

Tameside Hospital NHS Foundation Trust CPT Final report

28 July 2015



Monitor

Wellington House
133 – 155 Waterloo Road
London
SE1 8UG

Dear Sirs

This report has been prepared for you, Monitor, in respect of Tameside Hospital NHS Foundation Trust (the “Trust”) in accordance with the terms of our agreement dated 10 November 2014 (the “agreement”) and the variation letter and solely for the purpose and on the terms agreed with you. We accept no liability (including for negligence) to anyone else in connection with this report.

This report contains information obtained or derived from a variety of third party sources as indicated within the document. We have not sought to establish the reliability of those sources or verified the information so provided.

We understand that you may wish to publish this report on your website, and in doing so we would draw to your, and any other person who may access and read this report, attention to the following:

1. The report is provided to Monitor, in accordance with Monitor’s instructions, as a summary of the work carried out by PwC under the agreement and variation letter, which was performed exclusively for Monitor’s benefit and use.
2. The report may therefore not include all matters relevant to the reader.
3. The report does not constitute professional advice to any third party.
4. The information contained in this report should not be acted on by any other party without first obtaining specific professional advice.
5. PwC accepts no liability (including for negligence) to any party, other than Monitor, in connection with this document.

This is our final report.

Yours faithfully



PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP is a limited liability partnership registered in England with registered number OC303525. The registered office of PricewaterhouseCoopers LLP is 1 Embankment Place, London WC2N 6RH. PricewaterhouseCoopers LLP is authorised and regulated by the Financial Conduct Authority for designated investment business.



David Morris
Partner

Damien Ashford
Director

PricewaterhouseCoopers LLP
Cornwall Court, 19 Cornwall Street,
Birmingham, B3 2DT
T: 0121 265 5000
F: 0121 232 2725

Contents

Report overview	4
Context and previous work of the CPT	5
At a glance	7
Model of care	10
Clinical sustainability	23
Financial sustainability	26
Engagement	33
Implementation	37
Glossary	41

If you are familiar with the context and previous work of the CPT, go straight to page 7 for the headlines of our work.

Report overview

Report section	Page number	Description	Structure within report
Context and previous work of the CPT	5	<ul style="list-style-type: none"> Overview of the different phases of work the CPT has undertaken. 	<ul style="list-style-type: none"> Provides background and context to this report.
At a glance	7	<ul style="list-style-type: none"> Provides a high level overview of the key points and headlines of the CPT in developing and recommending an integrated care model. 	<ul style="list-style-type: none"> Allows the reader to quickly see the headlines and key points.
Model of care	10	<ul style="list-style-type: none"> Sets out what the model of integrated care will look like and how it drives better outcomes for patients delivered through a single provider. Includes how urgent care will be dealt with and the expected hospital configuration. 	<ul style="list-style-type: none"> Follows the approach of the CPT to focus on the patient and services in the design of the model of care.
Clinical sustainability	23	<ul style="list-style-type: none"> Illustrates why the model of care is clinically sustainable. 	<ul style="list-style-type: none"> Follows the model of care to support the assessment of clinical sustainability.
Financial sustainability	26	<ul style="list-style-type: none"> Describes the financial challenge, how the financial impact has been modelled and sets out the financial benefits from an integrated model of care over 5 years. Assesses the financial sustainability after the benefits from the model of care. 	<ul style="list-style-type: none"> Follows the model of care to support the assessment of financial sustainability.
Engagement	33	<ul style="list-style-type: none"> Describes whether public consultation is needed and the CPT's approach to showing public consultation in the implementation plan. Demonstrates the CPT's local engagement and ownership in the model of care and other aspects of the CPT's work. 	<ul style="list-style-type: none"> Consideration of consultation approach within the implementation plan.
Implementation	37	<ul style="list-style-type: none"> Overview of the implementation plan and the governance of the programme. 	<ul style="list-style-type: none"> At the end of the report to support next steps.
Glossary	43	<ul style="list-style-type: none"> Sets out definitions of key terms and acronyms used throughout this report. 	<ul style="list-style-type: none"> For reference.

Context and previous work of the CPT

This section sets out the background to the CPT's work in previous phases.

