 will no longer be ring fenced to CYP mental health within the CCG's baseline budget;
- Ongoing capacity to enable transformation and service restructure within our specialist Healthy Young Minds (CAMHS) service and ongoing issues with the provision and accuracy of data, whilst we await the roll out of the new patient record system;
- Ongoing capacity of CCG/SCB officers to drive system wide transformation. These risks will be mitigated through GM shared approaches;
- Delays to service implementation due to recruitment difficulties from a limited pool of qualified practitioners;
- Delay in establishing training and engagement for multi-agency practitioners;
- Autonomous commissioning across schools and other agencies not aligning with system model.
- Scale and pace of changes brings challenges in relation to how all partners are kept informed and aware of developments and new pathways.

10. CONCLUSION

10.1. The substantial work undertaken within the Local Transformation Plan is building strong foundations for the next phase of work and transformation. Mental Health is everyone business and as such it falls beyond the resources of a single provider to effectively meet the emotional wellbeing and mental health needs of children and young people in Tameside and Glossop. Clearly if we are to improve and sustain access to services then this requires more than additional funds alone but rather a new, whole-system approach that includes the active participation of all partners and key stakeholders. We need to promote and deliver a view that Health Young Minds (CAMHS) should be seen as part of a wider network of services providing a range of support for emotional and mental health needs, which includes General Practitioners, School Nursing, Health Visiting, Youth Offending and third sector provision (to name a few) that is sited and accessible within our neighbourhoods.

10.2. Our aims to improve access and partnership working to bring about a whole system approach to meeting the emotional and mental health needs of children and young people may seem simple, but holds a number inherent challenges. As such our investment and energy should be supported and aligned with Greater Manchester Health and Social Care Partnership (GM devolution, GM Mental Health Strategy, GM Children's Review and GM i-Thrive) to maximise success and assist in mitigating any barriers.

10.3. Finally, it is imperative that the Single Commission function remains committed to delivering the Local Transformation Plan and the recommendations set out in Future in Minds and the implementation of Five Year Forward View for Mental Health and Parity of Esteem.

11. RECOMMENDATIONS

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

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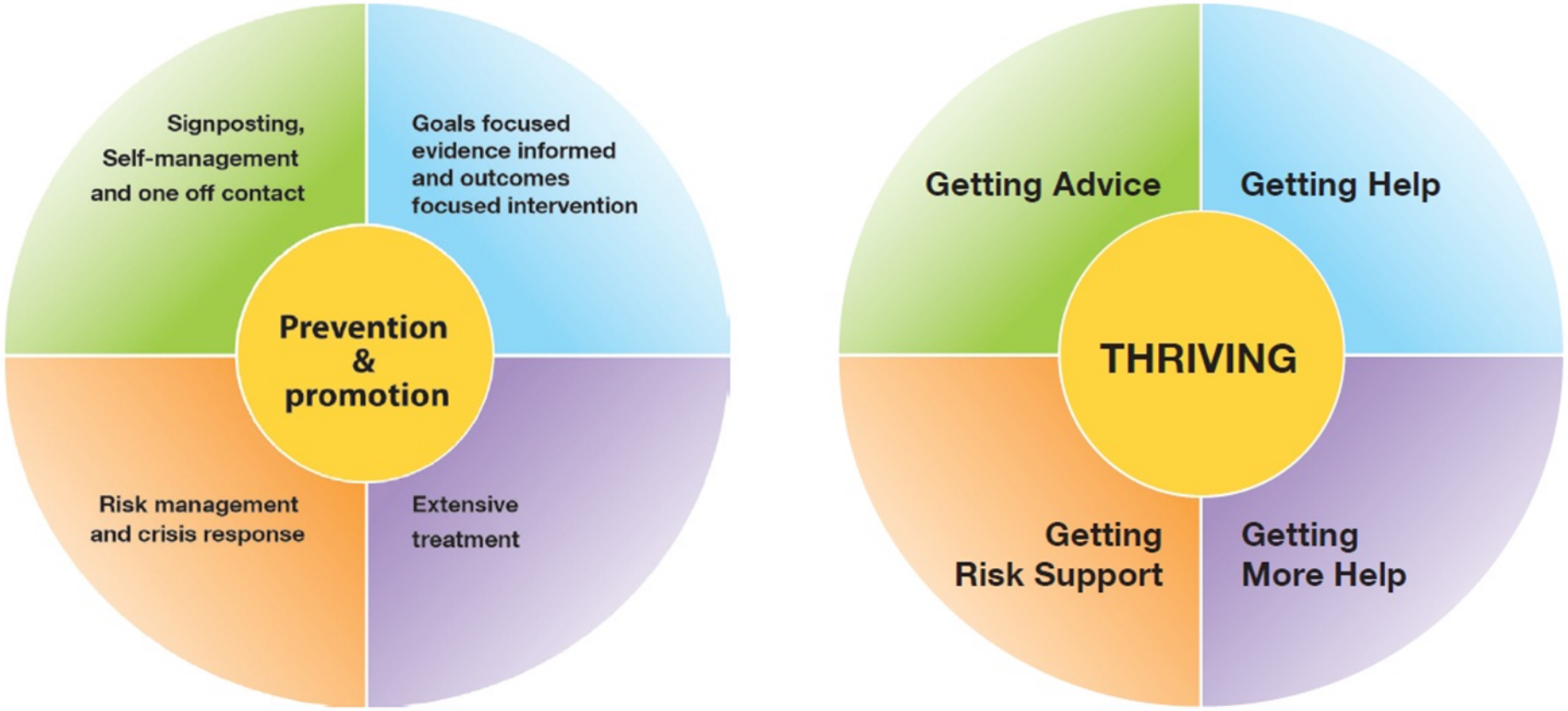
Thrive Model for CAMHS

The Anna Freud Centre and Tavistock and Portman NHS (2014)

The THRIVE model below conceptualises four clusters (or groupings) for young people with mental health issues and their families, as part of the wider group of young people who are supported to thrive by a variety of prevention and promotion initiatives in the community.

The image to the left describes the input that offered for each group; that to the right describes the state of being of people in that group - using language informed by consultation with young people and parents with experience of service use.



Each of the four groupings is distinct in terms of:

Needs and/or choices of the individuals within each group6

- Skill mix required to meet these needs
- Dominant metaphor used to describe needs (wellbeing, ill health, support)
- Resources required to meet the needs and/or choices of people in that group
- The groups are not distinguished by severity of need or type of problem.

The middle designation of “thriving” is included to indicate the wider community needs of the population supported by prevention and promotion initiatives

Thrive replaces the tiered model with a conceptualisation of a whole system approach that addresses the key issues outlined above and is aligned to emerging thinking on payment systems, quality improvement and performance management. The framework outlines groups of children and young people, and the sort of support they may need, and tries to draw a clearer distinction between treatment on the one hand and support on the other. It focuses on a wish to build on individual and community strengths wherever possible, and to ensure children, young people and families are active decision makers in the process of choosing the right approach. Rather than an escalator model of increasing severity or complexity, we suggest a framework that seeks to identify somewhat resource-homogenous groups (it is appreciated that there will be large variations in need within each group) who share a conceptual framework as to their current needs and choices.

Getting Advice: Within this grouping would be children, young people and families adjusting to life circumstances, with mild or temporary difficulties, where the best intervention is within the community with the possible addition of self-support. This group may also include, however, those with chronic, fluctuating or ongoing severe difficulties, for which they are choosing to manage their own health and/or are on the road to recovery.

Getting Help: This grouping comprises those children, young people and families who would benefit from focused, evidence-based treatment, with clear aims, and criteria for assessing whether aims have been achieved. This grouping would include children and young people with difficulties that fell within the remit of NICE guidance but also where it was less clear which NICE guidance would guide practice.

Getting More Help: This grouping comprises those young people and families who would benefit from extensive long-term treatment which may include inpatient care, but may also include extensive outpatient provision.

Getting Risk Support: This grouping comprises those children, young people and families who are currently unable to benefit from evidence-based treatment but remain a significant concern and risk. This group might include children and young people who routinely go into crisis but are not able to make use of help offered, or where help offered has not been able to make a difference; who self-harm; or who have emerging personality disorders or ongoing issues that have not yet responded to treatment.

LTP 2015-2017 Early Priorities

Period	Key Priority	Thematic Domain
June 2015 to March 2016	**Getting Help** – we will ensure children, young people and those who care for them can access help when and where they need it through a single point of access that covers the whole system and not just specialist CAMHS; providing a clear understandable service offer (what support should be received). We aim to: - • Review access pathways for specialist CAMHS, benchmarked with other similar partnership area service(s). • Undertake referral mapping and audit to identify low and high referral sources; Identify key sources of redirected referrals and focus of redirection (which services are families signposted to); Re-referral rates. • Identify the hard to reach young people and families by locality and collect baseline information on access to specialist CAMHS and benchmark findings • Develop and produce access pathways and a clear, '*understandable'* CAMHS 'local offer' for meeting emotional wellbeing and mental health needs, which includes self-referral • Develop and plan, in partnership, interventions (training needs analysis and programme, supervision, link practitioners) to encourage self-referral and improve referral quality and appropriateness (address low and high referral sources/routes). • Ensure that the most experienced professionals with expert knowledge of children and young people's mental health are accessible from the start' across the system; particularly placing them where children and young people are most vulnerable (LAC, Youth Offending), so that there are no gaps through which they can fall • Work with NHE England and the Department for Education to pilot and test the named lead approach and the training programme with schools. • We will ensure that all GPs have a named CAMHS Consultant to improve communication and access between primary care and CAMHS • Implement Single Point of Access (SPA) within the integrated Public Service Reform Hub to improve access for children, young people and those who care for them • Place the third sector within the management of the NHS CAMHS service to enable a joined up offer between statutory and voluntary services; offer mediation within referral appeals • Implement local waiting time targets that seek the improvement in access specialist CAMHS services support and treatment • Agree our parenting programme offer, ensuring that we have consistent access to high quality	A, C, D, E, F

	evidence based parenting programmes, delivered to model fidelity	
September 2015 to March 2017	**Community Eating Disorders Pathway** – we will work with our identified CCG partners and Pennine Care NHS Foundation Trust to develop and deliver a community based eating disorder service that meets the requirements established by NHS England (July 2015), 'Access and Waiting Time Standard for Children and Young People with an Eating Disorder'. We aim to: - • Ensure the service model is developed in partnership with key stakeholders, placing the voice of the child and those who care for them at the heart; utilising national guidance, local clinical expertise, performance data and service user feedback • Review the range of services available for young people with eating disorders, including inpatient treatment, support from the In reach/Outreach team (IROR) and community CAMHS intervention ensuring that the new service provision builds on and takes into account existing provision and expertise • Explore the true need in providing support to young people across a full pathway form emerging, lower levels to moderate and severe, ensuring support is readily available for all levels of need • Scope and ensure that Paediatric and Dietician services are seamless delivered within an integrated Eating Disorders Pathway • Ensure the reduction of inequalities in access and outcomes; service design and communications should be appropriate and accessible to diverse communities. Scope building services in more visible, more central and more accessible sites may assist in addressing socio-economic or cultural barriers to access. • Review and consider the findings from the Surveillance Review December 2013 of the 2004 NICE Eating Disorders Guidance with emerging evidence that day patient care is equally effective as in-patient care but associated with lower cost • Ensure CYP accessing the service are offered a generic mental health assessment to identify/exclude any co-morbid needs, a specialised eating disorder assessment, a baseline physical health screening and an individualised care plan. • Ensure the service can offer a range of therapeutic interventions, which are evidence based and underpinned by a multidisciplinary team (MDT) ethos and approach. The MDT will work in close collaboration with the virtual team members that they regularly interface with such as Acute Trust Paediatric and Medical services, and with Primary Care, to ensure young people's co-existing physical health needs are met.	A, B, C, D, E
October 2015 to	**Transition to Adulthood** – we will continue to explore all avenues to smooth the transition from children's to adult services by taking a developmental, personalised approach rather than being dictated by	A, B, C, D, E

October 2016	chronological birthdates. We aim to:- • Establish an all age Eating Disorder Service, enabling young people to stay on within the same service until they are ready to be discharged. • Establish an all age ADHD service to support CAMHS graduates and families as well as adults. • Review mental health provision for young people aged 16 and 17 and engage young people in the design of options for consideration • Strengthen the integrated pathways between CAMHS and AMHS, using the learning from the transformation plan to better support the service transition in particular for vulnerable groups including CSE, Looked after young people and young people who self-harm. • Explore evidence base and options for vulnerable young people to continue within the CAMH service until they are ready to leave. • Develop a CQUIN that builds upon and improves transition arrangements between CAMHS and Adult Mental Health.	
September 2015 to December 2016	**Parental Mental Health** – we will continue our focus on Parent Infant Mental Health and expand this to include parents of children of all ages. We aim to:- • Undertake a whole system audit of practice based on the NICE Guidance on Ante and Postnatal Mental Health and check our findings against gathered experiences of care in the perinatal period from parents. • Refresh our Integrated Parent Infant Mental Health Pathway in line with recent developments including NICE Guidance on Ante and Postnatal Mental Health. Review training programme and amend as required. • Establish a pathway for families with high needs, such as those within the child protection system and parents with learning needs, from early pregnancy to school. To support this we will extend the capacity of our Early Attachment Service to deliver intensive evidence based parenting programmes such as Mellow Parenting to prospective mothers and their partners and to extend provision for dads. • When published, work with partners across GM to agree a sector solution to the expectations of the NHS England Perinatal Mental Health Standards to ensure women have access to specialist perinatal services when they are required, including access to Mother and Baby Units/community based alternatives as an option for all expectant mothers or those in the first year after birth. • Build on last year's Parental Mental Health CQUIN, CCG Carers review, evidence base on outcomes for children where parents have mental health needs and agree whole system requirements to promote good outcomes for children.	A, B, C, D, E, F

October 2015 to May 2016	**Neurodevelopmental Umbrella Pathway** – we will work with all partners across the health and economy and children's social care and education to deliver an umbrella pathway for children and young people where there are queries or concerns about difficulties in the following areas: Attention, concentration, impulsivity and hyperactivity (ADHD and ASD). In addition we will strive to widen the pathway within a phased approach to also cover: Learning, thinking behaviours; Tics and other motor mannerisms; and other difficulties such as sensory processing. We aim to:- • Work with CYP and those who care for them to improve assessment, diagnosis, management, on-going support and outcome plans for all children and young people, whether a specific diagnosis is reached or not • Establish multi agency partnership and steering group to review, develop and implement a pilot Neurodevelopmental Umbrella Pathway, continuing to work in partnership with the ADHD Foundation • Deliver the GM and Lancashire Strategic Clinical Network ADHD standards • Ensure timely access to NICE concordant care through the delivery of Neurodevelopmental Umbrella Pathway - drawing on, but not limited to, Attention deficit hyperactivity disorder: Diagnosis and management of ADHD in children, young people and adults; and Autism: The management and support of children and young people on the autism spectrum • Ensure clear ownership and accountability for the pathway • Review and monitor the effectiveness and impact on resources and ensure provision is sustainable	A, B, C, D, E
August 2015 to June 2016	**Develop the Workforce** – we develop training programmes that lead to an appropriately skilled workforce across the whole system that seek to ensure a 'no wrong door' approach and promotes early invention and timely access. We aim to:- • Implement workforce audits that leads to the development of training pathway and programme that cuts across the whole workforce; including volunteers, support staff and receptionists • Establish multi agency partnership and steering group to review, develop and implement a training programme that can be accessed by all agencies and organisations across Tameside and Glossop that are working with children, young people and those who care for them. This will include training and development on adult mental health to enable children's services staff to support parents into adult mental health provision if required • Promote access to e-learning and tuition lead courses to all CYP workforces, including volunteers, across Tameside and Glossop; minimising the barriers to access • Develop and implement Self-Harm and Suicide Strategy, guidance for all practitioners across setting supported by training and supervision (action learning model) • Maintain and roll out CYP IAPT from our NHS CAMHS service to all partners, including the third sector	B,C D, F

	and education. • Develop and implement training programme for parents and carers	
September 2015 to April 2016	**Coping** – we will ensure access to a range of information and develop the infrastructure that enable those children, young people and those who care for them the choice over their care that enables self-directed care and management. We aim to:- • Develop and support infrastructure that enables self-directed care and management (e-platforms and apps), one off contact (online or face to face) and peer mentoring • Develop choice and control for children, young people and those who care for them through: promotion of the local offer; Personal Health Budgets (PHB); establish and maintain Service User Fora • Ensure promotion of mental health and emotional wellbeing through tackling stigma campaigns, workshops and local events (e.g. World Mental Health Day)	A, B, C
September 2015 to June 2016	**Getting Risk Support** – we will continue to develop preventative and proactive as well as intervention services for children and young people who are vulnerable such as those who are looked after, in the criminal justice system, those with a mental Health crisis and those requiring in-patient care. We aim to:- • Review interface between CAMHS community based and CAMHS inpatient services (including secure) • Review interface between CAMHS (PCFT) and Paediatrics (THFT). • Establish interface meetings to ensure effective pathways and joint working between CAMHS and Tameside Hospital emergency department through to the Paediatric ward. • Build effective risk management and early intervention for children and young people at risk of a crisis • Refresh our Crisis Care Concordat to ensure that children and young people are appropriately reflected (see appendix 4 Tameside Template action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat). • Review crisis care for children and young people within our evaluation of RAID services at Tameside General Hospital in line with NHS England Psychiatric Liaison Standards. • Review CAMHS In-reach Outreach Service in conjunction with the development of the home treatment aspect of the Community Eating Disorder service and develop urgent/crisis care home treatment model, ensuring cross organisational support and integrated delivery. • Scope opportunities in conjunction with the LA to develop Edge of Care services in localities to prevent family breakdown and reduce the use of unplanned care episodes • Work with colleagues in GM to develop a local approach to commissioning CAMHS Inpatient care and alternatives to in-patient care in line with GM Devolution. • Ensure, with the Local Safeguarding Children's Boards (LSCBs), that findings from Serious Case Reviews (SCRs) in relation to emotional well and mental health are implemented	A, B, C, D, E

	• Review CAMHS pathway for Child Sex Exploitation (CSE) and develop action plan based on findings	
September 2015 to March 2017	**Joint Commissioning** – in line with our Care Together plans we will integrate the commissioning of emotional and mental health services and ensure a Mindful approach to commissioning that ensures services meet the emotional wellbeing and mental health needs of children, young people and those who care for them. We aim to:- • Maintain our commitment to systematically ensuring the voice of the child is heard and acted upon within commissioning arrangements • Build on our engagement with children and young people by developing and maintaining Service User Fora to provide a direct voice into our Programme Board and future commissioning intentions; ensuring decisions around design and delivery are shaped by those best placed to know what works and help monitor effectiveness • Place the Voice of Child statements as KPI's and audit within all service specifications commissioned to deliver emotional wellbeing and mental health service for CYP and those who care for them • Ensure all service specifications (including physical health) highlight emotional wellbeing and mental health requirements of the provider. • Expand the remit and terms of the current Children, Young People's emotional Wellbeing and Mental Health Transformation Programme Board until 2020. • Pilot CAMHS Modelling Tool to support the of improved mental health services for children and young people beyond 2016/17 • Ensure outcome based commissioning is developed and that Routine Outcomes Measure (ROMS) are stipulated within service specifications • Review and consider implementation of online web based IT system to capture and collate data from CAMHS and partners agencies, ensuring business intelligence support form CORC. • Establish New service specification for Community CAMHS 2016/17 based on Local Transformation Plan principles and Thrive Model for CAMHS; placing the voice of child 'I' statements at the heart service specifications • Through the CCG Nursing and Quality Directorate undertake audit and quality visit to PCFT CAMHS and ensuring NICE concordant delivery • Develop and Maintain Pennine Care CAMHS Commissioning and Provider interface, with those CCGs who commission Pennine Care NHS Foundation Trust as their CAMHS provider (Tameside and Glossop, Oldham, Trafford, Stockport, Bury and Haywood, Middleton and Rochdale) • Work with all partners within our work to create an Integrated Care Organisation that supports a single point of access to all children and young people's provision (including Mental Health). This will ensure	A, B, C, D, E, F

	smooth pathways into a range of support with a significant reduction in ‘asks for help’ being rejected and/or referred on. We will ensure direct access to help for children, young people and those who care for them.	

Thematic Domain Key:

A. The voice of the child - reforming care delivery based on the needs of young people, children and those who care for them;
B. Developing resilience, prevention, early intervention and promoting good mental health and wellbeing;
C. Improving access to appropriate services that are as close to home as possible and at the right time that are implementing evidence based pathways;
D. Promoting working across agencies leading to a clear joined up approach for the benefit of children and young people in Tameside and Glossop;
E. Improved accountability, transparency and ownership of an integrated whole system; and
F. Development of training programmes that lead to an appropriately skilled workforce across the whole system

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Priority	Thematic	Description Narrative	CYP Rating 0/90	CYP Range 0 -10	Board Rating	Total	Delivery grp
1	Voice of the Child / Schools and Ed	CYP Voice: Training for teachers about mental health to improve PHSE					Education
2	Voice of the Child / Schools and Ed	CYP Voice: Improve Teacher awareness of mental health issues					Education
3	Voice of the Child / Schools and Ed	CYP Voice: Improve awareness across 'whole school'/those working and support pupils that focus on understanding, respect & confidentiality					Education
4	Voice of the Child / Schools and Ed	CYP Voice: Improve Teachers ability to manage CYP are upset, angry, depressed or anxious					Education
5	Voice of the Child / Improving Access	CYP Voice : Raise the profile of those service who are providing mental health support - who can help					Coping/Getting advice
6	Voice of the Child / Improving Access	CYP Voice: Let us know who can help					Coping/Getting advice
7	Voice of the Child / Improving Access	CYP Voice: Help and support for those whilst waiting for treatment - formal support					Getting Help
8	Voice of the Child	Continuation of the engagement of Children, Young People and Families in the co-production of the CAMHS Service to ensure the Voice of the Child is embedded	90.0	10	10	100	LWW
9	Vulnerable Groups/Transition	Continuation of dedicated Youth Offending and Transition post to support those involved in the criminal justice system and post 16 years of age.	89.0	9 - 10	10	99	Getting Help
10	Improving Access	Ensure CYP are seen in the right place at the right time, close to home; and seek to reduce re-referrals.	86.5	9 - 10	10	97	Getting Help
11	Schools / Education	Develop Emotional Wellbeing and Resilience Programme in all Primary Schools	86.5	9 - 10	10	97	Education
12	Vulnerable Groups	Continuation of the dedicated Looked after Children (LAC) HYM/CAMHS provision	86.0	8 - 10	10	96	Getting Help
13	Neurodevelopmental	Vulnerable Groups: Continuation of dedicated Neurodevelopmental (ADHD ASC) additional resources within HYM/CAMHS ADHD and ASD	85.0	7 - 10	10	95	Getting More Help
14	Transition	Ensure seamless transition from Healthy Young Minds to Healthy Minds, CMT - from children's to adult services	84.0	9 - 10	10	94	GM/Cluster
15	Schools / Education	Expand CAMHS school link pilot to all schools across Tameside and Glossop with schools dedicated project support	80.0	8 - 9	10	90	Education
16	Vulnerable Groups	Continuation of the Vulnerable Families Post in Parent Infant Mental Health pathway	79.0	8 - 10	10	89	Getting More Help
17	Vulnerable Groups	Review children and young people from BME communities accessing support and ensure service are proactive	85.0	6 - 10		85	CCG
18	Improving Access	Review and clarify the support and treatment options for Borderline Personality Disorder	72.0	6 - 9.5	10	82	Getting Help
19	Making Better Use of Information	Continuation of cross-system evaluation and monitoring (partnership with CORC/Anna Freud Centre)	73.0	9 - 10	7	80	CCG
20	Vulnerable Groups	Continuation of dedicated vulnerable group work with all C/YP and their carers, to address EWB and mental health problems / issues	70.0	6 - 10	10	80	Getting Help
21	Improving Access / Workforce	Increasing access to timely advice, consultation and training to the children and young people's workforce	69.0	7 - 9	10	79	Getting Help
25	Partnership	Support Third Sector and partnership coordination, ensuring a whole system integrated approach to meeting needs	68.5	7 - 8	9	78	CCG
26	Parents and Carers	Develop and clarify Parent and Carers training and support (Mind Ed)	67.5	6- 10	7	75	CCG
27	Improving Access	Continuation of drop-in/open access support from Third Sector organisations, before during and after treatment.	61.0	5 - 9	9	70	Coping/Getting advice
28	Improving Access	Continuation of support from the Early Help Service and develop Neighbourhood (5) offers to ensure timely support that is close to home	60.0	6 - 9	9	69	Getting Help
29	Improving Access	Evaluate and look to increase clinic sites to improve access to services – where HYM/CAMHS can operate from, to minimise the barriers to engaging and enable better choice and control	81.0	7 - 10			
30	Schools / Education	Expand CAMHS school link pilot to all schools across Tameside and Glossop project support with dedicated HYM (CAMHS) clinical time	80.0	8 - 10			
31	Social Media Group	Ensure promotion of mental health and emotional wellbeing through tackling stigma campaigns, workshops and local events (e.g. World Mental Health Day)	53.0	4.5 - 9			Coping/Getting advice

32	Workforce	Offer and promote training for YOT staff in neurodevelopmental issues and speech and language issues					GM/Cluster
33	Workforce	Ensure Multi-agency ADOS training to increase capacity for ADOS assessments within the Neuro umbrella pathway					
34	Challenging Behaviour	*Funded: Challenging behaviour review and development - pilot project*					
35	GM Approaches	*Mandatory Greater Manchester Crisis Care Pathways*					
36	GM Approaches	*Mandatory Greater Manchester CAMHS 24/7 on call stabilisation*					
37	Crisis Care	*Mandatory/Funded: Ensure clarity within existing resources to deliver CYP MH liaison service*					
38	Eating Disorders	*Mandatory Expansion of new Community Earing disorder service through phased development*					

DO not use
Coping/Getting advice
Getting Help
Getting More Help
Getting Risk support
Other
GM/Cluster

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**ATRIAL FIBRILLATION PATHWAY AND COMMUNICATIONS STRATEGY**
Report Summary:	Atrial Fibrillation is a common heart arrhythmia and increases the risk of stroke. In order to improve health outcomes for people with Arterial Fibrillation, and to also achieve significant financial savings for the NHS and social care, more patients (in particular those who are asymptomatic) need to be identified, treated and managed appropriately. The Heart Disease Programme Board identified the need for: • a clear pathway to identify, treat and manage Atrial Fibrillation; • key messages about Atrial Fibrillation to be communicated to the Neighbourhoods (including Primary Care) and also people living in Tameside and Glossop. Included in this report is a copy of the proposed pathway (**Appendix 1**), a draft communications plan (**Appendix 2**) and targets for increasing the identification and management of people with Atrial Fibrillation.
Recommendations:	The Single Commissioning Board are asked to 1. Approve the pathway for use in Primary Care; 2. Note that further discussions are to be held with Tameside and Glossop Integrated Care NHS Foundation Trust to further develop the draft communications plan to identify more people who have undiagnosed Atrial Fibrillation; 3. Agree with the aim to implement the pathway as the approach to identifying 550 more people by the end of 2016/17 and reduce the number of people who are admitted for a stroke but have known Atrial Fibrillation and are not anticoagulated.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The costs associated with this are all included in the wider Integrated Care Fund, but are not part of the S.75 as some costs fall within the list of exclusions. Finance Group has reviewed this report and fully support the principles contained within, which aligns well with the principles of Care Together. However we must sound a note of caution with regard the calculated savings which we believe need more work if they are to form the basis of the decision making process. While the £23k per stroke calculation may have academic rigour behind it, it is a theoretical figure based on the long term costs associated with stroke in different areas. It does not represent a short term cashable benefit; therefore realisation of savings in 17/18 cannot be as quoted. The report talks about implementing a new communications strategy to which there is no cost attached, which would further reduce any saving.

Legal Implications: **(Authorised by the Borough Solicitor)**	To avoid sustainable challenge the proposals agreed and as set out in this report should be effectively monitored to ensure compliance with targets in achieving improved outcomes and reducing the costs to the system. Whilst the health benefits will significantly reduce health inequalities, the financial savings of £41K are finely balanced. Moreover do not take into account any spend required for the communications strategy.
How do proposals align with Health & Wellbeing Strategy?	The proposed pathway and communications plan will align with the H&WB strategy by: • Providing a clear pathway for Primary Care which will support the identification of the undiagnosed Atrial Fibrillation patients; • Providing a clear plan of how to treat and manage people with Atrial Fibrillation in Primary Care and in the community which will increase independence and reduce ill health; • Producing a neighbourhood communications strategy that will provide targeted awareness and improve identification.
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Healthy Lives (early intervention and prevention); • Enabling self-care; • Neighbourhood-based identification and management.
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering people to identify the symptoms of Atrial Fibrillation in themselves or others; • Encourage neighbourhood teams to identify and undertake pulse checks on people who may be at high risk of Atrial Fibrillation; • Recommend that Primary Care follow the pathway to identify more people and manage them appropriately.
Recommendations / views of the Professional Reference Group:	PRG agreed to the three recommendations. There was a concern raised about the impact the pathway may have on primary care and this is something that would be addressed with the full implementation plan. The implementation of the pathway would support the reduction of unwanted variation in healthcare and this is an area of change that is highlighted within the RightCare data.
Public and Patient Implications:	The new pathway would support the identification of Atrial Fibrillation across Tameside and Glossop. This would then allow for improved management and reduction in risk for future strokes.
Quality Implications:	A quality impact assessment has been completed and is attached.
How do the proposals help to reduce health inequalities?	The incidence of Atrial Fibrillation increases with age. By identifying Atrial Fibrillation early, and by supporting and managing people appropriately, it will ultimately reduce the number of people who would go on to have a stroke.
What are the Equality and Diversity implications?	It is anticipated that the proposal will not have a negative effect on any of the protected characteristic group(s) within the Equality Act.

	An Equality Impact assessment has been completed and is attached.
What are the safeguarding implications?	None.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. GP Practices and neighbourhood teams would have IG policies in place and they would be expected to adhere to these.
Risk Management:	By following the pathway is it expected that there would be a reduction in risk as more people would be identified.
Access to Information :	The background papers relating to this report can be inspected by contacting Samantha Hogg, Commissioning Development Manager by: Telephone: 07342 055 999 e-mail: Samantha.hogg@nhs.net

1. BACKGROUND

1.1 This report sets out the following proposals:

- Approval of the Atrial Fibrillation Pathway;
- Approval of a Communications plan for the neighbourhoods;
- Approval of targets to achieve by the end of 2017/18.

Atrial Fibrillation

1.2 Atrial Fibrillation (Atrial Fibrillation) is a common heart arrhythmia. Atrial Fibrillation is associated with symptoms such as breathlessness, palpitations, dizziness and chest discomfort and is a major predisposing factor for stroke (NICE, 2014). However Atrial Fibrillation can also be asymptomatic and will often only be diagnosed once a person has had a stroke.

1.3 In order to improve health outcomes for people with Atrial Fibrillation, and to also achieve significant financial savings for the NHS and social care, more patients (in particular those who are asymptomatic) need to be identified and prescribed anti-coagulants.

1.4 Circulation pathways, including Atrial Fibrillation identification and management, have been identified in the latest NHS England 'Right Care' data as one of 5 priorities where Tameside & Glossop could improve outcomes and financial efficiency when benchmarked with 10 comparator CCGs.

1.5 The recorded prevalence in England is 1.7% and the recorded prevalence in Tameside and Glossop is 1.64% (Quality and Outcomes Framework 2015/16). However, 2.4% of the population is expected to have Atrial Fibrillation (National Cardiovascular Intelligence Network, 2015). This would mean that an extra 1,860 people in Tameside and Glossop may need to be identified.

1.6 Using data collected by Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) 29 people were admitted to Tameside Hospital with a diagnosis of stroke, but they had not been prescribed anticoagulation for their Atrial Fibrillation prior to admission (Sentinel Stroke National Audit Programme, July 2015 and June 2016).

1.7 Training was offered to GP practices and was taken up by 28 practices during Quarter 3/Quarter 4 of 2015/16 and Quarter 1 of 2016/17. An additional 165 people have been identified in 2015/16 and there was a reduction in the exception rate by 4%. This number is expected to rise further following the training. However, there are still a large number of people who are estimated to have Atrial Fibrillation but have not been diagnosed.

1.8 The Heart Disease Programme Board (an executive group that includes representation from Cardiologists, Senior Management at the Integrated Care Organisation, Primary Care, Commissioning, and the Academic Health Science Network) identified the need for further work around Atrial Fibrillation and developed the Atrial Fibrillation Task and Finish Group that is chaired by Dr Tom Jones (Clinical Lead for Long Term Conditions).

1.9 The Atrial Fibrillation Task and Finish Group identified the need for a clear pathway and a way to communicate the importance of Atrial Fibrillation to Primary Care, the people working in the Neighbourhoods and also people living in Tameside and Glossop.

2. PATHWAY

2.1 A pathway (see **Appendix 1**) was developed using national guidelines (e.g. NICE 2014), other North West pathways (e.g. Cheshire and Merseyside Strategic Clinical Network, 2015) and input from GPs and Cardiologists.

2.2 The pathway focuses on Primary Care and how GP practices can:

- Identify Atrial Fibrillation, including regular pulse checks in flu clinics, and reviewing practice data (such as by using GRASP-Atrial Fibrillation audit tool);
- Treat Atrial Fibrillation by changing the heart rate and prescribing anticoagulation if required;
- Manage people with Atrial Fibrillation in Primary Care by booking in annual reviews and reviewing medication;
- Providing clear details of when to refer to Secondary Care, when to use Cardiology Advice and Guidance and a reminder that ECGs are offered in the community.

3. COMMUNICATIONS PLAN

3.1 A draft communications plan has been developed (see **Appendix 2**). The plan includes communicating key messages with the over 65's and families and further work with nursing/residential homes and medical professionals.

3.2 There have been initial discussions with the lead and programme managers for the Healthy Neighbourhoods workstream at Tameside and Glossop Integrated Care Foundation Trust around the communications plan being fully developed and rolled out by the neighbourhood teams. The Atrial Fibrillation pathway and communications could then be used as a pilot for future neighbourhood wide initiatives.

4. PROPOSED PATHWAY

4.1 If the pathway and communications plan is implemented, it is anticipated that there will be:

- An **increase** in identification of 550 patients (30% of estimated missing patients) by the end of 2017/18;
- 50% **reduction** in the number of people admitted for a stroke without being anticoagulated (approximately 15 people);
- A **reduction** in cardiology referrals and an **increase** in the use of Advice and guidance and diagnostics in the community;
- An **increase** in the number of people who receive appropriate anticoagulation.

5. FINANCIAL ENVELOPE FOR THE Atrial Fibrillation PATHWAY

5.1 It is anticipated that there would be some cost saving to the economy

Table 1: Potential savings and costs related to the implementation of the Atrial Fibrillation pathway

Target	Detail	Cost per person	Total (Per Annum)
50% Reduction in known Atrial Fibrillation/non-coagulated strokes (*National Audit Office, 2010, av. Cost for acute + rehab)	Approximately 15 people	£23,315*	£349,725
Reduction in referrals to cardiology	Approximately 100 appointments	£150	£15,000
Increase in appropriate prescribing of anti-coagulants	Approximately 550 Warfarin = 330 NOAC = 220	 £241* £803*	 (-£79,530) (-£176,660)

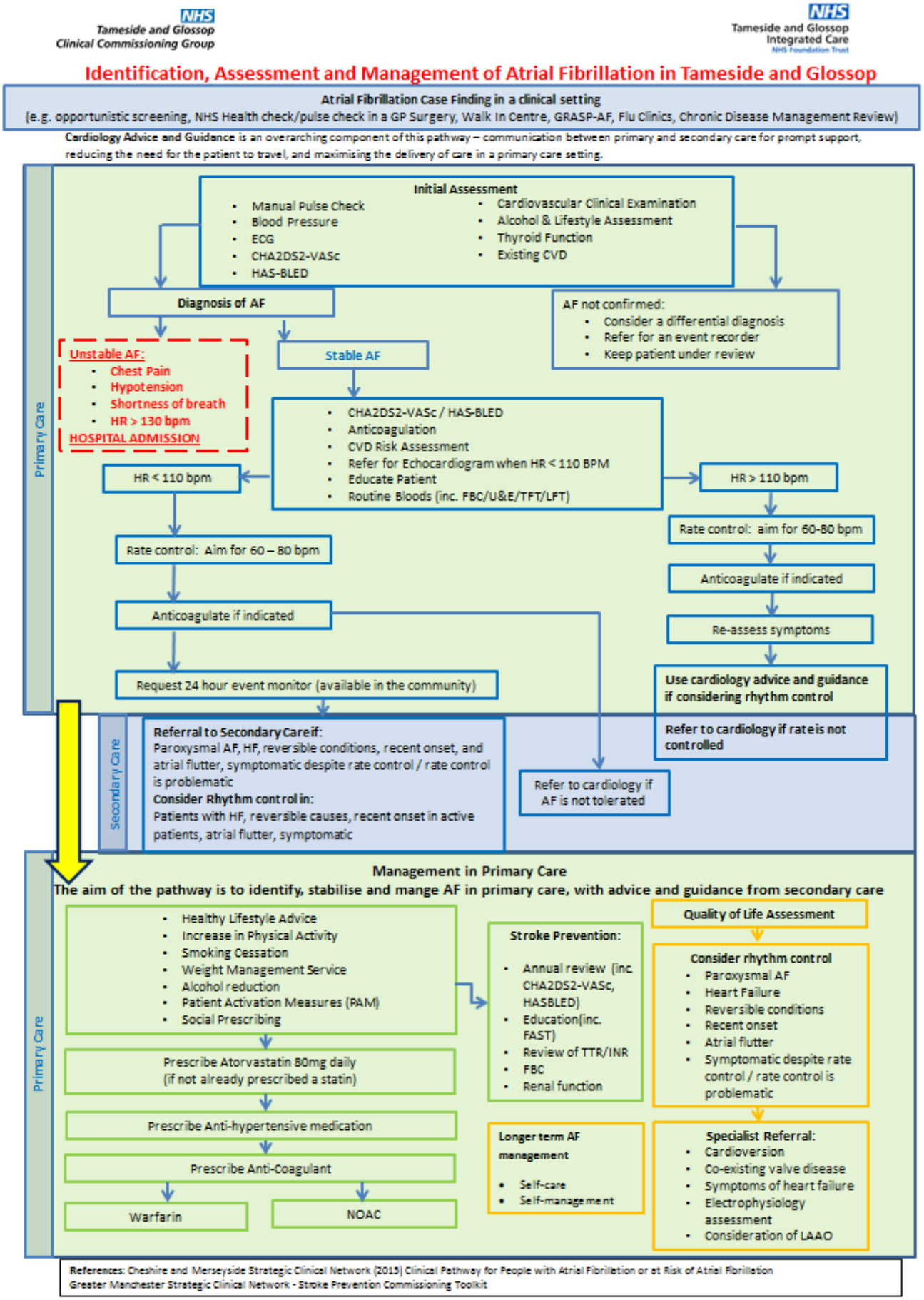
(*NICE Technology Appraisal 2012)			
Increase in diagnostics	12-lead = 550 Echo = 550 24 hr ECG = 200	£26.32 £69.54 £74.00	(-£14,476) (-£38,247) (-£14,800)
Communications plan	Neighbourhood budget		tbc
Total			£41,012 saving

5.2 As the Atrial Fibrillation work will support self-care, the potential for the communications to be funded from the Neighbourhood budget has been discussed. There are further conversations underway to confirm where the funding would come from but it is anticipated that the cost would be less than £5,000.

6. RECOMMENDATIONS

6.1 As detailed on the front on the report.

APPENDIX 1: Proposed Pathway



Appendix 2: Draft Communications Plan

Aim:						
To identify the people who require a diagnosis of Atrial Fibrillation and ensure they are managed appropriately in Primary Care (where possible).						
Audience	**Key Messages**	**Media**	**Channels**	**Call to Action**	**Outcome/Target**	**Tracking / controls**
- 65+ at risk	- Check their own pulse - anyone could be at risk - increased risk of stroke therefore disability/death - reduce risk with PA, diet, smoking, weight etc.	- Phone - Letter - Outreach - Radio - Social media - Third Sector	- Local report - Local radio - Age UK	- Go to GP practice if aware of symptoms	- More awareness of Atrial Fibrillation	- Identification of 550 patients (30% of estimated missing patients) but the end of 2017/18 - 50% reduction in the number of people admitted for a stroke without being anticoagulated
- Families with over 65's	- remind each other to check pulses - spot signs / symptoms - tiredness / dizziness is not a "normal" part of ageing	- Signpost - e-bulletins - events - social media	- Carers week - Facebook / twitter	- Encourage family member to go to the GP practice if they are aware of symptoms		
- GPs	- identify patients - follow pathway - know how many short - identify optimal management	- Events - Desktop / screensaver - E signatures	- Events (Target?) - Newsletter - Hospital Open Day - CCG Intranet - Neighbourhood meetings	- Share pathway in the practice -review GRASP-Atrial Fibrillation figures -check pulses in clinic -anti coag prescribed	- Fewer Atrial Fibrillation related strokes due to incorrect/no medication	

				- encourage patients to be aware of symptoms		
- Secondary care health professionals	- pulse check part of triage as standard (A&E, outpatients) - share the pathway - train the trainer?	- 10 x 6 sheets - Bulletin Screens - Team meetings - Notice boards	- Events - Newsletter - Hospital Open Day - Workforce development	- Check pulses - inform GP of positive cases	- Fewer Atrial Fibrillation related strokes - Increased prevalence	
- Community teams (DN, Physio, OT)	- Pulse checks in those who are high risk - train the trainer?	- Cascade via email - Team meeting Intranet	- Events - Newsletter - Hospital Open Day - Workforce development	- inform GP of positive cases		
- Nursing Homes / Care Homes	- Pulse checks in those who are high risk - train the trainer?	- Link with Tim Wilde (commissioner)	- Newsletter - Training	- Inform GP of positive cases		

Appendix 3: Equality Impact Assessment

Subject / Title	Atrial Fibrillation

Team	**Department**	**Directorate**
Atrial Fibrillation Task and Finish Group	Heart Disease Programme Board	ICO/SCF

Start Date	**Completion Date**
15.11.16	*28.11.16*

Project Lead Officer	Samantha Hogg
Contract / Commissioning Manager	Alison Lewin
Assistant Director/ Director	Clare Watson (HDPB = Trish Cavanagh)

EIA Group (lead contact first)	**Job title**	**Service**
Samantha Hogg	Commissioning Development Manager	SCF
Emily Parry-Harries	Speciality Registrar	SCF

PART 1 – INITIAL SCREENING

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

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

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

1a.	**What is the project, proposal or service / contract change?**	Atrial Fibrillation (Atrial Fibrillation) is a common heart arrhythmia and increases the risk of stroke. In order to improve health outcomes for people with Atrial Fibrillation, and to also achieve significant financial savings for the NHS and social care, more patients (in particular those who are asymptomatic) need to be identified, treated and managed appropriately. The Heart Disease Programme Board (an executive group that includes representation from Cardiologists, Senior Management at the ICO, Primary Care, Commissioning, and the Academic Health Science Network) identified the need for further work around Atrial Fibrillation and developed the Atrial Fibrillation Task and Finish Group that is chaired by Dr Tom Jones (Clinical Lead for Cardiology). The Heart Disease Programme Board identified the need for: • a clear pathway to identify, treat and manage Atrial Fibrillation • key messages about Atrial Fibrillation to be communicated to the Neighbourhoods (inc. Primary Care) and also people living in Tameside and Glossop

1b.	**What are the main aims of the project, proposal or service / contract change?**	**Pathway:** A pathway (see appendix 1) was developed using national guidelines (e.g. NICE 2014), other North West pathways (e.g. Cheshire and Merseyside SCN, 2015) and input from GPs and Cardiologists. The pathway focuses on Primary Care and how GP practices can: • Identify Atrial Fibrillation, including regular pulse checks in flu clinics, and reviewing practice data (such as by using GRASP-Atrial Fibrillation) • Treat Atrial Fibrillation by changing the heart rate and prescribing anticoagulation if required • Manage people with Atrial Fibrillation in Primary Care by booking in annual reviews and reviewing medication • Providing clear details of when to refer to Secondary Care, when to use Cardiology Advice and Guidance and a reminder that ECGs are offered in the community **Communications:** A draft communications plan has been developed. The plan includes communicating key messages with the over 65's and families and further work with nursing/residential homes and medical professionals. There have been initial discussions with the Neighbourhood team at TGICFT around the communications plan being fully developed and rolled out by the neighbourhood teams. The Atrial Fibrillation pathway and communications could then be used as a pilot for future neighbourhood wide initiatives. **Aims:** If the pathway/comms is implemented it is anticipated that there will be: • An **increase** in identification of 550 patients (30% of estimated missing patients) by the end of 2017/18 • 50% **reduction** in the number of people admitted for a stroke without being anticoagulated (approximately 15 people) • A **reduction** in cardiology referrals and an **increase** in the use of Advice and guidance and diagnostics in the community • An **increase** in the number of people who receive appropriate anticoagulation

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

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation

Age	**X (positive)**			**The likelihood of Atrial Fibrillation increases with age. The comms will target those over 65 but will provide key messages for all ages.**
Disability			**x**	**It is not anticipated that there would be any impact to people with a disability.**
Ethnicity			**x**	**It is not anticipated there would be any impact. There is little evidence to suggest that different ethnicities will be more likely to develop Atrial Fibrillation.**
Sex / Gender	**X (positive)**			**Males are more likely to develop Atrial Fibrillation but females with Atrial Fibrillation are more likely to go on to have a stroke, therefore, there will also be a focus on identifying females and ensuring both are manages appropriately.**
Religion or Belief			**x**	**It is not anticipated that there would be any impact to people of different religions/beliefs.**
Sexual Orientation			**x**	**It is not anticipated that there would be any impact related to sexual orientation.**
Gender Reassignment	**X (positive)**			**As above, there may be some effect of Atrial Fibrillation related to sex; therefore, comms will provide details of the effect based on gender.**
Pregnancy & Maternity			**x**	**It is not anticipated that there would be any impact related to pregnancy/maternity**
Marriage & Civil Partnership			**x**	**It is not anticipated that there would be any impact related to marriage/civil partnership.**
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health			**x**	**It is not anticipated that there would be any impact related to mental health**
Carers	**X (positive)**			**Atrial Fibrillation is often a pre-cursor to stroke, and stroke will often require the person to need a carer. By reducing the likelihood of stroke, would reduce the need for someone to be cared for.**
Military Veterans			**x**	**It is not anticipated that there would be any impact related to military veterans**
Breast Feeding			**x**	**It is not anticipated that there would be any impact related to breastfeeding**
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				

Group (*please state)*	Direct Impact	Indirect Impact	Little / No Impact	Explanation

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

1d.	**Does the project, proposal or service / contract change require a full EIA?**	**Yes**	**No**
			x
1e.	**What are your reasons for the decision made at 1d?**	The changes made to the Atrial Fibrillation pathway and the comms to be sent out would support the identification and management of Atrial Fibrillation, therefore it is not anticipated that there would be any detrimental affect due to the pathway and therefore no mitigating factors.	