Monitor took action to put the Trust in Special Measures. It also appointed a CPT to focus on the Trust becoming an Integrated Care Organisation as a solution to its financial problems.

❶ Overview of the Tameside and Glossop health and care economy

- The Tameside and Glossop health economy is part of the Greater Manchester area and serves a population of approximately 250,000 residents.
- There are 2 main commissioners within the economy – Tameside and Glossop CCG and Tameside Metropolitan Borough Council.
- There is a single acute provider, Tameside Hospital NHS Foundation Trust (the Trust). Community services and mental health services are provided by organisations based out of the area. There are 41 GP practices grouped into 4 localities in Tameside and one locality in Glossop, Derbyshire. The social services in the Glossop locality are commissioned by Derbyshire County Council.
- The health and care economy has estimated it's combined income in FY20 to be c£433m with a combined deficit of c£69m pa.

❷ In Summer 2013, Monitor took action to address unacceptable standards of care and the Trust being financially unsustainable

- In July 2013, the Trust was placed in Special Measures following findings from the Keogh Review. In early 2014, the Trust was deemed clinically and financially unsustainable.
- Partly in response to these concerns, the CCG initiated the development of a programme called Care Together, that had integrated care at its heart.

- In September 2014, Monitor took further action and announced the appointment of a CPT; '*...the first time the NHS will try to create a full Integrated Care Organisation (ICO) at a foundation trust...lead to long term benefits for patients....the team will build on the work already done...'*
- The CPT's work has been in 4 phases:
 - Phase 1 – review of the current preferred solution;
 - Phase 2 – determine the viability of the ICO;
 - Phase 3 – test and confirm sustainability; and
 - Phase 4 – implementation plan.

❸ In Phase 1, we reported that there was a recognised need for change but very little consensus over a model of care

- Our Phase 1 review identified that some areas within Care Together were strong, others needed substantial further work. Key findings included:
 - There was a collective recognition of the need for change amongst local leaders and a willingness to pursue a move towards integrated care;
 - Whilst there was a high level strategy and some emerging business cases (e.g. dermatology), there was no overall model of care that described the services that would bring the full benefits of integrated care to local people;
 - There was significant difference of opinion between the CCG and Trust regarding the acute footprint at Tameside Hospital; and
 - The estimates of the financial benefits of the strategy were not owned by the various stakeholders in the economy and were in some places unrealistic.

Context and previous work of the CPT

4 In Phase 2, we worked closely with local stakeholders to build on existing thinking to design and develop a pioneering new model of care. We identified substantial patient benefits and estimated a financial benefit of £20m - £34m pa

- In developing our Phase 2 findings, we worked with patient groups, care professionals, local leaders and others to design the new model of care that would drive significant benefits to local residents, who would be healthier and need less care.
- We also found there to be substantial financial benefits driven by the model of care of between £20m - £34m pa although there would be significant one-off implementation costs.
- We reported that in our view the combined deficit in the health and care economy would be reduced but not fully addressed.

5 In this document we report at the end of Phases 3 and 4 of our work on an exciting way forward for the Trust and system

- This report comes at the end of an intense 6 months of activity by the CPT.
- What is proposed and planned here really is the first in the UK - a fully integrated care organisation with a capitated contract, which has not yet been achieved in the UK.

The CPT was appointed by Monitor to consider a financially and clinically sustainable solution for Tameside Hospital NHS Foundation Trust within the context of the Tameside local health economy. The recommendations set out in the report have been shared with the local health economy which will consider the recommendations and their implications for the local health economy.

At a glance

PwC view:

- *What emerges from 6 months of work by the CPT and Monitor is a first of its type in the UK.*
- *On implementation, the patients and population served by the local health economy will be able to easily access high quality healthcare.*
- *The financial benefits from this work are significant and equate to a c£28m pa reduction against existing running costs.*
- *Providing the new model of care requires a delivery vehicle that could be the first trust in the UK to provide a fully integrated range of services.*
- *The system has a growing financial deficit driven largely by the underfunding of social care costs.*

1 This is an executive report at the end of the Tameside Hospital NHS Foundation Trust CPT

This report has been written for Monitor at the end of the CPT.