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

Appendix 4: Quality Impact Assessment

Title of scheme: Atrial Fibrillation (Atrial Fibrillation)
Project Lead for scheme: Atrial Fibrillation Task and Finish Group (Chair: Dr Tom Jones, QIA completed by: Samantha Hogg, Commissioning Development Manager)
Brief description of scheme:

- Atrial Fibrillation Pathway for Primary Care (identification, treatment, management, referral)
- Communication of the key Atrial Fibrillation messages to neighbourhoods and the people who live within Tameside and Glossop.

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.						**What is the likelihood of risk occurring?**	**What is the overall risk score (impact x likelihood)**			
	Negligible **1**	**Minor** **2**	**Moderate** **3**	**Major** **4**	**Catastrophic** **5**	**1-5**	**Low** **1-5**	**Moderate** **6-12**	**High** **15-25**	**Comments**
Patient Safety	x					1	x			The new pathway would encourage GP Practices to identify, treat and manage patients within the community. The comms would also encourage other practitioners to regularly check pulses

Clinical effectiveness	x					1	x			Following the pathway would help to identify and manage people with Atrial Fibrillation and reduce their risk of stroke
Patient experience	x					1	x			The pathway follows national guidance and therefore would provide patients with support close to home
Safeguarding children or adults	x					1	x			Local safeguarding policies would be followed

Please consider any anticipated impact on the following additional areas only as appropriate to the case being presented. NB please see appendix 1 for examples of impact on additional areas.						**What is the likelihood of risk occurring ?**	**What is the overall risk score (impact x likelihood)**			**Comments**
	Negligible **1**	**Minor** **2**	**Moderate** **3**	**Major** **4**	**Catastrophic** **5**	**1-5**	**Low** **1-5**	**Moderate** **6-12**	**High** **15-25**	
Human resources/ organisationa	x					1	x			As part of the comms plan there would be additional training developed to

I development/ staffing/ competence										support the members of staff
Statutory duty/ inspections	x					1	x			The pathway follows NICE guidelines and uses pathways from neighbouring areas
Adverse publicity/ reputation	x					1	x			The pathway will help to support GPs to identify and manage people with ADF therefore reducing the risk of stroke
Finance	x					1	x			Overall, there should be a reduction in spend if strokes are prevented
Service/business interruption	x					1	x			There may be a small increase in waiting times for diagnostics if more people are identified
Environmental impact	x					1	x			It is not anticipated that there would be an impact on the environment
Compliance with NHS Constitution	x					1	x			The pathway will incorporate national guidelines and follow the NHS constitution.

Partnerships		x				1	x			The pathway/comms will be implemented as part of the neighbourhood work and will require positive partnerships working
Public Choice	x					1	x			Where possible the patient will be supported within their local area, but will e referred to secondary care if there are any concerns from the patient/GP
Public Access		x				1	x			There may be an increase in waiting times if a large number of people are identified, but work is underway to put in place community diagnostics

Has an equality analysis assessment been completed?	YES	Please submit to PRG alongside this assessment
Is there evidence of appropriate public engagement / consultation?	NO	The pathway is clinical. However, the comms plan is only draft and further work will be required.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**NHS RIGHT CARE**
Report Summary:	The NHS Right Care programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners. The approach has been tested and proven successful in recent years in a number of different health economies. As a programme it focuses relentlessly on value, increasing quality and releasing funds for reallocation to address future demand. NHS England has committed significant funding to rolling out the Right Care approach. By December 2016, all CCGs will be working with an NHS Right Care Delivery Partner. NHS England is investing in this programme to enable every health economy in England to embed the NHS Right Care approach at the heart of their transformation programmes. It is a programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources. This report sets out the national, GM and locality approach to the implementation of NHS Right Care, including the identification of the priorities for Tameside and Glossop.
Recommendations:	Single Commissioning Board are asked to consider and discuss the content of the report, and to approve the proposals related to the implementation of Right Care in Tameside and Glossop in section 5 of the report, and ensuring this is addressed as a system wide programme, engaging the Integrated Care Foundation Trust.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	As the focus of the Right Care programme is to improve population-based healthcare, reduce unwarranted variation and therefore optimise financial efficiencies, this will include both the Section 75 and Aligned budget sections of the Integrated Commissioning Fund. This Programme is nationally driven and promoted and is congruent with the Care Together Strategy. Whilst supportive of the actions being proposed to implement the Programme in Tameside & Glossop it will be necessary for the SCB to ensure the following further considerations are taken into account and fully evaluated prior to implementation of any proposal: - The impact of Healthier Together on any Right Care proposals; - How the Right Care proposals might overlap with existing transformation schemes; - How proposals would be performance managed within the

	Savings Assurance process whilst being cognisant of the level of challenge and scrutiny outlined in the Savings Assurance Guidance Notes.
Legal Implications: **(Authorised by the Borough Solicitor)**	The economy will be under considerable scrutiny to deliver. It will be important to receive regular reports to ensure on track.
How do proposals align with Health & Wellbeing Strategy?	The project team supporting the implementation of NHS Right Care in Tameside & Glossop will include representatives from the Single Commission public health team, to ensure any identified priorities are taken forward in a way which is aligned with the locality Health & Wellbeing Strategy.
How do proposals align with Locality Plan?	As outlined in the report, the implementation of the Right Care priorities will be aligned with the Locality Plan. This approach is also supported at a GM level in terms of alignment with the GM Strategic Plan.
How do proposals align with the Commissioning Strategy?	As above, the project team will ensure alignment with the locality's Commissioning Strategy.
Recommendations / views of the Professional Reference Group:	To proceed as per the recommendation in the report, ensuring this is addressed as a system wide programme, engaging the Integrated Care Foundation Trust.
Public and Patient Implications:	The project team will ensure patient and public involvement in projects arising from the implementation of the Right Care approach.
Quality Implications:	The NHS Right Care programme includes within it areas where the CCG can make changes to improve quality and outcomes, therefore quality is at the heart of this project and approach. Quality implications will be assessed and recorded throughout the project.
How do the proposals help to reduce health inequalities?	The NHS Right Care approach is designed to identify opportunities for changes to improve outcomes and efficiency, and the project team will ensure any approach taken helps to reduce / does not have a negative impact on health inequalities. Any project arising from this work will be subject to an equality impact assessment in line with the approach agreed for the Single Commission.
What are the Equality and Diversity implications?	Any project arising from this work will be subject to an equality impact assessment in line with the approach agreed for the Single Commission.
What are the safeguarding implications?	Any project arising from this work will assessed for potential safeguarding implications. The CCG Nursing and Quality Directorate are included in the project team membership.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Any project arising from this work will be assessed on an individual basis for information governance and privacy impact implications.

Risk Management:	A risk assessment will be undertaken for any project arising from this programme of work.
Access to Information :	The background reports relating to this report can be inspected by contacting Alison Lewin, Deputy Director of Transformation  Telephone: 07979 713019  e-mail: alison.lewin@nhs.net

1 INTRODUCTION AND BACKGROUND

1.1 The NHS Right Care programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners.

1.2 The approach has been tested and proven successful in recent years in a number of different health economies. As a programme it focuses relentlessly on value, increasing quality and releasing funds for reallocation to address future demand.

1.3 NHS England has committed significant funding to rolling out the Right Care approach. By December 2016 all CCGs will be working with an NHS Right Care Delivery Partner.

1.4 NHS England is investing in this programme to enable every health economy in England to embed the NHS Right Care approach at the heart of their transformation programmes. It is a programme committed to improving people's health and outcomes. It makes sure that the right person has the right care, in the right place, at the right time, making the best use of available resources.

1.5 NHS Right Care is all about:

- Intelligence – using data and evidence to shine a light on unwarranted variation to support an improvement in quality
- Innovation – working in partnership with a wide range of organisations, national programmes and patient groups to develop and test new concepts and influence policy
- Implementation and improvement – supporting local health economies to carry out sustainable change.

1.6 Data packs and a range of supporting information is available on the NHS England website. Data packs were refreshed in October 2016 (previous packs were released in January 2016).

1.7 The foreword to the October 'refresh' of the NHS Right Care data, written by Sir Bruce Keogh, National Medical Director for NHSE, reads as follows:

> *The Commissioning for Value packs and the NHS Right Care programme place the NHS at the forefront of addressing unwarranted variation in care. I know that professionals - doctors, nurses, allied health professionals - and the managers who support their endeavours, all want to deliver the best possible care in the most effective way. We all assume we do so. What Commissioning for Value does is shine an honest light on what we are doing. The Right Care approach then gives us a methodology for quality improvement, led by clinicians. It not only improves quality but also makes best use of the taxpayers' pound ensuring the NHS continues to be one of the best value health and care systems in the world*

2 NHS ENGLAND REQUIREMENTS

2.1 On 20 October Paul Baumann, Matthew Cripps and Richard Barker wrote to all CCGs in the North setting out NHS England's expectations in relation to the roll out of the Right Care programme. The letter outlined the requirements for CCGs in relation to Right Care and operational planning and the CCG Improvement and Assessment Framework as well as an immediate requirement to identify internal leadership with the CCG to deliver the Right Care approach.

2.2 The NHSE letter stated that CCGs will be expected to:

- Review, understand and address areas of unwarranted variation within the September 2016 CfV pack by the end of 2017/18. This will involve working through several cycles of the RightCare approach, focussing on multiple pathways
- Have completed this approach for 40% of the opportunities highlighted by the end of 2017/18 and plan to address 80% of the opportunities by 2018/19.

2.3 Progress against the above will be assessed through robust evaluation and within the CCG Improvement and Assessment Framework (IAF). The IAF includes two NHS RightCare indicators, which will assess whether CCGs improve in terms of spend and outcomes in the areas they select as NHS RightCare priorities under the programme.

2.4 Exec Operational and Clinical Lead nominations were sent to the national NHS Right Care Team as follows:

	Name	**Role**
Executive Lead	Clare Watson	Director of Commissioning
Operational Lead	Alison Lewin	Deputy Director of Transformation
Clinical Lead	Dr Alison Lea *Dr Thomas Jones*	GP / Governing Body member *Clinical Lead for Long Term Conditions*

2.5 On 16 November 2016, Tameside and Glossop CCG received a letter from Jon Rouse, Chief Officer of GM Health and Social Care Partnership, which set out how the NHS Right Care programme would be implemented in the context of Greater Manchester and devolution. The letter stated that 'NHS Right Care is a key tool in the delivery of high quality sustainable healthcare and its focus on reducing unwarranted variation, ensuring the people of Greater Manchester have the right care, in the right place at the right time is wholly consistent with the aims set out in our GM strategic plan "Taking Charge"'.

2.6 The intention of the GM Health & Social Care Partnership is to tailor the programme for the needs of Greater Manchester and to ensure alignment with the work done to date at GM and locality level. This approach will ensure the tools and techniques of the Right Care programme can complement the GM Thematic work streams and locality plans.

2.7 The letter from Jon Rouse stated that this alignment will be achieved by:
- Securing a dedicated GM NHS Right Care Delivery Partner who will be embedded within the Partnership team;
- Ensuring the reduction of unwarranted variation is aligned to locality plans and delivers real savings against locality costs;
- Widening the analysis of unwarranted variation into social care and wider determinants of health and wellbeing;
- Identifying RightCare opportunities that can be delivered across GM and aligning with thematic work across themes 1, 2 and 3;
- Embedding the opportunities identified through the RightCare analysis with the emergent GM clinical strategy.

2.8 Steve Wilson, Executive Lead for Finance and Investment will be the Partnership SRO for GM Right Care. Dr Gillian Greenhough has been appointed to the post of Associate Director of NHS Right Care in the Partnership team. Dr Gillian is a RightCare Delivery Partner and a GP by background.

2.9 The NHS Right Care team ran 2 national workshops in November – one which was held in Manchester, and which was attended by representatives from the CCG. A follow up event for GM, to focus on 'the unique elements of the delivery of GM RightCare' is due to be arranged early 2017. At the time of writing this report details were not available.

2.10 Tameside & Glossop CCG have been allocated a Right Care Delivery Partner – Carl Marsh – and officers have already held initial meetings to work with him to take forward Right Care in the locality.

3 NHS RIGHT CARE DATA PACKS

3.1 NHS Right Care resources include CCG level 'where to look' data packs, which identify the areas where CCGs can make the most effective improvements in terms of financial efficiency and outcome improvement. These data packs were initially produced in January 2016 and refreshed in October 2016. They can be found on the NHS England website https://www.england.nhs.uk/wp-content/uploads/2016/10/cfv-tameside-and-glossop-oct16.pdf.

3.2 Each CCG is compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for the population. The analysis in the Tameside & Glossop pack is based on a comparison with the most similar CCGs which are:

- NHS Rotherham CCG
- NHS Stoke on Trent CCG
- NHS Bury CCG
- NHS Wakefield CCG
- NHS Hartlepool and Stockton-On-Tees CCG
- NHS Barnsley CCG
- NHS St Helens CCG
- NHS Halton CCG
- NHS South Tees CCG
- NHS Telford and Wrekin CCG

3.3 The Commissioning for Value approach begins with a review of indicative data across the 10 highest spending programmes of care to highlight the top priorities / opportunities for transformation and improvement. This used nationally held data to indicate where CCGs may gain the highest value healthcare improvement.

3.4 The 'where to look' slides identify opportunities to improve value in healthcare commissioning and provision, and contain a number of key areas where CCGs should focus for improvement.

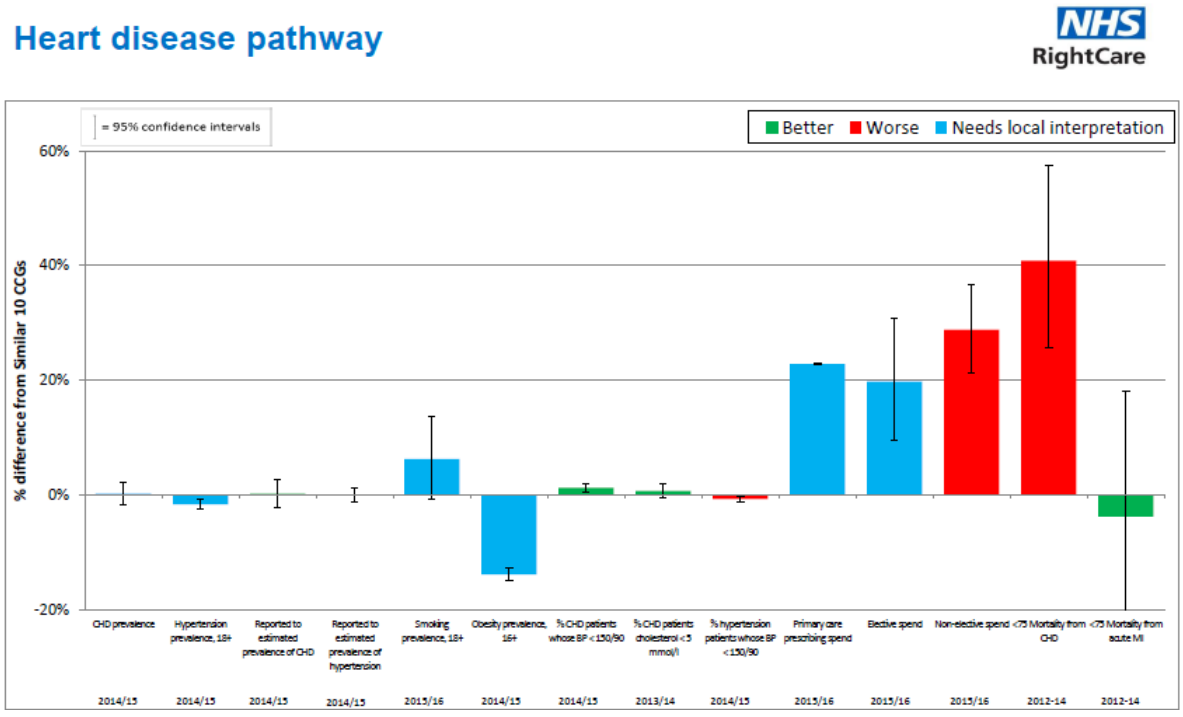
3.5 The NHS Right Care team are clear that CCGs / localities should not seek to add up all the spend opportunities in the pack to find total potential savings. Each programme of care is shown as a pathway and the recommendation is that the pathways are looked at as a whole. For example, in order to reduce spending for non-elective activity within cardiovascular disease, it may be necessary to increase resources in primary care prevention or prescribing. This should result in better value and a net reduction in costs, but will not be equivalent to the total sum of all savings opportunities.

4 TAMESIDE & GLOSSOP RIGHT CARE PRIORITIES

4.1 The 'where to look' pack for Tameside & Glossop identifies the opportunity areas below as 'step 1' of the process.

4.2 The pack also identifies a range of detailed improvement opportunities within the areas identified above, from a 'spend' and quality perspective.

4.3 The Right Care approach recommends reviews on a pathway basis as 'step 2'. To support this approach, the pack also includes 19 'pathways on a page'. The pathways present a wide range of key indicators for different conditions and enables exploration of the opportunities in those programmes at condition level. The intention of these pathways is not to provide a definitive view, but to help commissioners explore potential opportunities. These slides help to understand how performance in one part of the pathway may affect outcomes further along the pathway. Below is an example of a 'pathway on a page' for heart disease.



4.4 'Step 3' recommends the review of complex patients. The pack includes analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that the CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2015/16. Nationally the most common conditions of admissions for complex patients are circulation;

cancer; and gastro-intestinal problems. The availability of robust risk stratification data for Tameside & Glossop will enable us to build on this element of the Right Care process using local (and more detailed and timely) data.

5 IMPLEMENTING RIGHT CARE IN TAMESIDE & GLOSSOP

5.1 The implementation of the Right Care approach is key to the delivery of the locality wide quality improvement and Savings Assurance programme (encompassing the CCG Financial Recovery Plan).

5.2 A project team to support the implementation of the Right Care programme in Tameside and Glossop has been formed, with initial officer and clinical representation from the single commission and ICFT, including representatives from the finance, commissioning, business intelligence, medicines management and public health teams. The initial role for this team will be to support the executive and clinical leads in the identification of Tameside and Glossop priorities and develop an implementation plan to align with the Locality Plan, transformation programme, and the Savings Assurance process. This process will be supported by the NHS Right Care Delivery Partner.

5.3 We will ensure that the implementation of the Right Care approach in Tameside & Glossop is aligned with existing areas of work, for example the Care Together programme, or the Savings Assurance process, thus embedding the work within existing governance and working groups.

5.4 The project team will ensure all requirements of the NHSE programme are met, including the CCG Improvement and Assessment Framework and Quality Indicator requirements.

5.5 The project team are due to meet on 24 January, with the Right Care Delivery Partner, to progress the development and implementation of the programme. This will include a detailed review of the data packs to identify proposed detailed priorities. The team will work with the Delivery Partner to continue to follow the Right Care recommended approach, to include:

- Identify the priority programmes and complex patients in the locality and compare against current improvement activity and plans;
- Look at the focus packs on the NHS Right Care website for those areas which are a priority for your locality;
- Engage with clinicians and other local stakeholders, including public health teams in local authorities and commissioning support organisations and explore the priority opportunities further using local data;
- Ensure planning round submissions, and returns for the CCG Improvement and Assessment Framework reflect the opportunities identified;
- Discuss the opportunities highlighted in this pack as part of the STP planning process and consider STP wide action where appropriate;
- Revisit the NHS Right Care website regularly as new content, including updates to tools to support the use of the Commissioning for Value packs, is regularly added;
- Discuss and agree next steps with the Delivery Partner.