- During the CPT, we have worked closely with Monitor's Enforcement Team, the Trust, CCG and TMBC and others and received helpful input.
- The CPT's brief was to develop an integrated care model and its implementation plans to create a clinically and financially sustainable Trust. Full details of the CPT's brief are set out in the service order.

2 We have worked with the local health and care economy to develop and optimise the integrated model of care

- The CPT has developed a new and exciting model of care, that integrates care across the Tameside and Glossop area. Key aspects of the model of care are:
 - Locality Community Care Teams ('LCCTs') in each of the 5 localities;
 - A new Urgent Integrated Care Service ('UICS'); and
 - Tameside Hospital as an elective surgical centre with an A&E (as part of the UICS), maternity services and a reduction in medical beds and overall activity by c18%.
- We have engaged with primary care GPs on a number of occasions and in a number of ways. The GPs shared a range of views and are broadly supportive of the proposed way forward.
- The CPT has engaged widely in the development of the model of care and worked daily with the CCG, Council and Trust, who support this new model of care. More details of this engagement can be found from page 34.

3 The model of care drives financial benefits of c£28m pa

- The model of care drives significant financial benefits over and above 'normal' efficiencies in the system (CIPs and QIPP) reducing the cost to the tax payer and helping to relieve the financial burden in the system.
- The redesign of services has been done in a way that balances financial benefits for the system and the need for a clinically sustainable model. In doing so, consideration has been given to the Trust's existing PFI obligations, the skills and experience of existing staff across the economy and importantly the needs of the population.
- We believe that our acute configuration is clinically sustainable and the most affordable.
- The model of care is complementary with Healthier Together, the Greater Manchester health and social care reform programme.

4 We have put forward a rationale that indicates that the current Foundation Trust should transition into the first fully integrated care provider in the UK

- We have put forward a case indicating why the integrated care provider should be grown out of the Trust. It is now for the CCG to consider how to take this forward.
- Assuming the Trust transitions into a new integrated care provider, it would be a pioneering delivery vehicle. This would mean the way in which services are delivered locally would go much further than those models outlined in the 5 Year Forward View.
- The Trust, in its new form, will need to develop in many ways to effectively deliver a broader and larger range of services and look and feel like an integrated care provider and not like the existing acute Trust.
- The Trust would need to develop its leadership capacity and capability to be able to take forward the delivery of such different and broader services, on a larger scale. This is likely to mean increasing clinical and operational leadership capability to provide the model of care.

At a glance

PwC view:

- *Even with benefits from the model of care of c£28m pa, the residual health and care economy deficit is c£42m pa. We have apportioned this deficit between the commissioners and have provided a rationale for this on page 30.*
- *As a result, the Trust would be financially sustainable.*
- *The combined forecast deficit of c£216m over the next 5 years and implementation costs of c£48m will need addressing. Without the benefit and implementation costs, the combined deficit for addressing is estimated at c£299m.*
- *Beyond year 5, the system would provide better care and be more affordable.*

5 There is a substantial financial benefit from the model of care but a health and care economy deficit remains. This is forecast at c£42m pa

- Before the benefits of the model of care but after normal efficiencies, the system forecast deficit of c£69m in 5 years is comprised of the Trust c£23m, TMBC of c£46m and the CCG is breakeven. The benefit from the model of care is c£28m leaving a residual deficit of c£42m pa (figures are rounded to the nearest £m).
- The CEOs of the Trust, CCG and Council consider the residual deficit as a shared issue and this is consistent with TMBC and the CCG's co-commissioning where they are pooling budgets.
- However, on the basis that the model of care costs what the CPT has estimated and it is the model the commissioners wish to commission, we believe the deficit should rest with the commissioners. This is supported locally although not yet fully ratified.
- As a result, the Trust would be financially sustainable with income and costs of c£414m annually. However, with a long term capitated contract, the Trust would bear the downside risk if the cost of provision was greater than the level of the contract.