6 RECOMMENDATIONS

6.1 As set out on the front of the report.

Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Reporting Officer of Professional Reference Group	Angela Hardman, Director of Public Health and Performance
Subject:	**COMMUNITY HEALTH CHECKS CONTRACT EXTENSION**
Report Summary:	Approval is sought to extend an existing contract for the extension of an existing contract where there is no remaining extension provision available within the contract. The current contract for the provision of community based NHS Health Checks expires on 30 June 2017. The funding is within the Single Commission Pooled budgets. The report requests authority to extend the contract for 9 months to 31 March 2018 to allow retendering aligned to the commissioning intentions of the Greater Manchester Partnership. The Community NHS Health Checks contract was let under a 24 months, plus 12 months basis and was extended for the allowable 12 months following a report to the Single Commissioning board in June 2016. The contract has been successful in achieving its aims and objectives and the extension would allow Tameside residents to continue to benefit from current and future delivery whilst waiting for the strategic direction for Greater Manchester to be confirmed. The Community Health Checks programme forms a key part of the emerging Wellbeing Service as part of the Healthy Lives model of care within the Care Together programme. The Community Health Checks programme contributed to the overall good Tameside performance for NHS Health Checks in 2014/15 that attracted a Public Health Premium payment from Public Health England. An increase NHS Health Checks has been included in the Tameside and Glossop Health Premium target for 2016/17. The Community Health Checks Programme is a priority as outlined in the GM Devolution Public Health Programme and is a mandated service within the Public Health Grant. In order to minimise the disruption to ongoing activity and continue delivery of the local NHS Health Check programme until the outcome of the GM Devolution 'Find and Treat Programme' review can inform the implementation of the local Health Lives model of care and the Community NHS Health Checks contract review, an extension to the contract is required. The value for the extension period is £71,925
Recommendations:	That the Single Commissioning Board approves the extension of the contract for 9 months from 1 July 2017 to 31 March 2018 following an efficiency review.
Financial Implications: **(Authorised by the statutory**	The budget for this funding falls within the Section 75 of the Single Commissioning Board. The Finance Group recognise the importance of this work to the Public Health national

Section 151 Officer & Chief Finance Officer)	agenda and the Care Together strategy. It is also acknowledged that this is a contributory factor to the achievement of Quality Premium funding. The Finance Group are supportive of this proposal but would recommend that this is treated consistently with the timelines for review of all contracts across the Single Commission. Furthermore, it is anticipated that this has the potential to be provided by the ICFT in the future.
Legal Implications: **(Authorised by the Borough Solicitor)**	In the circumstances it would not be cost effective to retender the contract at this time given the intention to allow retendering aligned to the commissioning intentions of the Greater Manchester Partnership. There are no issues with the performance of the contract which is reported to be operating well and delivering against agreed objectives.
How do proposals align with Health & Wellbeing Strategy?	The service supports the Health and Wellbeing Strategy vision supporting the domains of working well and living well and addresses health inequalities by contributing to achieving the Health and Wellbeing Board 'Turning the Curve on Blood Pressure' aspiration to increase the percentage of people with hypertension known to their GP.
How do proposals align with Locality Plan?	The Service will sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from the rise in obesity and sedentary living, and reduce the gap between Tameside and England.
How do proposals align with the Commissioning Strategy?	The overall aim of this service is to provide the community element of an integrated NHS Health Checks Programme to people in various community settings across Tameside that will improve health outcomes and the quality of life of the Tameside eligible population. This will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability. This service continues to fulfil this aim and is targeting those most at risk.
Recommendations / views of the Professional Reference Group:	PRG noted the report and agreed the recommendations with the addition of a commitment to carry out an efficiency review of the contract.
Public and Patient Implications:	In November 2015 the current provider team was successful in winning the 'Best Impact on Patient Experience' Award at the National Heart UK Health Check Awards.
Quality Implications:	The Community Health Check service has been subject to routine quarterly performance management and monitoring. All the performance data is available if required.
How do the proposals help to reduce health inequalities?	The service contributes towards achieving the following local outcomes: • Reduce CVD mortality in Tameside at a rate faster than the national average; • Make a significant contribution towards reducing health inequalities within the Borough (including socio-economic, ethnic and gender inequalities) by improving the identification and management of people in

disadvantaged communities;

- Contribute to achieving an increase in the percentage of people with hypertension known to their GP;
- Improve health and quality of life by enabling more people to be identified at an earlier stage of vascular change, with a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability;
- Sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from current lifestyles and associated risk factors;
- Prevent diabetes in many of those at increased risk of this disease;
- Empower Tameside people to understand their individual risk / risk factors and the choices they can make to reduce that risk;
- Facilitate and improve access and uptake to health improvement lifestyle/preventive services to those with greatest need;
- Support the improvement to long term health outcomes and the quality of life for patients and their carers.

What are the Equality and Diversity implications?

The Community Health Check service targets vulnerable and hard to reach populations to increase the overall take-up of NHS Health Checks in the Borough in order to improve health outcomes and the quality of life of the Tameside eligible population.

What are the safeguarding implications?

None.

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

The current contract includes requirements for information governance and handling of personal data.

Risk Management:

It is essential to maintain momentum to systematically identify and implement preventative approaches to tackle risk of heart disease, stroke, diabetes, kidney disease and hypertension as they represent one of the most significant challenges to the local health and social care system.

Access to Information :

The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant in Public Health Medicine

 Telephone: 0161 342 4251

 e-mail: gideon.smith@tameside.gov.uk

1. BACKGROUND

1.1 The NHS Health Check is a national programme of systematic prevention that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease. It is aimed at people aged 40-74 who have not been previously diagnosed with one of these conditions (including hypertension) and consists of a face to face individual risk assessment followed by risk management advice and interventions.

1.2 An evaluation of the national programme published in 2016 provides evidence of the impact of the programme:

"The NHS Health Check in England: an evaluation of the first 4 years." *(Robson J, et al. http://bmjopen.bmj.com/content/6/1/e008840)*

▪ *This is the first national study describing implementation of the new National Health Service (NHS) Health Check programme 2009–2012.*

▪ *It is based on a large representative sample of 655 general practices in England with 1.68 million people aged 40–74 years eligible for an NHS Health Check of whom 214 295 attended.*

Results:
Attendance by population groups at higher cardiovascular disease (CVD) risk, such as the more socially disadvantaged 14.9%, was higher than that of the more affluent 12.3%.

Among attendees 7844 new cases of:
- *hypertension (38/1000 Checks),*
- *1934 new cases of type 2 diabetes (9/1000 Checks) and*
- *807 new cases of chronic kidney disease (4/1000 Checks) were identified.*

Of the 27 624 people found to be at high CVD risk (20% or more 10-year risk) when attending an NHS Health Check,
- *19.3% (5325) were newly prescribed statins and*
- *8.8% (2438) were newly prescribed antihypertensive therapy.*

Conclusions:
Newly identified comorbidities were an important feature of the NHS Health Checks. Statin treatment at national scale for 1 in 5 attendees at highest CVD risk is likely to have contributed to important reductions in their CVD events.

1.3 For those at low risk, the risk management might be no more than general advice on healthy lifestyle. Others may be assisted to join a lifestyle programme such as weight management programme or a smoking cessation service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment.

1.4 Local NHS Health Checks have been delivered through a General Practice (GP) Local Enhanced Service (LES) since the start of the programme in 2010. This involves GPs sending invites to eligible patients on their practice list inviting them to attend.

1.5 From 1 April 2013, local authorities took over responsibility for the national NHS Health Check programme, previously the responsibility of Primary Care Trusts (PCTs). The provision of NHS Health Check risk assessments is a mandatory requirement for local authorities as set out in regulations 4 and 5 of the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013, S.I. 2013/351

1.6 Prior to April 2013 a Community Health Check service had been commissioned by the PCT to complement the provision within General Practice, however, this service concluded before the transfer of Public Health responsibilities to the Council. A review of service provision by Public Health highlighted the need to recommence the provision of this service. A review of NHS Health Checks by TMBC Health and Care Scrutiny Committee also recommended reintroducing a Community NHS Health Checks programme.

1.7 The Community Health Check service targets vulnerable and hard to reach populations to increase the overall take-up of NHS Health Checks in the Borough in order to improve health outcomes and the quality of life of the Tameside eligible population. The programme will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability.

1.8 In June 2014, following a competitive tender, a two year contract to provide NHS Community Health Checks was awarded to Pennine Care Foundation Trust. The contract included the option, subject to agreement between the parties, to extend for up to a further one year. The contract includes a three month no fault termination clause. The contract commenced on 1 July 2014 and has an annual value of £95,900.

1.9 Following a report to the Single Commissioning Board in June 2016 the option to extend the contract for 12 months was exercised and the contract was extended until 30 June 2017.

1.10 The contract to provide community health checks expires on 30 June 2017 and Public Health Commissioners would like to extend the contract for a further 9 months (from July 1 2017 to March 31 2018).

1.11 The Community Health Checks Programme is a priority as outlined in the GM Devolution Public Health Programme and is a mandated service within the Public Health Grant. Each Council with in GM currently commissions a local programme, and local leads meet together regularly with Public Health England (PHE) North West to review practice and performance, implementation of new guidance and strategic direction. The group has recently undertaken a PHE Standard Assessment and Review involving all GM programmes on behalf of GM Directors of Public Health to inform current discussion of the strategic direction in GM.

1.12 The current strategic location of NHS Health Checks in GM is within the proposed 'Find and Treat' programme, which itself is likely to be located within the GM Primary Care Standards. In addition there is potential for NHS Health Checks to be included amongst options of services to be commissioned collaboratively across GM. This approach is very closely in line with the current Tameside and Glossop model which has aligned the primary care element of the service with the Primary Care Quality Scheme, and commissioned a targeted community service.

1.13 This proposed contract extension will enable there to be time for the GM strategic direction on the 'Find and Treat' programme to inform the implementation of the local Neighbourhood model of care, and any revisions of the Community NHS Health Checks programme specification for subsequent retendering.

2. VALUE OF CONTRACT

2.1 The value of the contract for the 9 month extension is £71,925. This is at the same pro rata value the contract was awarded at in 2014.

3. GROUNDS UPON WHICH WAIVER /AUTHORISATION TO PROCEED SOUGHT

3.1 To allow retendering aligned to the commissioning intentions of the Greater Manchester Partnership.

3.2 In order to minimise the disruption to ongoing activity and continue delivery of the local NHS Health Check programme until the outcome of the GM Devolution 'Find and Treat Programme' review can inform the implementation of the local Health Lives model of care and the Community NHS Health Checks contract review.

3.3 The contract is working effectively with Pennine Care NHS Foundation Trust achieving objectives set out in the agreed service specification.

3.4 The Community Health Check service has been subject to routine quarterly performance management and monitoring. All the performance data is available if required.

3.5 The service has proved to be very successful in reaching the target demographic and increasing the take-up of health checks. The service is on target to deliver 2000 health checks and mini MOT's as required in the Specification

July – June 2014/15:

Full Health Checks

Service Specification Activity and KPI's

Description of KPI	Annual Threshold	Forecast	YTD target	YTD	Qtr. 1	Qrt2	Qtr. 3	Qtr. 4	Graph	Comments
Provide a minimum of 2000 full health checks per annum	2000		1500	896	(Pilot)	313	224	359		Out of the 596 health checks that were delivered during this quarter, 359 were full health checks. We have targeted clients that are eligible for full health checks but in community venues this remains challenging.
Number of male clients				303		97	85	121		Out of the 359 full health check clients (121) 34% of the clients were male, we hope this figure will increase as we target more sports venues and clubs and workplaces with a high male workforce.
Number of female clients				593		216	139	238		Out of the 359 full health check clients (238) 66% of the clients were female
Number of clients with high cholesterol >6				135		39	44	52		Out of the 359 full health check clients (52)14% had a total cholesterol of >6
Number of clients with a CVD risk of >20%				22		8	9	5		Out of the 359 health checks (5) 1% clients had a CVD risk >20%

July – June 2015/16:

KPI Provide a minimum of 2000 checks per annum	Annual Target	YTD Target	YTD	Q2	Q3	Q4	Q1 (April-	Comments
Number of full Health Checks	2000		1297(Combined)	306	339	357	295	**Full year figure is 1297 for full health checks. 2039 combined total for full/mini checks**
Males				96 (37%)	109 (30%)	92(26%)	98(33%)	
Females				210 (69%)	230 (64%)	265(74%)	197(66%)	
Cholesterol >6				38 (12%)	41 (11%)	55(15%)	51(17%)	
CVD risk >20%				2	6	4	12	
Quintile 1 (20% most deprived)				29%	21%	22%	23%	
Ethnicity (% BME Clients)				11%	6%	18 (5%)	8 (2.7%)	
% Clients who smoke				16%	10%	54 (15%)	59(19%)	
% Clients with a BMI >30				35%	28%	77(21%)	74(25%)	
Number of clients with irregular pulse				4	2	2	3	
Number of clients with high BP (either figure > 80/100 (fast Track)				27 (9%)	20 (6%)	21	22(7%)	

KPI Provide mini checks to residents who do not meet the full criteria for an NHS health Check	Annual Target	YTD Target	YTD	Q2	Q3	Q4	Q1	Comments
Number of mini Health Checks	No target			155	136	221	230	Full Year figure is 742

July –Dec 2016

KPI	Annual Target	Quarterly Target	YTD	Q2 (July-Sept 16)	Q3	Q4	Q1 (April - June 17)
Total number of Health Checks delivered in community and workplaces (full & minis)	2000	500	945	489	456		
Number of full Health Checks				248	220		
Number of male clients				81 (33%)	47 (21%)		
Number of female clients				167 (67%)	173 (79%)		
Number of clients with high cholesterol >6				52 (20%)	30 (9%)		
Number of clients with a CVD risk of >20%				4	9		
Quintile 1 20% most deprived				23%	26%		
Ethnicity (% of BME clients)				19 (7.6%)	8 (3.5%)		
Number of clients who smoke				42 (16%)	32 (14.5%)		
Number of clients with a BMI > 30				66 (26%)	58 (26%)		
Number of clients with Irregular pulse				3	1		
Number of clients with high BP (either figure above 80/100: fast track to GP)				20 (8%)	9 (4%)		

3.6 The proposal for the continued delivery of the Service will complement the delivery of health checks within primary care and ensure that targets are met.

4. STRATEGIC FIT

4.1 The service supports the Health and Wellbeing strategy vision supporting the domains of working well and living well and addresses health inequalities by contributing to achieving the Health and Wellbeing Board 'Turning the Curve on Blood Pressure' aspiration to increase the percentage of people with hypertension known to their GP.

4.2 The Community Health Checks programme contributed to the overall good Tameside performance for NHS Health Checks in 2014/15 that attracted a Public Health Premium payment from Public Health England.

4.3 An increase NHS Health Checks have been included in the Tameside and Glossop Health Premium target for 2016/17.

4.4 The Community Health Checks Programme is a priority as outlined in the GM Devolution Public Health Programme and Tameside makes an active contribution the GM Health Check Network.

4.5 Specific commitment is given to a review and re-design of current arrangements for NHS Health Checks in ***"COMMISSIONING FOR REFORM - The Greater Manchester Commissioning Strategy"***, timetabled for Q4 2016/17:

> *6. Find and Treat Programme: GM commissioning of NHS Health Checks programme to address variation in price and outcomes and drive up standards; Commissioning a bespoke integrated intervention for the 10% most deprived communities with the poorest health to provide an enhanced service with broader support packages including social support and access to work.*

4.6 Following the review of services to develop a comprehensive local Wellness offer to support lifestyle change, including access by hard to reach groups, the Community Health Checks programme forms a key part of the emerging Wellbeing Service as part of the Neighbourhood model of care within the Care Together programme.

4.7 The outcome of the GM Devolution 'Find and Treat Programme' review will inform the implementation of the local Neighbourhood model of care, and any revisions of the Community NHS Health Checks programme will be included in a contract review during 2017.

4.8 The overall aim of this service is to provide the community element of an integrated NHS Health Checks Programme to people in various community settings across Tameside that will improve health outcomes and the quality of life of the Tameside eligible population. This will ensure that people have a better chance of putting in place positive ways to substantially reduce their risk thus reducing the population's risk of cardiovascular morbidity, premature death or disability. This service continues to fulfil this aim and is targeting those most at risk.

4.9 The Service will sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from the rise in obesity and sedentary living, and reduce the gap between Tameside and England.

4.10 The Service offers a real opportunity to make significant inroads into reducing health inequalities, including socio-economic, ethnic, and gender inequalities. The current provider has been flexible and innovative in their approach:

- In November 2015 the team were successful in winning the 'Best Impact on Patient Experience' Award at the National Heart UK Health Check Awards.

- Piloted provision of NHS Health Checks within local pharmacies.

- Adopted direct access to individuals receiving invitations to the programme from General Practice.

- Providing NHS Health Checks in GP surgeries.

4.11 The service contributes towards achieving the following local **outcomes**:

- Reduce CVD mortality in Tameside at a rate faster than the national average;
- Make a significant contribution towards reducing health inequalities within the Borough (including socio-economic, ethnic and gender inequalities) by improving the identification and management of people in disadvantaged communities;
- Contribute to achieving an increase in the percentage of people with hypertension known to their GP;
- Improve health and quality of life by enabling more people to be identified at an earlier stage of vascular change, with a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability;
- Sustain the continuing increase in life expectancy and reduction in premature mortality that is under threat from current lifestyles and associated risk factors;
- Prevent diabetes in many of those at increased risk of this disease;
- Empower Tameside people to understand their individual risk / risk factors and the choices they can make to reduce that risk;
- Facilitate and improve access and uptake to health improvement lifestyle/preventive services to those with greatest need;
- Support the improvement to long term health outcomes and the quality of life for patients and their carers.

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

5.1 To allow retendering aligned to the commissioning intentions of the Greater Manchester Partnership.

5.2 The contract is operating well and delivering against agreed objectives.

5.3 It is essential to maintain momentum to systematically identify and implement preventative approaches to tackle risk of heart disease, stroke, diabetes, kidney disease and hypertension as they represent one of the most significant challenges to the local health and social care system.

5. RECOMMENDATIONS

6.1 As set out on the front of the report.

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Report to:	**SINGLE COMMISSIONING BOARD**
Date:	14 February 2017
Reporting Officer of Professional Reference Group	Angela Hardman – Director of Public Health and Performance
Subject:	**WOMEN AND THEIR FAMILIES CENTRE GRANT EXTENSION**
Report Summary:	This report requests funding for an extension to the existing grant to the Women and Their Families Centre to 31 March 2018. This is in order to align Public Health funding and provision to match that provided by the Office of the Police Crime Commissioner until 31 March 2018 - which was secured to expand this service into 2 additional areas. It is noted that a form of market testing will be necessary to support consideration of continued support to Centre provision beyond 31 March 2018. The current grant has enabled the delivery of an effective service that both achieves good value and has realised significant outcomes in the early intervention of women offenders and non-offenders. Continuing to provide the Women and Their Families Centre will enable the service to continue to embed and expand their work significantly to support women victims and offenders (who are often both) and their children to deal with the multiple issues and deprivation they face. The breadth of the work being provided, alongside the integration with major partners in Tameside detailing the number of clients and families seen, evidences the clear necessity to continue with such vital provision. An extension would include a paragraph to acknowledge that the grant may novate during its term. The Centre has been supported by a grant since 2011. Initially this was via the Tameside Council Community Safety Unit (Drug & Alcohol Action Team), moving to Public Health from 2013. With the establishment of the Single Commissioning grant payments require sign off by the Single Commissioning Board.
Recommendations:	Single Commissioning Board is asked to agree: 1. A continuation of the current grant of £99,570pa to the Women and Families Centre for 2016/17 and an extension to 31 March 2018. 2. Market testing to support consideration of funding of the Centre beyond 31 March 2018.
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	Currently the budget for this proposal is within the section 75 pooled budget. In the light of the financial pressures faced by the Health and Social Care economy a thorough review is being conducted of all grants currently paid to the voluntary and third sector.

	The review will include refocussing the economy wide outcomes of grants to align with current economy needs, reducing overall funding made available through grants and developing new working relationships with the voluntary and third sector. It is recommended that extension of this grant is aligned to the overarching economy wide review and whilst an initial funding commitment can be given, this may be subject to change upon completion of the economy wide exercise.
Legal Implications: **(Authorised by the Borough Solicitor)**	In light of the proposals for Care together it is important that contracts are ceased, extended and/or renewed reflecting the future – this includes where a decision is made to extend to include novation clause.
How do proposals align with Health & Wellbeing Strategy?	The impact of the Women and Their Families Centre is mostly within the Starting Well, Developing Well and Living Well priorities, particularly: domestic abuse; reducing child poverty; ensuring children are ready for school; enabling a multi-agency approach to troubled families; emotional wellbeing; reducing homelessness; reducing reoffending.
How do proposals align with Locality Plan?	The Centre makes an important contribution to the implementation of Healthy Lives and Enabling self-care dimensions of the model of care for a very vulnerable group of women and their families.
How do proposals align with the Commissioning Strategy?	The Centre contributes to the delivery of the Clinical Challenges for Children and Families, and Mental Health.
Recommendations / views of the Professional Reference Group:	PRG noted the performance review and the role of the service, and supported the recommendations with the understanding that: • the grant the Women and Families Centre is in scope for the Single Commission review of grants; • the grant attracts matched funding of £44,500 from the GM Police and Crime Commissioner.
Public and Patient Implications:	The report includes details of self-reported wellbeing, case studies and comments by women who use the Centre.
Quality Implications:	The Centre is subject to quarterly monitoring. The report includes performance, cost-benefit, partner comments and users feedback.
How do the proposals help to reduce health inequalities?	The service is tailored to provide support to a very vulnerable group of women and their families. Long-term potential benefits are significant in terms of improving their life chances.
What are the Equality and Diversity implications?	The Centre provides access for women of all ages, ethnicities, abilities and protected characteristics.
What are the safeguarding implications?	The Centre is required to comply with Tameside Council adult and children safeguarding requirements.

What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications associated with this report.
Risk Management:	There are no risk management issues associated with this report.
Access to Information :	The background papers relating to this report can be inspected by contacting Gideon Smith, Consultant in Public Health Medicine  Telephone: 0161 342 4251  e-mail: gideon.smith@tameside.gov.uk

1.0 BACKGROUND

1.1 In 2011, the Probation service, along with the Council's Community Safety Unit (Drug & Alcohol Action Team) agreed a proposal for a women-only centre to be provided in order to manage the women of Tameside who were both offenders and non-offenders in a completely different way, and The Women and Their Families Centre was established.

1.2 The appended report details current provision and considers the options for the future.

1.3 The Women and Their Families Centre offers a safe place for women to obtain advice and support and also a programme of courses which aim to offer new opportunities for women only. These include practical courses, health and wellbeing groups, groups for drugs and alcohol, domestic abuse and more. They provide group peer support and one-to-one support for women who want to make changes in their life, but don't know where to start.

1.4 Since the Centre opened many women have utilised its services. Based on the last year an average of 279 women have utilised the centre each quarter. This includes women who attend for more than one quarter. On average, approximately 45% are new attendees quarter. Only 30% of the women who attend do so to secure adequate completions of requirements for criminal justice purposes, the remaining 70% are referral by other agencies and self.

1.5 The Centre has been supported by a grant since 2011. Initially this was via the Tameside Council Community Safety Unit (Drug & Alcohol Action Team), moving to Public Health from 2013. With the establishment of the Single Commissioning grant payments require sign off by the Single Commissioning Board.

1.6 The departure of two public health team members in 2015/16 was associated with an oversight in securing formal commitment to continued funding within the Single Commission governance arrangements, and Single Commissioning Board is requested to endorse the grant for 2016/17.

1.7 This report requests funding for an extension to the existing grant to the Women and Their Families Centre to 31 March 2018. This is in order to align Public Health funding and provision to match £44,500 provided by the Office of the Police Crime Commissioner until 31 March 2018 - which was secured to expand this service into the two additional areas of Ridgehill and Hattersley.

2.0 COST BENEFIT ANALYSIS

2.1 In November 2016, the Public Service Reform team within the Office of the Police Crime Commissioner produced a brief cost benefit analysis using the recognised 'New Economy' model. Currently, based upon data for the women offenders within the centre, the report details that for every £1 spent on the Women Centre benefits realised show gross benefits of £3.88. Within the wider system of social care the benefits increase to £1:£25.32 and to the NHS alone £1 spent at the centre saves £6.71.

2.2 A further cost benefit analysis should be available late summer 2017 which will consolidate data received from more women within the centre using a new data system.

3.0 OPTIONS

Cease or reduce grant

3.1 This will result in affected women being at higher risk of disengagement from all linked services, including domestic abuse, drug & alcohol, mental health, offending, health and

emotional well-being. Children who attend with their mother will also not realise the benefits of their parent being involved in a centre which is proven to increase women's health and mental health as well as a greater understanding of their financial, housing and health situation which helps prepares children for school readiness. The risk to the Council is ceasing the only women-only service which is providing neutral space, 1:1 provision and group course provision for offenders and non-offenders that also allows all neighbouring agencies to meet women and increase attendance at those services.

Extend grant provision for 12 months and market testing

3.2 The provision can continue to be funded on a grant basis for one year until 31 March 2018, with a view to receiving an updated cost benefit analysis, market testing, and preparing a plan to tender the women centre provision separately or as part of a framework of services devised by Public Health.

Novation

3.3 To take account of potential directions of local commissioning, an extension would include a paragraph similar to this one to acknowledge that the grant may novate during its term:

The Provider acknowledges that the Commissioner has entered into a pooled funding agreement with Tameside and Glossop Clinical Commissioning Group which may result in the delegation of funding and functions to the Tameside and Glossop Integrated Care NHS Foundation Trust. The Provider hereby consents to the Commissioner assigning the benefit and burden of this Agreement to Tameside and Glossop Integrated Care NHS Foundation Trust upon the giving of notice in writing from the Commissioner. The Provider shall enter into such legal documentation as reasonably required by Tameside and Glossop Integrated Care NHS Foundation Trust to effect such assignment.

4.0 CONCLUSIONS

4.1 The current grant to the Women and Their Families Centre has enabled the delivery of an effective service that both achieves good value and has realised significant outcomes in the early intervention of women offenders and non-offenders.

4.2 The cost benefit analysis evidence some of the wider benefits realised from a small closely led team of probation workers and volunteers who have worked together to change the behaviours and lives of women and their children who attend the centre forever.

4.3 Continuing to provide a Women and Families Centre will enable the service to continue to embed and expand their work significantly to support women victims and offenders (who are often both) and their children to deal with the multiple issues and deprivation they face. This work will affect current and future generations of Tameside's female population to help deal with their problems, understand acceptable behaviour and grow mutually respectful relationships with their children and partners.

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

5.0 RECOMMENDATIONS

5.1 As set out on the front of the report.

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WOMEN & THEIR FAMILIES CENTRE

1) EXECUTIVE SUMMARY

1.1 The Women and Their Families Centre offers a safe place for women to obtain advice and support and also a programme of courses which aim to offer new opportunities for women only. These include practical courses, health and wellbeing groups, groups for drugs and alcohol, domestic abuse and more. They provide group peer support and one-to-one support for women who want to make changes in their life, but don't know where to start.

1.2 Since the centre opened many women have utilised its services. Based on the last year an average of 279 women have utilised the centre *each quarter*. This includes women who attend for more than one quarter. On average, approximately 45% are new attendees quarter. Only 30% of the women who attend do so to secure adequate completions of requirements for criminal justice purposes, the remaining 70% are referral by other agencies and self.

1.3 The women benefit greatly from being in a secure, neutral environment and often state that they would not attend elsewhere due to this reason.

1.4 The centre has helped many women over the period so far by joint working with other agencies to bring groups, courses and advice to the centre. The centre assists women to attend the Freedom programme (identification and advice on empowerment over domestic abuse) Parenting courses, and gain advice, support and treatment for housing, finance and drugs and alcohol issues as well as ensuring all women offenders meet the conditions of any probation order. By providing the crèche on site during groups/advice, many women attend who would not be able to due to lack of alternative childcare.

1.5 This centre has proven to be a very valuable service and resource and is considerably good value for money in differing ways, which can be seen by the cost benefit analysis. The centre shows the demand for women-only provision and is working with women and families to address pressing issues around increased demand for this service via partner agencies with particular regard to children.

1.6 This report requests funding by way of, firstly, a request for an extension to the existing grant. This is in order to align Public Health funding and provision to match that provided by the Office of the Police Crime Commissioner until 31 March 2018 - which was secured to expand this service into 2 additional areas. Additionally, continued support is requested to fund centre provision beyond 31 March 2018 in recognition of the continued work and female-only provision to women in the borough. It is noted that a form of market testing will be necessary beyond 31 March 2018.

2. INTRODUCTION / GRANT

2.1 In 2011, the Probation service, along with the Council's Community Safety Unit (Drug & Alcohol Action Team) agreed a proposal for a women-only centre to be provided in order to manage the women of Tameside who were both offenders and none offenders in a completely different way.

2.2 Women were known to be one of Tameside's 'hard-to-reach' groups within the borough and until then had proven to be difficult to draw into the multiple services on offer. Women offenders were historically only included within the same services as men, however, adverse effects on the family unit – namely for children – are known to be much higher when a woman is taken into custody which breaks up the family.

2.3 The idea was to help women who required assistance due to domestic abuse, offending, drug and alcohol, mental health, financial and housing issues, to provide advice, guidance, support, and where necessary and possible, avoid custodial sentences and keep family units together.

2.4 A grant was provided and the centre began in 2011.

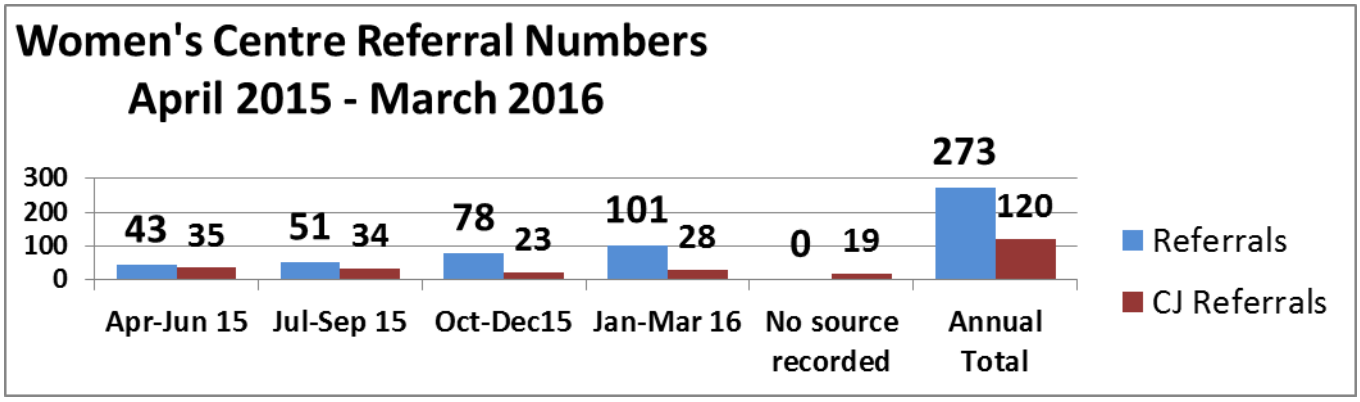
2.5 Immediately, there were a high number of attendees and the centre has continually shown no evidence of stigma attached to the fact that the probation service (now Community Rehabilitation Company) conduct and manage all groups and access. All women who were subject to a probation order attended the centre to see their worker and non-offenders also attended referred by partner agencies.

2.6 The Women and Their Families Centre offers a programme of courses which aim to offer new opportunities for women, including practical courses, health and wellbeing groups and more. They provide group peer support and 1:1 support for women who want to make changes in their life, but don't know where to start.

2.7 The centre hosts partner agencies sessions on neutral ground for women who some admittedly state they would not attend at the services bases. Integration has been established with major partners such as Bridges, Greater Manchester Police, My Recovery Tameside, Probation (CRC/NPS), Leap, Job Centre Plus and Department for Works & Pensions. Other services refer into Centre and this engages the women and ensures that their young children are safe whilst they attend a whole host of groups and sessions which makes attendances at other services possible. Stakeholders provide feedback on the service later in the report.

3. REFERRALS

3.1 The number of women who attended the women and families centre in 2015-2016 are graphed below. 393 women were referred in in the year. 30% of referrals come from a criminal justice referrer.



4. STATISTICS AND DEMOGRAPHICS

- Women from all ages can, and do, attend.
- Some women attend more than one centre and some attend multiple times a week.
- 87 women accessed domestic abuse interventions provided by agencies at the centre.

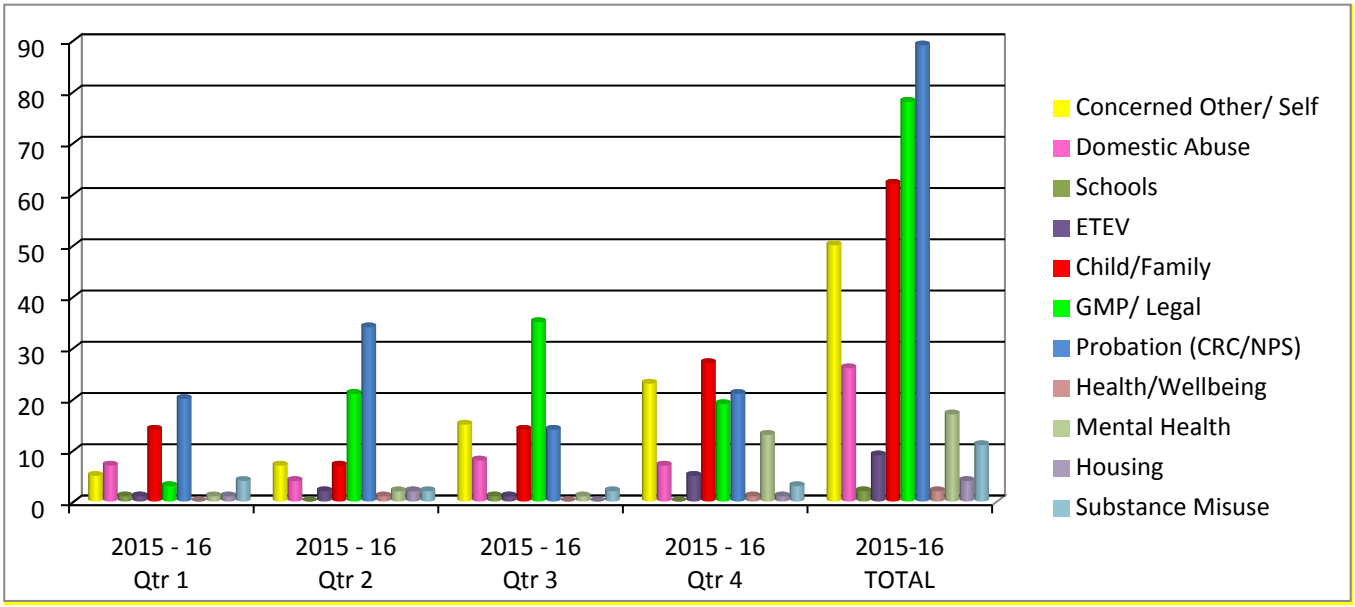
- Age varies from 16 to 75+, however, the majority of women are between 18 – 45 yrs and the highest group are 26-35 yrs.

- The majority of women are White-British, however numbers of Pakistani, African have increased and small numbers of women from many backgrounds have attended, with numbers having increased overall.

5. REFERRAL SOURCES – 2015/16

5.1 Referrals from Early Help and Children's Social care have doubled over the year 2015-2016.

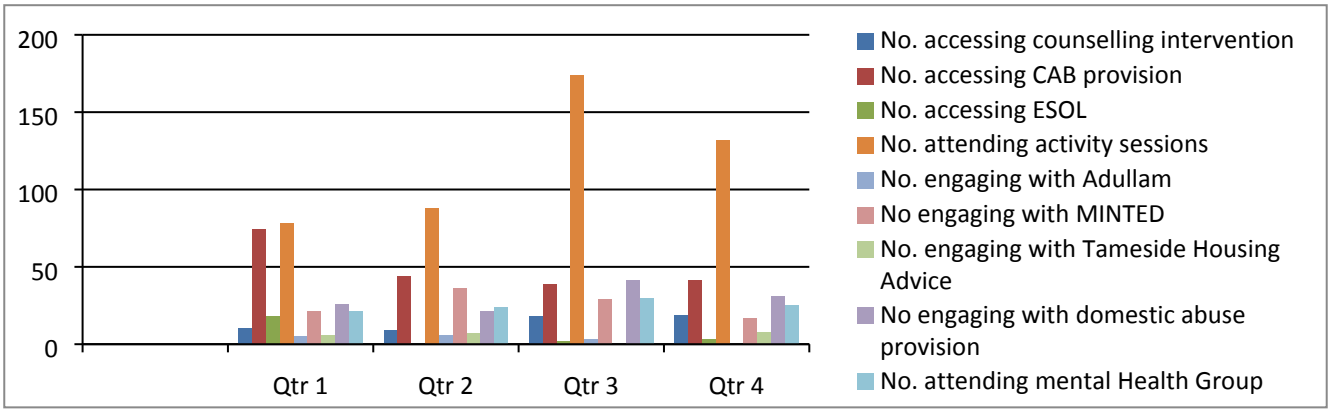
5.2 Police, Probation, Children's/Early help and self-referrals remain the highest referral routes



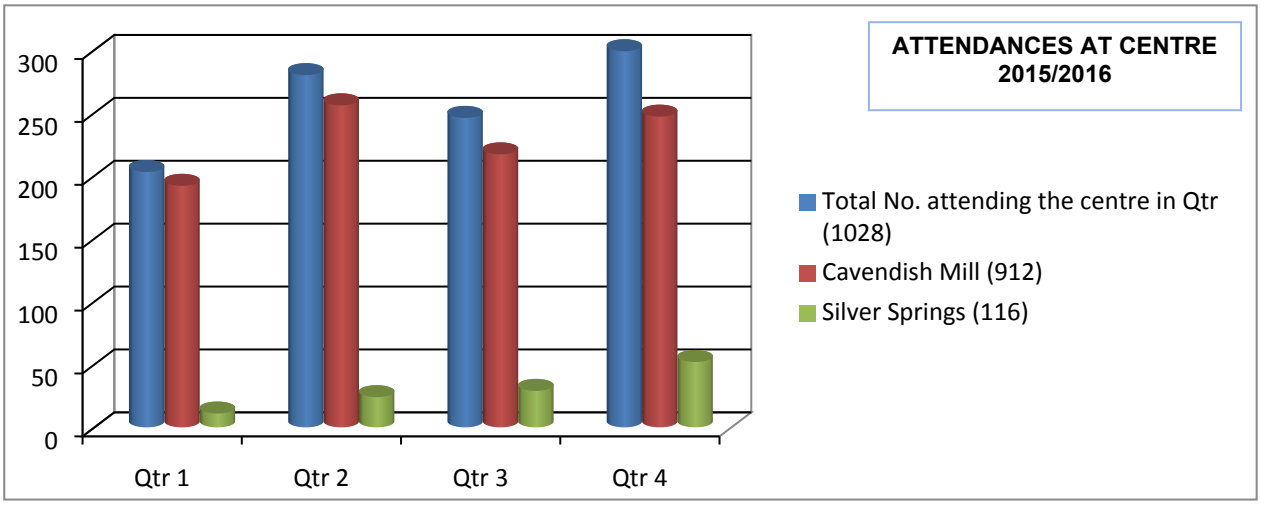
6. Accessing Groups, Support and Interventions

6.1 More women are engaging in other activities and progressing to use the multiple agencies who work out of the centre as they engage in sessions that give them the confidence needed, to tackle their issues, attend counselling and move onto other needs.

6.2 A lack of external funding for ESOL saw these sessions stall for a period however the centre are discussing the provision with Hyde Community Action and it is hoped these will return early in 2017.



7. ATTENDANCE DATA 2015/16



	2015-2016				
ATTENDANCES AT CENTRE	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**TOTAL**
Total No. attending the centre in Qtr	203	280	246	299	**1028**
Cavendish Mill	192	256	217	247	**912**
Silver Springs	11	24	29	52	**116**

7.1 The centre has seen a high number of women attending for sessions to support them and their families.

- 472 women accessed activity sessions.
- 56 accessed counselling (inc. 2 x dual diagnosis and 7 x Off the Record)
- 198 attended CAB sessions
- 23 attended ESOL sessions
- 103 accessed Minted sessions
- 119 attended Bridges/Domestic abuse provision
- 100 engaged with the Mental Health groups

8. Activity sessions

8.1 These vary and are flexible to need, recently these have included: International Women's Day, Gym access, Baking, PINK!, Narcotics Anonymous, Easter Egg Hunt (for children under 7), Royal Exchange (theatre production and visits) and a Creative Minds group.

9. Offenders

9.1 From a probation service focus, the related women within the criminal justice route are assessed against 12 pathways. Data on 224 assessments has been collated so far (of women who engage and are assessed).

9.2 As can be seen in the table below, the greatest need is around Attitudes, Thinking & Behavior (93.3% of women), followed by mental health and wellbeing (71.9%) and Domestic Abuse (57.6%).

9.3 Of the women assessed, 91.5% have multiple needs. 57.6% have needs in at least 5 of the 12 pathways.

	As at end Sept 16	
% with need at assessment	**Number**	**%**
Attitudes, Thinking, behaviour	209	93.3%
Mental health/Wellbeing	161	71.9%
Domestic Abuse	129	57.6%
Training	104	46.4%
Finance/Debt	103	46.0%
Substance misuse	102	45.5%
Accommodation	92	41.1%
Education	52	23.2%
Volunteering	48	21.4%
Employment	40	17.9%
Physical health	30	13.4%
Sex working	3	1.3%
Total cases assessed	**224**	

10. Expansion (Ridgehill / Hattersley)

10.1 Recently, the Police Crime Commissioner has agreed to funding that will provide an extra Coordinator role to bolster the main grant, initially this is for 1 year. This role has been recruited to in November 2016 and the coordinator is beginning to work more within the additional areas.

10.2 This coordinator will provide the necessary expansion of services into both Ridgehill (to further the work that has begun) and work with the Hattersley women via the Hattersley hub. Until now, the centre has attempted to provide some limited provision at both sites and now aim to build on this over the coming year.

11. Provision within the Centre

11.1 Within the Women's Centre, women learn and develop new skills, from English and Maths through to practical skills. These include IT knowledge which can be used to assist with job applications and planning and understanding of healthier ways to live well such as living and cooking within a budget and cultural diversities and awareness allowing cross-cultural learning.

11.2 These are vital skills needed to provide for their families which can often be taken for granted, however, disadvantages experienced when growing up mean that some women were never shown or given a chance to learn certain things, leaving them less privileged than their peers.

11.3 Mental health affects a lot, if not all, of the women who attend the centre in differing ways from complex issues which requires community mental health support through to milder problems that can receive help in groups provided in the centre. Many women attend groups to increase their self-esteem and confidence following engagement in negative relationships, this gives them the ability to look for work, care for their children and manage a house with income and expenses which they could not have achieved before. In 2016 a specific group 'Opt in' aimed at helping those with mental health issues had to leave their existing premises at Wilshaw House and were in need of a place to hold their group. The Women's Centre were approached for support and now 'Opt-in' have re-established their meetings through facilities at the centre.

11.4 Some of the sessions, groups and 'drop ins' are below and whilst some are static others move flexibly to the current needs of women attending with groups created around their present requirements.

DROP INS

CAB/Minted Money, finance & debt advice	**Leap** 'Daisy Chain' parenting support sessions	**My Recovery Tameside** Drug & Alcohol Recovery Advice, support, referrals & training
Bridges Domestic Abuse ADVICE, support & Freedom Programme.	**Anew** Recovery housing Women-only Apply sessions.	**Foundation** Housing support
Opt In Mental Health Support	**Adullum** **Unlocking Potentials** Tenancy advice sessions	**Bromley Legal Group** Legal advice sessions

SESSIONS/GROUPS

12. Outcomes/Case studies

☑ 212 women attended substance misuse treatment with centre's help.

☑ 142 women accessed Employment, training and or education interventions including maths, English.

☑ 45 women now volunteer as a result of attending.

☑ 52 are accessing employment

☑ 28 women and their children (who were not already registered) registered with a GP / Dentist

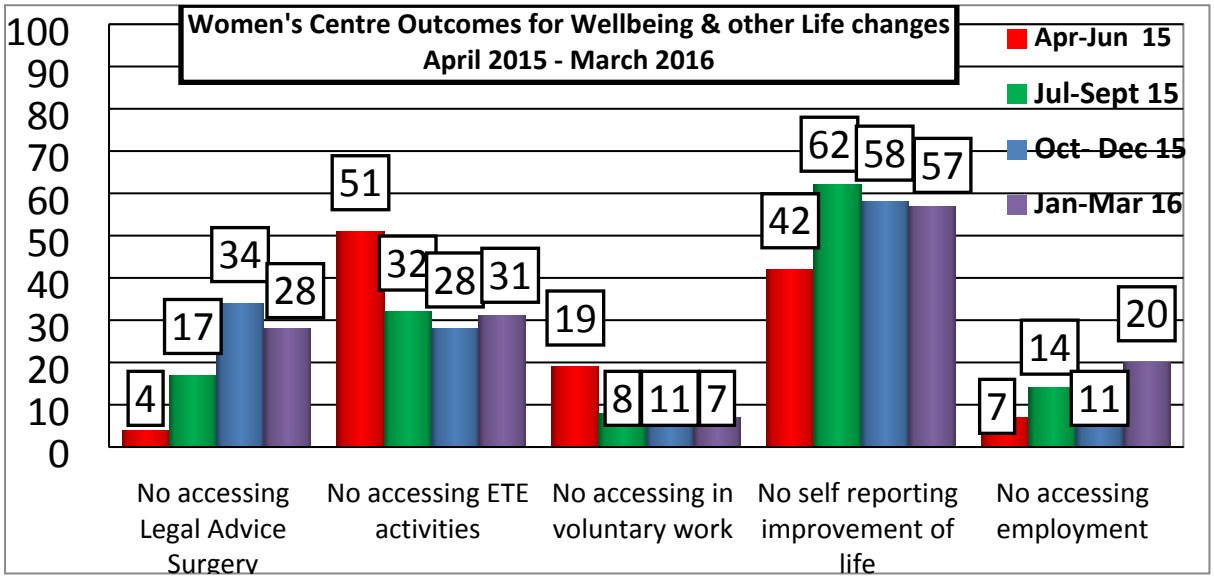
☑ 219 reported a self-improvement in their life due to abstinence, completion of orders, eating problems

☑ 83 accessed the free legal advice surgery

☑ During the year, 64 women successfully completed their order/licence and 212 women successfully completed requirements.

13. Wellbeing –self reported improvement

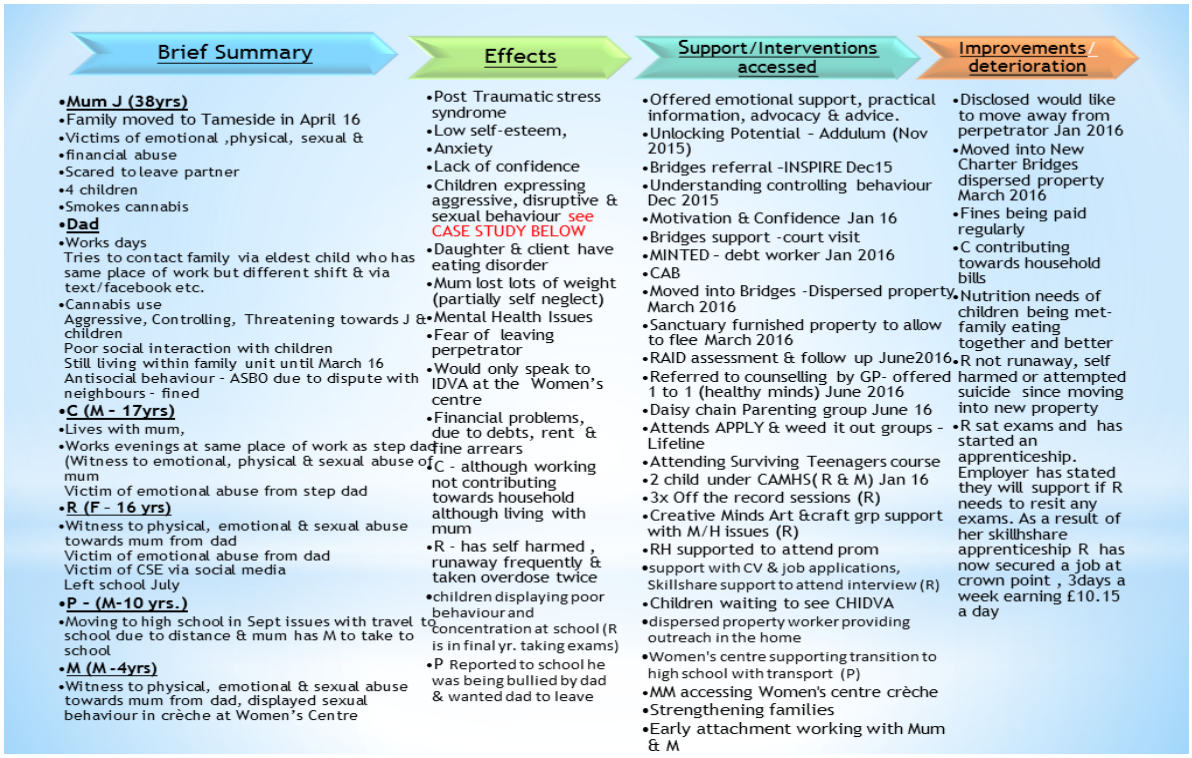
13.1 Periodically, women report on how they feel the centre is helping them improve their lives, which can be in many ways. The 4th column seen below shows the effect woman attending feel the centre has.



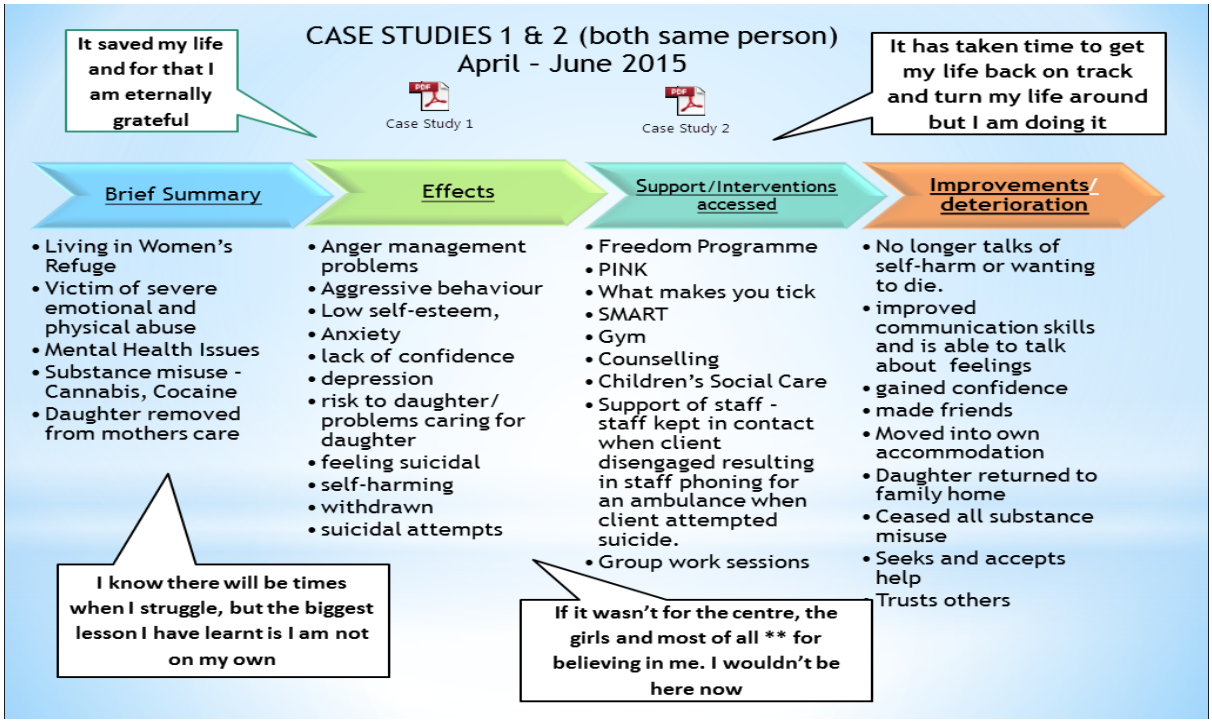
14. CASE STUDIES

14.1 A couple of summarised case studies are included here below to show; a sample of the presenting issues, effects, interventions and outcomes for some women at the centre.

Case Study 1.



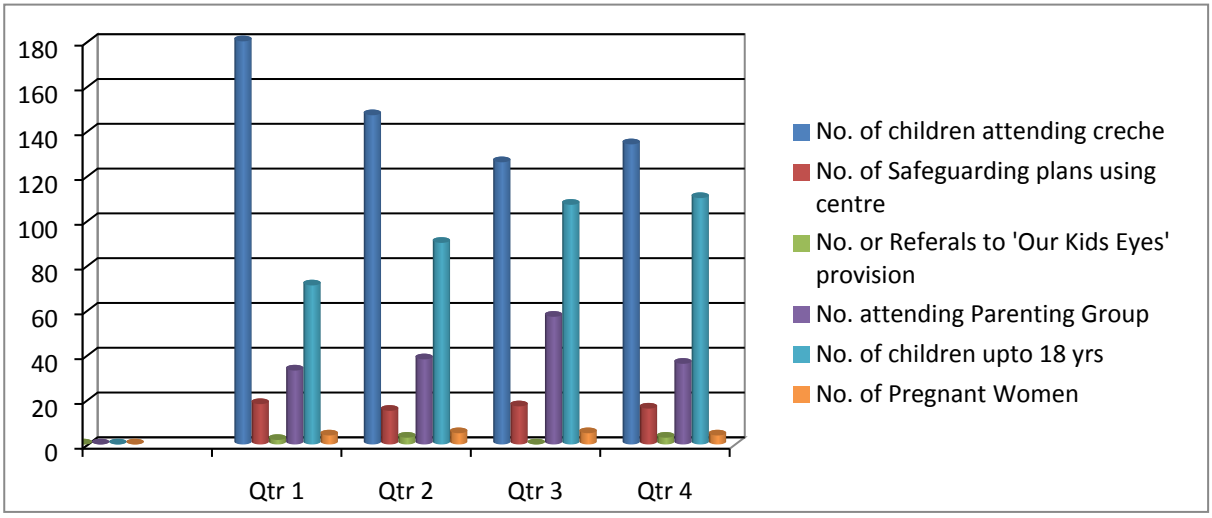
Case Study 2.



15. CHILDREN

15.1 In 2015/2016

- 587 attendances were recorded for children at the crèche during 15/16
- 66 safeguarding plans were completed at the centre
- 164 women attended a parenting peer support group
- Women engaging had a total of 387 children. In Qtr 4 of 15/16 69% were in mum's care.
- 18 pregnant women referred into the centre for support
- Referrals to Leap increased following changes in children's provision for parenting/ counselling.

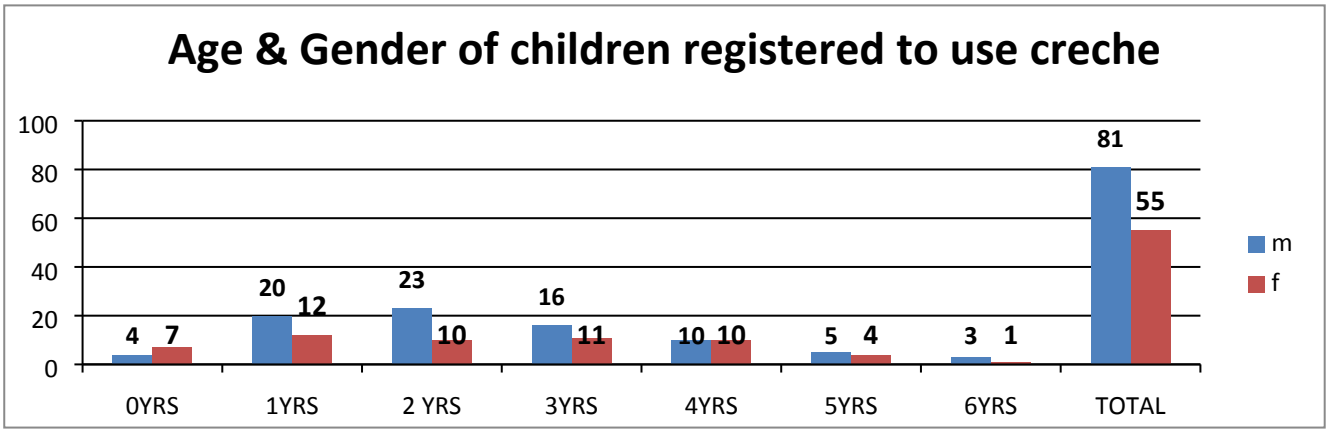


16. Crèche

16.1 Due to changes within the crèche provision, this information below dates from a collection we produced in May 16, but does give a flavour of children attending within the centre.

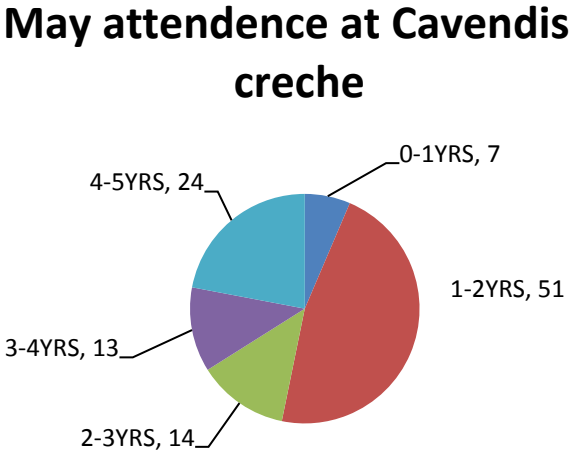
16.2 Whilst women attend the centre for a group, they can place their child into the on-site crèche free of charge (for 5yrs & under). This allows the parent/carer to access a wide range of support programmes whilst children access qualified learning support. Many women state they could not attend groups/1:1 sessions without this provision. It is also clear from some parents comments that some children do not experience any other forms of crèche or qualified learning or structured activities outside of their home due to the situations they presently experience.

16.3 At the time of data collection, 136 children were registered to use the crèche over 2 sites (Cavendish Mill and Ridgehill)



16.4 The crèche runs 2 sessions a day Monday, Tuesday & Friday's at Cavendish Mill.

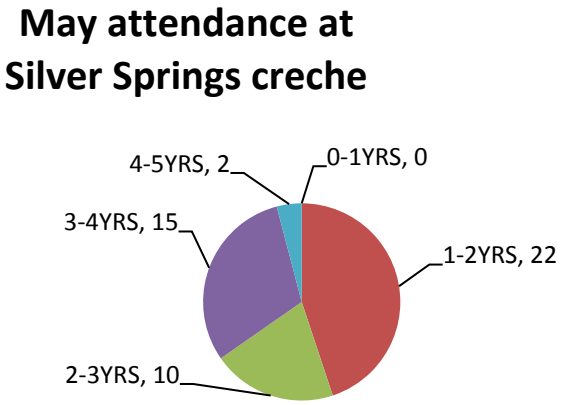
Attendance at Cavendish	May (Total 16 sessions)
0-1YRS	7
1-2YRS	51
2-3YRS	14
3-4YRS	13
4-5YRS	24
No FAMILIES	99
No CHILDREN	109
ESOL	7
SEN	3



16.5 The crèche runs 2 sessions on a Wednesday at Silver Springs, Ridge Hill Stalybridge.

Attendance at Silver Springs	May (Total 6 sessions)
0-1YRS	0
1-2YRS	22
2-3YRS	10

3-4YRS	15
4-5YRS	2
No FAMILIES	41
No CHILDREN	49
ESOL	20
SEN	0



16.6 In addition, as mentioned above, the centre expanded after May and now provide 1 day a week in Hattersley.

17. CURRENT FUNDING

17.1 The centre is currently funded via Public Health Grant of £99,570 per annum. Additionally for the year 2016-2017 the Office of the Police Crime Commissioner has provided funding of £44, 500 to provide an extension coordinator who will expand the centres activities more fully into the 2 areas mentioned previously in Hattersley and Ridge Hill.

18. COST BENEFIT ANALYSIS

18.1 In November 2016, the Public Service Reform team within the Office of the Police Crime Commissioner produced a brief cost benefit analysis using the recognised 'New Economy' model.

18.2 The model takes into consideration a number of factors including; mental health, reduced drug and/or alcohol use, reduced incidents of crime and reduced statutory homelessness. Outcomes measured demonstrate reductions in elements of police, criminal justice, temporary housing and health related costs and show improved wellbeing of individuals with outcomes such as – increased emotional wellbeing, reduced isolation, increased confidence/self-esteem and positive functioning (i.e. autonomy, control, aspirations).

18.3 Currently, based upon data for the women offenders within the centre, the report details that for every £1 spent on the Women Centre benefits realised show gross benefits of **£3.88.** Within the wider system of social care the benefits increase to **£1:£25.32** and to the NHS alone £1 spent at the centre saves **£6.71.**

18.4 These benefits are evident throughout the work shown in the case study examples, especially when you consider the intricate work that the coordinators within the centre do to negotiate, navigate and centralise all the services together in one place making it easier for women to meet services and increase rates of attendance overall.

18.5 A further cost benefit analysis should be available late summer 2017 which will consolidate data received from more women within the centre using a new data system.

19. PARTNER AGENCIES AND STAKEHOLDERS

19.1 Many agencies refer into and work with the Women's centre. A few comments have been gathered to understand the impact the centre has on the wider community.

Police

"We refer/signpost Victims of Domestic Incidents to the woman's centre on a regular basis through our OP Strive process. We find a lot of our DV incidents occur due to a concoction of factors from financial difficulties ,drug and alcohol abuse ,parenting problems and legal issues - to name a few.

The woman's centre is an extremely useful tool to be able to offer people who need involvement from a number of services and can get this all under one roof.

It also provides victims with a place they can meet people who are in similar situations to encourage them to seek support and remove any isolation they may feel."

Annabelle Biddle, GMP

Department for Work and Pensions

"We refer people we work with to the Women's Centre to access support and training. We've found the support and training they receive is excellent and helps us in our role supporting people to move closer to work.

Katherine Cotton, Troubled Families Employment Adviser, Tameside, DWP

Housing

"I have made referrals to, and had referrals from the Tameside Women's Centre. Without this resource being there, I fear a lot of these cases would be stuck in a revolving door of domestic violence without ever truly being resolved. I have found a good working relationship with the staff and they are always helpful and eager to assist me in any circumstance. "

Michael Ripley, Housing Advice Officer

"Very positive working relationship with the Women's Centre –Excellent solution focussed information sharing"

Jo Wells, Accommodation Officer, Tameside Housing Advice

"An invaluable service that benefits customers and professionals immensely. It is a safe & calm environment for meeting vulnerable customers, The partnership working is an effective way of everyone having the same information and co-ordinating a vulnerable households journey to recovery and normality. Without this service some vulnerable customers would not be able to get the support they need in the way it is needed."

Jenni Edgar, Team Leader – Accommodation Team

"…. Custody Detention Officers (CDOs) and sergeants at Ashton have developed a much closer working relationship with the Women's and family centre. …dedicated CDOs on each shift, have a better understanding of the services on offer. If there are any issues they are quick to raise them with me, which is great. Due to liaison and diversion posts effective from February I would expect all of our support / partner agencies to see an increase in referrals in the new year."

Inspector Bill Callaghan, Criminal Justice and Custody Branch, Greater Manchester Police

Anew

"These groups run twice a week and are very well attended. The benefits are that the individuals are empowered to look at making positive changes in their lives that will not only have a positive effect on them but also those around them. They will gain knowledge around addiction and also how their own thought process works. This also promotes self-awareness. I work very closely with the centre coordinator to ensure all the clients individual needs are catered for and this multi-agency working relationship works very well."

Matt Marriott, Anew, APPLY Group Facilitator

"Tameside Women's Centre forms an integral part of the Greater Manchester Whole System Approach (WSA) for women offenders. The WSA is recognised nationally as a ground breaking model of delivering interventions to women who are at risk of offending or who find themselves in contact with criminal justice agencies. The Government has been following with interest our approach across Greater Manchester and intends to launch a national WSA strategy by Easter 2017 drawing on the learning from GM.

Tameside is currently unique in its funding mechanism. Local leadership saw the opportunity to reach out to a group of women they had traditionally found hard to reach. Through the joint funding and delivery of this service it has grown and now serves the health needs of a significant number of women, the majority of which are not in touch with criminal justice. This approach is going to be taken to the GM Directors of Public Health services as the CBA for the element of savings funded by Tameside Public Health indicates for every one pound spent on the centre a saving of £6.70 is achieved for health outcomes.

Tameside is performing above average compared to other centres when we look at the "distance travelled" for a women against a range of 10 needs. This distance is indicative of improved resilience, greater confidence and less dependency on public services for the women. In Tameside on average there was a difference of 2.0 points between the first and most recent scores for clients included in this period (compared to a GM average of 1.6). The largest change was seen against offending (4.4 points compared to a GM average of 2.8) with 82% of clients seeing an increase in their scores. A positive change was seen against every scale."

20. QUOTES FROM WOMEN

If it wasn't for the centre, the girls and most of all ** for believing in me. I wouldn't be here now

Thank you for all the support you have given, never thought I would get this far and don't think I'd be able to do it .without your help

It saved my life and for that I am eternally grateful

I know there will be times when I struggle, but the biggest lesson I have learnt is I am not on my own

It has taken time to get my life back on track and turn my life around but I am doing it

From a Greater Manchester perspective, the GM Public Service Reform team support the centre, ***Martin Nugent, Justice and Rehabilitation, GM Public Service***

21. RISKS

21.1 Failure to extend.

21.1.1 The risk to the Council is ceasing the only women-only service which is providing neutral space, 1:1 provision and group course provision for offenders and non-offenders that also allows all neighbouring agencies to meet women and increase attendance at those services in a safe place.

21.2 Cost of provision

21.1.2 Currently as a grant, this is low cost provision and low risk. Equally there is a low risk of non-delivery due to the flexible nature of the centre delivery. The cost benefit analysis details the benefits of provision clearly well outweigh the costs within the wider partners regions. The grant is subject to examination via quarterly performance meetings. The GM OPCC also requires reports to be submitted regarding the outcome of their funding.

22. OPTIONS

22.1 Cease Grant

This will result in affected women being at higher risk of disengagement from all linked services, including domestic abuse, drug & alcohol, mental health, offending, health and emotional well-being. Children who attend with their mother will also not realise the benefits of their parent being involved in a centre which is proven to increase women's health and mental health as well as a greater understanding of their financial, housing and health situation which helps prepares children for school readiness.

22.2 Continue to fund as annual grant.

The provision can continue to be funded on a grant basis on a rolling year basis. This will continue to report as existing provision, including the expansion of provision into the two additional areas.

22.3 Extend grant provision for 12 months, expression of Interest & tender

The provision can continue to be funded on a grant basis for one year until 31 March 2018, with a view to receiving an updated cost benefit analysis, market testing, and preparing a plan to tender the Women Centre provision separately or as part of a framework of services devised by Public Health.

24. Conclusions

24.1 The current grant has enabled the delivery of an effective service that both achieves good value and has realised significant outcomes in the early intervention of women offenders and non-offenders.

24.2 The cost benefit analysis evidence some of the wider benefits realised from a small closely led team of probation workers and volunteers who have worked together to change the behaviours and lives of women and their children who attend the centre forever.

24.3 Continuing to provide a Women & Families Centre will enable the service to continue to embed and expand their work significantly to support women victims and offenders (who are often both) and their children to deal with the multiple issues and deprivation they face. This work will affect current and future generations of Tameside's female population to help deal with their problems, understand acceptable behaviour and grow mutually respectful relationships with their children and partners.

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

25.5 Finally, it should be noted that an extension would include a paragraph similar to this one below in order to acknowledge that the grant may novate during its term;

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Ashton Centre is open every Monday, Tuesday, Friday

We're right opposite ASDA.

Volunteering opportunities are available at the Women's Centre

Contact Michelle 07894 601159 for further information

Contact:

Nancy – 07947 106922

Paula – 07479 926556

Women & their Families Centre

Tameside Women's Centre

@Tamesidewomen

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Lancashire,
OL6 7DN
Telephone:
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Tracey - 07711 591878

Drop in

- Unlocking Potentials - tenancy advice
- Bridges - domestic violence support
- Legal advice
- Citizen Advice Bureau
- Minted – money, finance and debt advice
- My Recovery Tameside – Drug & Alcohol related support

Silver Springs

Where Women & their Families matter.
Wednesday's – at School Crescent, Ridgehill, Stalybridge
Coffee morning – Cooking - Arts & Crafts - & much more.....
Gym Session Friday's - 1pm-2pm @ Copley

Group Support

- Pennine Trust Health and Wellbeing - mental health issues
- Pink – confidence and self esteem
- Parenting support
- SMART – addictive behaviours
- Wellbeing for Women and their Families
- Your Anchor – support for family members of alcohol/drug users
- What Makes You Tick – aimed at women under 25 years old
- Believe & Achieve – employment/training focussed
- Purfitt – creative expression
- Creative writing
- Maths and English courses
- ICT courses
- Counselling sessions
- ESOL – Eastern & Central European (Self Esteem, confidence & Employability)

MONDAY	1 - 1 Room	1 - 1 Room (2)	Small Meeting Room	Large Meeting Room	IT Room
9:00am	1 - 1 Support	Citizens Advice Bureau			
10:00am			Wellbeing for Women and their Families	Cooking	English & Maths
11:00am					
12:00am		1 - 1 Room Probation	LUNCH	LUNCH	LUNCH
1:00pm			Magpie's LEAP Parenting	Coffee Afternoon	Royal Exchange
2:00pm				Knitting Arts & Crafts	
3:00pm					
4:00pm					
5:00pm		Your Anchor			
6:00pm			Closed	Closed	Closed
7:00pm					

TUESDAY	1 - 1 Room	1 - 1 Room (2)	Small Meeting Room	Large Meeting Room	IT Room
9:00am	1 - 1 Support	1 - 1 Room Probation	Arts & Crafts		
10:00am	Multi-Agency Drop-in Adullam			Same Smile, Different Culture Cooking	PINK Self - Esteem and Confidence
11:00am			WISER		
12:00am			LUNCH	LUNCH	LUNCH
1:00pm		Multi-Agency Drop-in Bridges	WISER	Apply	Daisy Chain (Leap)
2:00pm					
3:00pm	1 - 1 Support	1 - 1 Room Probation		Health & Wellbeing	SMART
4:00pm					
5:00pm					
6:00pm			Closed	NLP	Closed
7:00pm					

FRIDAY	1 - 1 Room	1 - 1 Room (2)	Small Meeting Room	Large Meeting Room	IT Room
9:00am					
10:00am	Counselling	1 - 1 Room Probation Life Line Surgery	What Makes You Tick?	Health Trainers Smoking Cessation	Primary Care Trust
11:00am					
12:00am			LUNCH	LUNCH	LUNCH
1:00pm			Lifeline	Apply	Bromley Legal Group
2:00pm					
3:00pm					

Gym session's
Monday 13.00 – 14:00
Thursday 11.30 – 12.30

Report to:	**SINGLE COMISSIONING BOARD**
Date:	14 February 2017
Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**EVALUATION OF THE PARKINSON'S DISEASE SPECIALIST NURSE POST**

Report Summary:

Parkinson's disease is a neurodegenerative movement disorder which commonly occurs in the later years of life. The consequence of inadequate management of the condition can result in poor control of symptoms with medication and side-effects, high levels of disability, mental health problems and increased carer burden, all of which lead to increased dependency on health and social care services

Parkinson's UK pump primed a Parkinson's Disease Specialist Nurse to work in Tameside and Glossop for 18 months. The nurse has been working with the Community Neuro Rehab Team (Community Neuro Rehab Team) and has a wide range of duties in order to support people with a diagnosis of Parkinson's Disease.

An evaluation of the post has been conducted with the aim that the Single Commission will to continue to commission the post if the evaluation shows that the Parkinson's Dedicated Nurse Specialist has had a positive effect on the economy as a whole.

Recommendations:

The Single Commissioning Board are asked to:-

(1) Review the evaluation report and Equality and Quality Impact Assessments.
(2) Agree to continue to commission the Parkinson Dedicated Nurse Specialist as part of the Community Neuro Rehab Team, with the overall aim to support patients and carers in the community and achieve the following outcomes:
    - Ensure a sustained reduction in the number of avoidable admissions,
    - Achieve a reduction in length of stay when an admission occurs,
    - Community Neuro Rehab Team will be the main point of contact for Parkinson's Disease patients and their carers as their condition progresses,
    - Provide training to other health professionals so they can support the long term management of the patient.
(3) Acknowledge that the funding for the Parkinson Dedicated Nurse Specialist will be covered within the block contract from 2017/18 onwards.

Financial Implications:

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

Parkinson's nurse is already included in the signed ICO contract for 2017/18 (funded from the S75). Therefore no funding decision required with regard to this report. However the report presents some interesting data for information which may be used by the Integrated Care Organisation in the future to direct the work of Parkinson's Nurse to best effect.

Legal Implications: **(Authorised by the Borough Solicitor)**	The Funding is accounted for. If it was decided not to continue this would on the face of it represent a saving. However, what needs to be taken into account when making such an evaluation is whether costs will show themselves further up the system and indeed whether they will be greater. To assist in making this determination it is important to consider the equality impact assessment and the health inequalities seeking to reduce.
How do proposals align with Health & Wellbeing Strategy?	The Parkinson Dedicated Nurse Specialist role aligns with the H&WB strategy by: • Providing a clear pathway for medical professionals to support the identification and management of people with Parkinson's Disease. • Providing easily accessible support in the community which will increase independence and reduce ill health
How do proposals align with Locality Plan?	The service is consistent with the following priority transformation programmes: • Enabling self-care • Neighbourhood-based management
How do proposals align with the Commissioning Strategy?	The service contributes to the Commissioning Strategy by: • Empowering people to identify the symptoms and manage their own care • Encourage neighbourhood teams to work with the Parkinson Dedicated Nurse Specialist to provide holistic support • Support primary care to manage people who are on their register
Recommendations / views of the Professional Reference Group:	PRG agreed with the recommendations.
Public and Patient Implications:	The Parkinson Dedicated Nurse Specialist supports people who have been diagnosed with Parkinson's and also their carers. Removing the service could have a negative impact on the patients, carers and the wider health economy.
Quality Implications:	A quality impact assessment has been completed and is attached (Appendix B). If the service is not commissioned it could have an impact on the patients and their carers. The full evaluation documents are collated together and available from Samantha Hogg. These include further details around the quality of the service and include a personal review by the Parkinson Dedicated Nurse Specialist.
How do the proposals help to reduce health inequalities?	The incidence of Parkinson's increases with age. By identifying people early and by supporting and managing people appropriately, it will ultimately improve the length of time that a person is able to control their symptoms.

What are the Equality and Diversity implications?	It is anticipated that the proposal to continue to commission the Parkinson Dedicated Nurse Specialist will not have a negative effect on any of the protected characteristic group(s) within the Equality Act. However, removing the service could have a negative impact. An Equality Impact assessment has been completed and is attached (**Appendix A**).
What are the safeguarding implications?	It is anticipated that there would be no safeguarding implications.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	Information governance is a core element of the NHS. The Tameside and Glossop Integrated Care NHS Foundation Trust, GP Practices and neighbourhood teams would have IG policies in place and they would be expected to adhere to these.
Risk Management:	By having the Parkinson Dedicated Nurse Specialist in post, it is expected that there would be a reduction in risk as more people would be supported locally.
Access to Information :	The background papers relating to this report can be inspected by contacting Samantha Hogg, Commissioning Development Manager by:  Telephone: 07342 055 999  e-mail: Samantha.hogg@nhs.net

1.0 BACKGROUND

1.1 Parkinson's disease is a neurodegenerative movement disorder which commonly occurs in the later years of life. It is estimated that 27.5 per 10,000 people over the age of 65 will develop Parkinson's disease. Therefore in Tameside and Glossop there will currently be over 450 people living with Parkinson's disease. Additionally, prevalence is expected to rise by an increase of 27% nationally by 2020.

1.2 The consequence of inadequate management of the condition can result in poor control of symptoms with medication and side-effects, high levels of disability, mental health problems and increased carer burden, all of which lead to increased dependency on health and social care services

1.3 Based on the population of Tameside and Glossop, it is estimated that there are currently around 440-480 people living with Parkinson's disease. Most GPs will have an average of 4 or 5 people on their caseload

2.0 PURPOSE OF THE ROLE

2.1 The aim of the Parkinson's Nurse Specialist (PNS) is to improve services for people with Parkinson's disease in Tameside and Glossop through the appointment of a PNS as part of local service redesign.

2.2 Providing support to people with Parkinson's in hospital or care homes costs much more than other forms of care. Although most patients want to stay at home, the reality has been that community services have not been available to make this happen. Parkinson's nurses can help people to stay at home. It has been estimated that by developing and funding community based services for people with Parkinson's the savings and health costs would be around £56 million, or comparative to 30% of the money spent supporting people in care homes.

2.3 The role of the PNS is outlined below, and their role would sit within the integrated Community Neuro rehab Team (Community Neuro Rehab Team):

- Care coordination for people with Parkinson's Disease and complex needs;
- Provide clinical monitoring, symptom control and medicine management as well as health promotion and wellbeing;
- First point of contact for information and signposting once triage has commenced in the integrated service;
- Support and advice when a person with Parkinson's Disease is admitted to hospital/respite to ensure continuity of their care plan;
- Expert patient and other self care group education and support sessions;
- Practice supervision for case managers involved with people with Parkinson's disease on their caseload;
- Specialist advice and support for other professionals working with an individual patient about specific symptoms/issues;
- Provision of training to other health and social care professionals and non-qualified staff about PD and its management.

3.0 FUNDING

3.1 The post has been pump primed by Parkinson's UK for 18 months. The Parkinson Dedicated Nurse Specialist started in December 2015 and the non-recurrent funding from Parkinson's UK will cease in June 2017.

3.2 Parkinson's UK agreed to provide the grant on the proviso that the future funding of the post would be provided by the CCG if the objectives of the service could be met following an evaluation of the service. This report includes the evaluation data.

3.3 The grant provided by Parkinson's UK is £12167.40 per quarter, with an annual cost of £48669.60 annual cost. This excluded any on-costs.

3.2 If was felt that the most suitable place for the Parkinson Dedicated Nurse Specialist to work was with the Community Neuro Rehab Team. Therefore the Parkinson's nurse payments have been paid to Tameside and Glossop Integrated Care NHS Foundation Trust.

4.0 AUDIT OF WORK (AUGUST 2016)

4.1 The audit was undertaken to review the type of work undertaken by the Parkinson Dedicated Nurse Specialist. This information is taken from a snapshot in August 2016.

4.2 The work was broken down into a number of functions which included administration, patient time, education and meetings. Of all of these functions, phone calls were the most common (50% of all tasks), with home visits (22%) and administration (19%) being a close second and third (see figure 1). The majority of the contacts were made with patients or their carers/family (82%) followed by other professionals (12%) and the patients GP (5%).

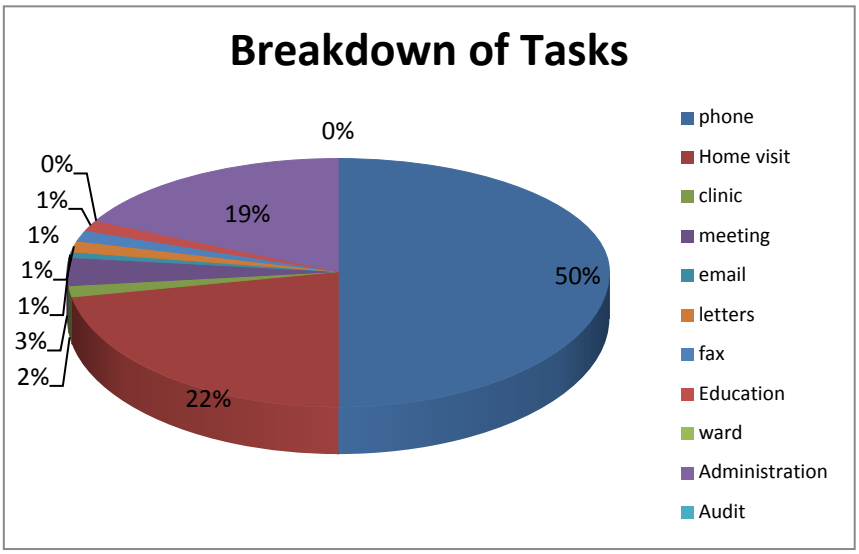

Figure 1: Breakdown of Tasks undertaken by the Parkinson Dedicated Nurse Specialist during August 2016

4.3 The reasons for consultation (e.g. phone, home visit, clinic appointment) varied; along with initial contact (23%), advice, support and information covered 53% of the queries. Some of these people then went on to need a home visits/clinic appointment with the nurse (38%), or required a change to their medication (15%); although the majority needed information (43%).

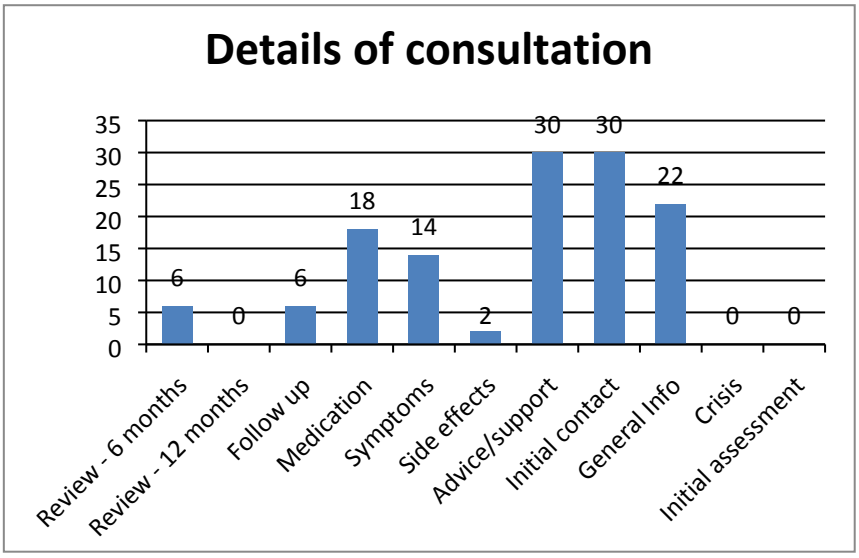

Figure 2: The Breakdown of the consultations undertaken in August 2016

4.4 If the Parkinson Dedicated Nurse Specialist had not been available, the outcomes highlighted in figure 3 would have been likely. The consultant would have been the main point of contact for a large number of people (40%), with the need for a GP appointment either at home or in surgery (24%) or another health professional contact (27%) also common.

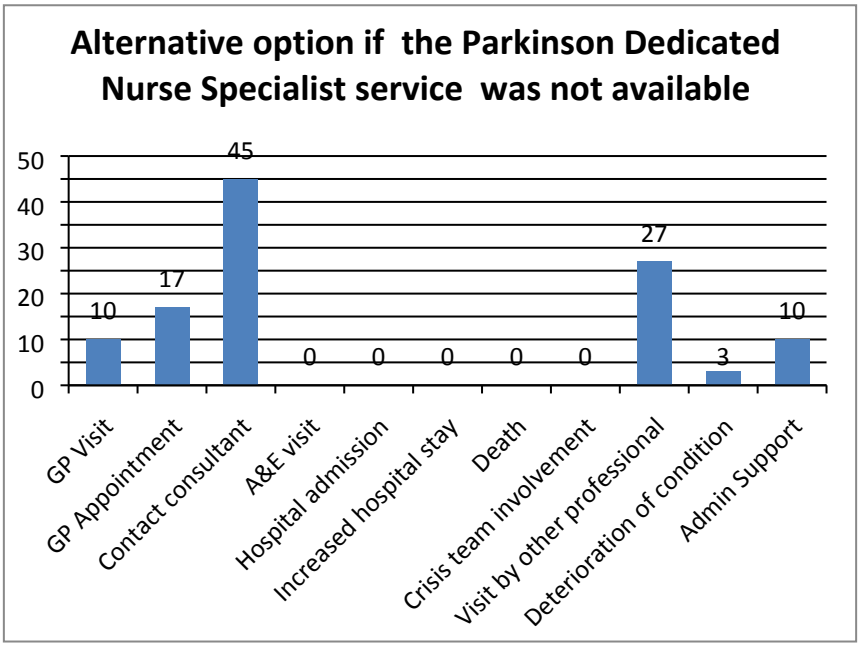

Figure 3: Alternative option if the Parkinson Dedicated Nurse Specialist role did not exist in Tameside and Glossop

5.0 ACCESS TO SUPPORT FOR PEOPLE DIAGNOSED WITH PARKINSON'S DISEASE

5.1 The Parkinson Dedicated Nurse Specialist started identifying patients and taking referrals from December 2015. There has been a marked increase in the number of patients who have access to specialist support since the Parkinson Dedicated Nurse Specialist has been in post.

Table 1: Number of referrals to Community Neuro Rehab Team for support with Parkinson's Disease

	2014	2015	2016 *	2015 – 2016 Difference
No. Parkinson's Patients accessing Community Neuro Rehab Team	25	60	105	+75%

* January – October 2016

5.2 The Parkinson Dedicated Nurse Specialist will be the point of contact in Community Neuro Rehab Team, but there are also MDT sessions arranged for Occupational Therapists, Speech and Language Therapists, Psychologists and Physiotherapists to provide further specialist support to people diagnosed with Parkinson's disease.

5.3 The support from the Parkinson Dedicated Nurse Specialist and Community Neuro Rehab Team is available at home or in a clinic setting and there has been some in reach to the hospital to support discharge.

6.0 ADMISSIONS AND ADVICE

6.1 Using psuedonymised data, the patients who have been reviewed by the Parkinson Dedicated Nurse Specialist in 2016 were tracked through the system and their Non-Elective Admission in 2016 was compared to previous years. There has been a decrease in the number of non-elective admissions which can be seen as 2016 progresses.

Table 2: The number of non-elective admissions for people who have had contact with the Parkinson Dedicated Nurse Specialist during 2016.

Month	***2014***	***2015***	***2016***
Jan	35	35	32
Feb	34	30	20
Mar	25	32	22
Apr	23	25	19
May	28	25	13
Jun	18	39	17
Jul	18	32	19
Aug	32	24	16
Sep	20	29	13
Oct	25	33	12
Nov	14	25	
Dec	30	32	
Total	***302***	***361***	***183***
Apr - Oct Total	***258***	***304***	***183***
Difference		***46***	***-121***
		17.8%	***-39.8%***

6.2 When comparing the activity in terms of bed days and actual costs for some of the specific Primary Diagnoses from SUS data, we can see some large reductions, of which some would specifically correlate with the work of the Parkinson Dedicated Nurse Specialist.

Table 3: 2015 and 2016 bed days and the related expenditure for people with a diagnosis of Parkinson's Disease

	Bed Days			Spend		
	2015 (12 mths)	2016 * (12 mths)	Increase/ (Decrease)	2015 (12 mths)	2016 * (12 mths)	Increase/ (Decrease)
Bronchopneumonia, unspecified	519	214	(305)	124,371	53,189	(71,182)
Unspecified acute lower respiratory infection	52	24	(28)	16,853	4,184	(12,669)
Parkinson's disease	146	28	(118)	31,650	4,218	(27,432)
Pneumonitis due to food and vomit	245	97	(148)	66,151	18,817	(47,334)
Open wound of scalp	129	18	(111)	26,476	6,775	(19,701)
Congestive heart failure	85	-	(85)	23,561	-	(23,561)
Tetany	29	4	(25)	16,069	4,619	(11,450)
Disorientation, unspecified	144	5	(139)	23,434	3,901	(19,533)
Total	**1349**	**390**	**(959)**	**23,434**	**95,703**	**(232,862)**

(* = 10 months data used to forecast the position at 12 months)

6.3 Looking at these specific Primary Diagnoses with Tariff costs applied, an element of the monetary savings are identified. It has to be highlighted that some of these costs would then offset the demand in the community, and the costs are not a cashable saving for the Single Commission due to the block contract agreement for 2017/18.

6.4 The financial information indicates ~£500k saving from 2015 to 2016 (FYE). However, with the increased requirement of community services, this would indicate there is a potential of the activity saving between £250k to £500k.

6.5 Further work will be required to develop pathways for people who have been admitted to hospital. The Parkinson Dedicated Nurse Specialist has made an effort to contact ward staff once she is aware that a patient has been admitted. The Parkinson Dedicated Nurse Specialist may be able to train some Parkinson's champions on the wards to help support people who have been admitted. There would need to be further work undertaken with the Urgent Care team to support patients to remain in their own home.

6.6 The Parkinson Dedicated Nurse Specialist has supported the hospital pharmacists with the medication requirements of inpatients with a diagnosis of Parkinson's Disease and has developed a safety bulletin for the hospital to use. This has helped to ensure the optimum

dose of medication is provided at the correct time to reduce the likelihood of the person "going off" and losing their independence. If a person does not receive their medication at the right time (which is often not at the usual medication times on the ward), the person is more likely to stiffen and may need help to go to the toilet, may have difficulty swallowing, and in the worst cases, they may become completely frozen.

7.0 REDUCTION IN MEDICAL APPOINTMENTS AND CONTACTS

7.1 Using the review undertaken in August, it is estimated that there would have been 45 less consultant contacts, 17 less GP contacts, and 10 less GP home visits. Assuming this is a typical month, there would be 540 less consultant contacts (which could then lead to appointments), 204 GP contacts, and 120 less GP home visits in a year. Using the cost of the Parkinson Dedicated Nurse Specialist vs clinician as a rough guide, the savings could be:

Table 3: Assumptions about time saved by having a Parkinson Dedicated Nurse Specialist in post

	Annual contacts	Saving
Consultant contacts	540	£11,070
GP contacts	204	£816
GP home visits	120	£1,440
Total saving		**£13,326**

7.2 Even though this is a potential saving, it is not a guaranteed cashable saving available within the system as these would have been additional requirements. However, it does represent the reduction in need for appointments and better management of patients.

7.3 The Parkinson Dedicated Nurse Specialist is able to identify suitable patients for Apo-morphine, undertakes the planning and Apo-morphine challenge at a local level. This has been undertaken in Tameside in a GP Practice and the patient was then followed up at home. If there was no Parkinson Dedicated Nurse Specialist, consultants would have to refer to Salford Royal to the Advanced Therapies clinic for assessment and potential admission. This demonstrates integrated local working with GP, Consultant and patient to ensure cost savings, and reduction in stress for patients by not going in to hospital.

8.0 AWARENESS RAISING AND WORKING WITH COLLEAGUES

8.1 The Parkinson Dedicated Nurse Specialist has delivered training to GPs, nurses, Community Neuro Rehab Team, hospital Pharmacists, Willowood Hospice, and the hospital SALT team.

8.2 There have also been meetings held with the local mental health team and meetings with the IV and Urgent Care teams. The Parkinson Dedicated Nurse Specialist has also met with practice managers, set up a stand at the hospital for Parkinsons awareness week and has presented at the Indian Community Centre.

8.3 The Parkinson Dedicated Nurse Specialist has also attended the PDSNA National Conference.

9.0 FEEDBACK FROM SERVICE USERS, CARERS, COLLEAGUES

Service Users and Carers

9.1 Twelve patients/carers from the Tameside and Glossop Parkinson's Disease support group completed questionnaires. Overall they felt that the Parkinson Dedicated Nurse Specialist service had been useful as they were able to ask for advice without having to try to contact their consultant. Also the Parkinson Dedicated Nurse Specialist nurse has also been able to help when appointments with the consultants have been a delayed or when the follow up appointment with the consultant is not yet due.

9.2 Some patients struggle to access support from the consultants and others make a GP appointment in order to ask for an appointment with the consultant. This is no longer required as the Parkinson Dedicated Nurse Specialist can provide support. Someone also felt that the support of the Parkinson Dedicated Nurse Specialist had helped them to remain living at home.

9.4 At least 5 of these patients have to visit their consultant in Oldham or Salford. This level of travel can be challenging for some people with a diagnosis of Parkinson's Disease.

Primary care

9.6 Four GPs responded to a survey. Three had previously been unable to gain specialist Parkinson's advice, and suggested that having someone to speak to quickly about medication and admission avoidance is helpful. They also felt it was important for someone to help support the whole Parkinson's pathway for the patient, GP and consultant. All practices suggested they would be willing to share practice data to identify patients who have not had a follow up so they could be supported by the Parkinson Dedicated Nurse Specialist.

Consultants

9.8 Four consultants from a range of Hospitals completed questionnaires. Their responses where outstandingly positive; all felt that the Parkinson Dedicated Nurse Specialist had provided support which had reduced the need for extra consultant appointments and had supported a reduction in hospital admissions.

"Prior to the Parkinson Dedicated Nurse Specialist taking up her post it was commonplace for the patients from Tameside and Glossop area to call with problems and request or require an earlier outpatient appointment. They had no local nurse specialist to call instead and I had no-one to refer the queries on to. It got to the point where I was contemplating stopping taking new referrals from that area as it was plain that the clinic burden was too great. The Parkinson Dedicated Nurse Specialist was known to me from her previous Parkinson Dedicated Nurse Specialist experience and her impact was immediate. I haven't had to bring a single patient back to clinic earlier in the last ten months since she has been in post as the Parkinson Dedicated Nurse Specialist."

Dr Jason Raw, Consultant Physician, Pennine Acute NHS Trust.

10.0 PATIENT WELLBEING

10.1 As part of the Initial appointment, all Parkinson's patients are asked to identify an area they would like to improve and this is logged using the Canadian Occupational Performance measure (COPM). A small audit of 15 patients has shown that all 15 have made

improvements in their COPM score. The tasks the people wanted to achieve included transferring from bed/chair/car, showering, dressing, sleeping and eating/drinking.

10.2 The Parkinson Dedicated Nurse Specialist has also been working with a Physiotherapist and a technical instructor and has set up new accessible activities. Line dancing was one of these activities and the 6 week course had 8 participants. The group provided positive feedback.

11.0 NICE GUIDELINES

11.1 NICE Clinical Guideline 35 and R77 are being met.

12.0 FUTURE COMMISSIONING

12.1 The Parkinson Dedicated Nurse Specialist is knowledgeable about the progression of Parkinson's Disease and is skilled in supporting people to manage their care. The Parkinson Dedicated Nurse Specialist has worked closely with colleagues in Community Neuro Rehab Team and this has become a mutually beneficial partnership; therefore it would be beneficial for the post to remain in Community Neuro Rehab Team. There will be an aspect of in-reach and training for secondary care colleagues, however, the main focus would be to provide support in the community.

12.2 With this in mind, it would be anticipated that the Parkinson Dedicated Nurse Specialist (as part of Community Neuro Rehab Team) would:

- Achieve a sustained reduction in the number of avoidable admissions,
- Achieve a reduction in LOS when an admission occurs,
- be the main point of contact for Parkinson's Disease patients and their carers as their condition progresses,
- Provide training to other health professionals so they can support the long term management of the patient.

12.2 Almost a fifth of the tasks undertaken by the Parkinson Dedicated Nurse Specialist is administration. A large proportion of this could be completed by an administration assistant so that the Parkinson Dedicated Nurse Specialist could spend more time spent with patients. The future commissioning of the Parkinson Dedicated Nurse Specialist would recommend that more time is spent undertaking clinical work and less undertaking administration duties.

13.0 HOST EMPLOYER

13.1 The post is currently situated with Community Neuro Rehab Team which is part of Tameside and Glossop Integrated Care Foundation Trust. The Community Neuro Rehab Team have found that the Parkinson Dedicated Nurse Specialist has provided additional knowledge and expertise and therefore it is proposed that the Parkinson Dedicated Nurse Specialist would remain as part of Community Neuro Rehab Team.

14.0 RECOMMENDATIONS

14.1 As set out on the front of the report.

Subject / Title	Continuation of the Parkinson's Disease Specialist Nurse Service

Team	**Department**	**Directorate**
Transformation	Commissioning	Single Commissioning Function

Start Date	**Completion Date**
01.09.16	19.01.17

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

EIA Group (lead contact first)	**Job title**	**Service**
Samantha Hogg	Commissioning Development Manager	Commissioning
Elizabeth Hartley	Parkinson's Disease Specialist Nurse	Community Neuro Rehab Team (TGICFT)
Rebecca Ward-Dooley	Area Development Manager	Parkinson's UK
Cheryl Madeley	Clinical Pathway Lead	Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT)

APPENDIX A

Tameside & Glossop Single Commissioning Function
Equality Impact Assessment (EIA) Form
PART 1 – INITIAL SCREENING

1a.	**What is the project, proposal or service / contract change?**	Parkinson's Disease (PD) is a neurodegenerative movement disorder which commonly occurs in the later years of life. The consequence of inadequate management of the condition can result in poor control of symptoms with medication and side-effects, high levels of disability, mental health problems and increased carer burden, all of which lead to increased dependency on health and social care services Parkinson's UK pump primed a Parkinson's Disease Specialist Nurse (Parkinson Dedicated Nurse Specialist) to work in Tameside and Glossop for 18 months. The nurse has been working with the Community Neuro Rehab Team (Community Neuro Rehab Team) and has a wide range of duties in order to support people with a Diagnosis of Parkinson's Disease. An evaluation of the post has been conducted with the aim that the Single Commission will to continue to fund the post if the evaluation shows that the post has had a positive effect on the economy as a whole. The proposal is that the service will continue to be funded; however, this EIA will look at the impact of the proposal not being accepted and what would happen if the service is discontinued.

1b.	**What are the main aims of the project, proposal or service / contract change?**	The role of the Parkinson Dedicated Nurse Specialist is outlined below, and their role would sit within the Community Neuro rehab Team (Community Neuro Rehab Team): • Care coordination for people with Parkinson's Disease and complex needs • Provide clinical monitoring, symptom control and medicine management as well as health promotion and wellbeing • First point of contact for information and signposting once triage has commenced in the integrated service • Support and advice when a person with Parkinson's Disease is admitted to hospital/respite to ensure continuity of their care plan • Expert patient and other self care group education and support sessions • Practice supervision for case managers involved with people with Parkinson's disease on their caseload. • Specialist advice and support for other professionals working with an individual patient about specific symptoms/issues. • Provision of training to other health and social care professionals and non-qualified staff about PD and its management **This Equality Impact Assessment will highlight what would happen if this role is no longer available.**

1c. Will the project, proposal or service / contract change have either a direct or indirect impact on any groups of people with protected equality characteristics?

Where a direct or indirect impact will occur as a result of the project, proposal or service / contract change please explain why and how that group of people will be affected.

Protected Characteristic	Direct Impact	Indirect Impact	Little / No Impact	Explanation
Age	X			The prevalence of Parkinson's Disease increases with age.
Disability	X			Parkinson's Disease is a neurodegenerative movement disorder which will not improve. It is a long term

				condition which could lead to permanent disability
Ethnicity	X			Parkinson's UK are undertaking research in the UK, but research from the USA suggests people from white ethnic backgrounds are more likely to develop PD
Sex / Gender	X			Parkinson's UK are undertaking research in the UK, but research from the USA suggests males may be slightly more likely to develop PD
Religion or Belief			X	
Sexual Orientation			X	
Gender Reassignment	X			As with Sex/Gender, there could be some impact if the Parkinson Dedicated Nurse Specialist service was not available.
Pregnancy & Maternity			X	
Marriage & Civil Partnership			X	
NHS Tameside & Glossop Clinical Commissioning Group locally determined protected groups?				
Mental Health	x			Certain mental health problems, like depression and disturbances are complications of Parkinson's disease and/or its treatment.
Carers	x			People with Parkinson's may deteriorate more rapidly and this may put extra pressure on their carers
Military Veterans			x	
Breast Feeding			x	
Are there any other groups who you feel may be impacted, directly or indirectly, by this project, proposal or service / contract change? (*e.g. vulnerable residents, isolated residents, low income households)*				
Group (*please state)*	**Direct Impact**	**Indirect Impact**	**Little / No Impact**	**Explanation**

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

1d.	Does the project, proposal or service / contract change require a full EIA?	Yes	No
		x	
1e.	What are your reasons for the decision made at 1d?	There would be an impact on people with Parkinson's disease if the service was no longer funded. It is not necessarily discrimination, but there would be a gap in support which could be detrimental to the health and wellbeing of those diagnosed with Parkinson's and those who care for someone with Parkinson's.	

PART 2 – FULL EQUALITY IMPACT ASSESSMENT

2a. Summary

Historically patients with a diagnosis of Parkinson's disease, Parkinsonism or Atypical Parkinson's in the Tameside and Glossop area have been referred to consultants across Greater Manchester (GM). The point of contact for patients for support, early review and crisis intervention was either through their GP or consultants secretary. This group of patients can present with complex needs and multiple pathology. Carers can be under strain. Early referral to the community neuro rehab team Community Neuro Rehab Team can support people with a new diagnosis and promote well-being. However referrals to this service is dependent upon a good knowledge of local services. Parkinson's patients known previously to Community Neuro Rehab Team are able to self-refer back as required. Before the Parkinson Dedicated Nurse Specialist was in post, there were no set community clinics in place and Parkinson's patients who needed assessment for Apo-morphine would be referred to Salford Royal which could lead to hospital admission.

An 18 month pump primed community post was agreed with Parkinson's UK and Tameside and Glossop CCG. The appointment required an autonomous nurse who has had exposure to caring for people with Parkinson's, non-medical prescriber and community practitioner. Nurses who take on this specialist role often need to have sufficient knowledge and experience to be immediately up and running due to the short period in which evidence is required to show an impact. Parkinson's nurses', who are based within a well-established functioning Community Neuro Rehab Team, enhance the service for both patients and Community Neuro Rehab Team by increasing the number of referrals and providing patients with timely access to the multi-disciplinary team.

The Parkinson Dedicated Nurse Specialist has now been in post for 12 months and an evaluation

has been completed. This has shown that the Parkinson Dedicated Nurse Specialist (as part of the Community Neuro Rehab Team) has had a positive impact on hospital admissions, has received a lot of positive feedback from patients and clinicians and has set up local services which have reduced the need for travel/admission.

The 18 month funding will cease in June 2017. It is recommended that the service continues, however, this EIA considers what would happen if the service was to stop.

2b. Issues to Consider

1. PD is a long-term condition and therefore meets the statutory definition of disability under the Equality Act 2010. Regular reviews are required as each person's needs will vary greatly. As the condition progresses, medication issues become more critical, and so regular adjustments are required. Also, the amount of care needed to support people in the community will increase. Parkinson's Disease will increase over time due to the aging population. It is anticipated it could increase by as much as 27%.

2. The aim of the PD nurse is to support people to better manage their condition in a holistic way which is also in line with the local commissioning strategy. By removing the nurse, there would be a gap which could then have a negative effect on those diagnosed with PD and also those who care for someone with PD.

3. Parkinson's UK have now set up Parkinson Dedicated Nurse Specialist service in all of the GM areas, therefore by removing the service, T&G would be the only area not to have a specialist nurse.

4. The financial information indicates ~£500k saving from 2015 to 2016 (FYE). However, with the increased requirement of community services, this would indicate there is a potential of the activity saving between £250k to £500k

5. There has been engagement with patients, carers, consultants, the Community Neuro Rehab Team and Primary Care. All felt that there was a need for a service which would co-ordinate care for patients. The consultant has found that it is particularly important as the clinic would not be continuing to take on patients without the support of the Parkinson Dedicated Nurse Specialist. Engagement included:

Audience	Approach	Key Findings
Patients & Carers	Sept 16= twelve people – Questionnaire given out to the local Parkinson's support group	• Overall they felt that the Parkinson Dedicated Nurse Specialist service had been useful as they were able to ask for advice without having to try to contact their consultant. Also the Parkinson Dedicated Nurse Specialist nurse has also been able to help when appointments with the consultants have been a delayed or when the follow up appointment with the consultant is not yet due. • Some patients struggle to access support from the consultants and

		others make a GP appointment in order to ask for an appointment with the consultant. This is no longer required as the Parkinson Dedicated Nurse Specialist can provide support. Someone also felt that the support of the Parkinson Dedicated Nurse Specialist had helped them to remain living at home. • At least 5 of these patients have to visit their consultant in Oldham or Salford. This level of travel can be challenging for some people with a diagnosis of Parkinson's Disease
Consultants from GM Hospitals	Sept 16 = four consultants – Questionnaire	• Their responses where outstandingly positive; all felt that the Parkinson Dedicated Nurse Specialist had provided support which had reduced the need for extra consultant appointments and had supported a reduction in hospital admissions
Primary Care	Oct 16 = four clinicians – online questionnaire available for 4 weeks	• They felt it was important for someone to help support the whole Parkinson's pathway for the patient, GP and consultant.

6. The Parkinson Dedicated Nurse Specialist has provided training to staff from a number of clinical backgrounds. This has helped to improve awareness of medications, awareness of the Parkinson's pathways and the impact of Parkinson's on the person's life.

7. The Parkinson Dedicated Nurse Specialist will ensure that appropriate and timely referrals are made to essential services (such as other therapies or social care)

2c. Impact

This EIA evidences that a lack of a Parkinson Dedicated Nurse Specialist would impact upon patients across a number of protected characteristic groups. If the nurse was no longer available there could be:

- An increase in admissions (locally it appears to have reduced hospital admissions by 50%),
- An increase in consultant appointments/contacts (locally it is anticipated there would have been 540 more contacts) and GP appointments (204 clinic visits, 120 home visits)
- Consultants may have to cap patient waiting lists due to the high volume of contacts/appointments required (feedback from consultant)
- Less support for Carers (the Parkinson Dedicated Nurse Specialist will empower and educate patients and carers, including running courses and explaining about medication and symptoms)
- A reduction in working age people being able to work (this is twofold – one for the person diagnosed with Parkinson's and also their carer/family members).

Having a Parkinson Dedicated Nurse Specialist in post is good practice and will help the system as

a whole. Engagement suggests this post is important and if removed, there would be an impact on the people diagnosed with Parkinson's disease, who tend to be older and will require extra support from carers.

The Parkinson Dedicated Nurse Specialist has also helped the hospital staff to become more aware and responsive to Parkinson's patients and the Parkinson Dedicated Nurse Specialist is working closely with End Of Life colleagues with the aim to reduce avoidable admissions near the end of life.

2d. Mitigations *(Where you have identified an impact, what can be done to reduce or mitigate the impact?)*	
There would be an increase in the number of consultant / GP contacts if the nurse was not available	*Due to the financial / funding constraints, it would be difficult to mitigate the impacts of not having a Parkinson Dedicated Nurse Specialist.* *There may need to be investment in self care / self management to encourage and equip people to manage their condition. This would link into the neighbourhood and healthy lives workstream.* *There may be a cap on referrals and so there would need to be thoughts about commissioning further consultant clinics.* *There may need to be further investment in formal carers*
Increased admissions	
Poor self-care	
Increased hours for carers	

2e. Evidence Sources

McMahon (1999) Parkinson's Disease Nurse Specialist: An important role in disease management. Neurology, 57(7)

Parkinson's Nurses: Affordable, Local, Accessible, and Expert Care. A Guide for Commissioners in England (2011).
https://www.parkinsons.org.uk/sites/default/files/publications/download/english/englandnursereport.pdf

NICE Clinical Guideline 35 (June 2006). Parkinson's disease – Diagnosis and management in primary and secondary care

Questionnaires completed by patients, carers, consultants and primary care

Financial and activity figures prepared by Tameside and Glossop Single Commission

Audit of Parkinson Dedicated Nurse Specialist workload – August 2016 (then extrapolated to forecast for 12 months)

2f. Monitoring progress

Issue / Action	Lead officer	Timescale
A review of service offers for Parkinson's patients and carers if the Parkinson Dedicated Nurse Specialist funding is not extended	*SH*	*April 2017*

Signature of Contract / Commissioning Manager	Date
SHOGG	**19.01.17**
Signature of Assistant Director / Director	**Date**

APPENDIX B

Title of scheme: Continuation of the Parkinson's Disease Specialist Nurse Service

Project Lead for scheme: Samantha Hogg

Brief description of scheme:

Parkinson's Disease (PD) is a neurodegenerative movement disorder which commonly occurs in the later years of life. The consequence of inadequate management of the condition can result in poor control of symptoms with medication and side-effects, high levels of disability, mental health problems and increased carer burden, all of which lead to increased dependency on health and social care services

Parkinson's UK pump primed a Parkinson's Disease Specialist Nurse (Parkinson Dedicated Nurse Specialist) to work in Tameside and Glossop for 18 months. The nurse has been working with the Community Neuro Rehab Team (Community Neuro Rehab Team) and has a wide range of duties in order to support people with a Diagnosis of Parkinson's Disease.

An evaluation of the post has been conducted with the aim that the Single Commission will to continue to fund the post if the evaluation shows that the post has had a positive effect on the economy as a whole.

The proposal is that the service will continue to be funded; however, this QIA will look at the impact of the proposal not being accepted and what would happen if the service is discontinued.

The potential impact of not continuing to commission a Parkinson Dedicated Nurse Specialist include:

- An increase in admissions (locally it appears to have reduced hospital admissions by 50%),
- An increase in consultant appointments/contacts (locally it is anticipated there would have been 540 more contacts) and GP appointments (204 clinic visits, 120 home visits)
- Consultants may have to cap patient waiting lists due to the high volume of contacts/appointments required (feedback from consultant)
- Less support for Carers (the Parkinson Dedicated Nurse Specialist will empower and educate patients and carers, including running courses and explaining about medication and symptoms)
- A reduction in working age people being able to work (this is twofold – one for the person diagnosed with Parkinson's and also their carer/family members).

What is the anticipated impact on the following areas of quality? NB please see appendix 1 for examples of impact on quality.						What is the likelihood of risk occurring?	What is the overall risk score (impact x likelihood)			
	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5	1-5	Low 1-5	Moderate 6-12	High 15-25	Comments
Patient Safety		x				2	4			It is not anticipated that there would be any direct patient safety implications but there may be some indirect implications due to the condition not being as proactively and effectively managed.
Clinical effectiveness			x			2	6			There may be an increase in patients experiencing poor control of symptoms (e.g. due to medication/side-effects) which could lead to higher levels of disability, mental health problems and increased carer burden. By removing the Parkinson Dedicated

										Nurse Specialist, it could lead to an increase in admissions to hospital for Parkinson's patients.
Patient experience	x					4	4			There may be some complaints received if the service was not recurrently funded.
Safeguarding children or adults	x					2	2			It is not anticipated that the having no Parkinson Dedicated Nurse Specialist in post would lead to any safeguarding incidents.
Human resources/ organisational development/ staffing/ competence	x					2	2			There could be some effect as the Parkinson Dedicated Nurse Specialist runs training events and has supported other members of staff to appropriately manage patients
Statutory duty/ inspections	x					5	5			If there was no Parkinson Dedicated Nurse Specialist in post, it would be difficult to achieve

										NICE Guidelines
Adverse publicity/ reputation		x				2	4			There may be some negativity if there is no longer a service to meet the public's expectations
Finance		x				5		10		Removing the Parkinson Dedicated Nurse Specialist could lead to an increase in admissions to hospital for Parkinson's patients.
Service/business interruption					x	4			20	If funding the Parkinson Dedicated Nurse Specialist is not an option, then the local community service would not exist and this would have consequences for the patients and carers. There would potentially increase admissions, and increase the need for formal carers and GP appointments.

Environmental impact	x					1	1			It is not anticipated that there would be any effect on the environment.
Compliance with NHS Constitution		x				4		8		There would be some impact as removing the service would have an impact on some of the protected characteristics groups (see EIA) and there could be a question raised regarding value for money if patients have to contact consultants/GPs instead of a Parkinson Dedicated Nurse Specialist
Partnerships	x					3	3			It is anticipated that there could be some impact on partnerships but this would be kept to a minimum
Public Choice		x				3		6		Having no Parkinson Dedicated Nurse Specialist available would affect choice, particularly if there are Parkinson Dedicated Nurse

										Specialist nurses available in the other areas of GM.
Public Access		x				5		10		There would no longer be access to this service, however, the patients could still access care elsewhere

Has an equality analysis assessment been completed?	YES	If the funding for the Parkinson Dedicated Nurse Specialist was not put in place, there could be an negative impact on some of the protected characteristics groups
Is there evidence of appropriate public engagement / consultation?	Yes	Engagement with patients, carers, consultants and GPs has been undertaken.