6 One-off implementation costs of c£48m and c£216m for deficits over 5 years across the NHS and local government will need addressing

- There are one-off implementation costs that are needed within the next 2-3 years including for capital, estates and people (training, role change etc.) related costs.
- We estimate these to be in the region of c£48m.
- The combined deficit and implementation costs will also need addressing but we note that the 5 year forecast shortfall is lower after the benefits of integrated care and one-off implementation costs.
- Also, from year 5 onward, better care would be provided to local residents and the system would be c£28m pa more affordable.

7 The local health and care economy will need support to deliver a change of this magnitude

- Significant change will be needed to existing services to deliver the benefits from this new model.
- Our experience of working with local leadership is that they will need additional capacity and capability to deliver change of this scale and to the pace shown by the implementation plans. Change of this scale will need to be implemented as well as the 'day job'.
- Local leadership recognise the need to improve their capacity and capability and are taking steps to address the issue. This includes a jointly appointed Independent Chair, Programme Director and PMO to support the delivery of the programme.

At a glance

PwC view:

- *We have sought to maximise local ownership of the implementation plans, with local Executives or Directors leading each component of the plan.*
- *Implementation risks will need careful management.*
- *With these matters considered, we recommend the model of care should be implemented.*

8 There is strong local support to the model of care, but there are implementation risks that will need careful management

- We have worked with local leaders to develop the implementation plans to deliver the model of care.
- We have engaged extensively in the local health and care economy throughout the CPT and taken key interim and final findings to the Trust's Board, CCG's Governing Body and TMBC's Cabinet.
- Key risks for implementation have been discussed and provided to Monitor and local leaders and will require careful management.

9 Next steps

- Some steps towards implementation have occurred already:
 - The Independent Chair of the new system wide Programme Board and the Programme Director have been appointed;
 - The CCG has been considering if it is comfortable the Trust becomes the provider of the model of care in line with relevant regulations;
 - The CCG included the model of care within its locality plans that have gone into the Greater Manchester Devolution; and
 - The first Programme Board has taken place.
- In the next 30 days:
 - Monitor to consider this report;
 - NHS England to clarify their local assurance process (previously the gateway process);
 - The next Programme Board meeting; and
 - Further consideration of the additional capability and capacity the stakeholders and the local economy should build.
- Beyond this, other key milestones are:
 - The CCG developing its commissioning intentions for the model of care and consulting with the scrutiny panels in Tameside and Derbyshire on whether public consultation is needed;
 - Addressing the implementation costs, linked with the Greater Manchester Devolution funding position;
 - Transferring services into the Trust; and
 - Changing services at the care provider level i.e. the roles of each individual, training and changing the model of service delivery.

Model of care

Model of care	10
Introduction to the model of care	11
Key elements of the model of care	13
Benefits of the model of care	14
Model of care: Primary care involvement	15
Model of care: Preventative and proactive care	16
Model of care: Urgent Integrated Care	17
Model of care: Planned care and maternity care	19
Model of care: Hospital specification	20
Model of care: Provider considerations	22

Integration of care provides an opportunity to improve both outcomes and affordability.

However, these benefits require care to be delivered in a fundamentally different way – through a new ‘model of care’.

The CPT has co-developed a model of care that provides the best opportunity for a viable and affordable provider.

The model of care described in this chapter is supported by implementation plans.

Introduction to the model of care

CPT key points:

- *The model of care co-developed by the CPT and local system provides a coherent description of how care could be delivered by the Trust.*
- *The model of care is informed by service specifications which include bottom up costed workforce models.*
- *There is local buy in for the model of care which has been aligned with the Care Together Programme.*
- *While primary care has been engaged and alignment increases with the CCG's primary care strategy, further work will need to be undertaken by the CCG on contract arrangements.*

Why develop a model of care?

- There is little robust evidence in the UK (or elsewhere) that simply combining teams or merging organisations delivers significantly better value care.
- International examples of successful Integrated Care Organisations (ICOs) that manage population demand risk have developed their own models of care over time in response to commercial pressures. These have significantly improved the financial and clinical value associated with services.
- In Tameside and Glossop, we have developed the model of care as part of the CPT process, in order to:
 - Calculate and demonstrate the potential benefits of how integrated care could improve value;
 - Help articulate to the local population and care professionals how care will be provided;
 - Create an evidence base to drive decisions on provider organisation form and commissioning; and
 - Assess clinical and financial sustainability.

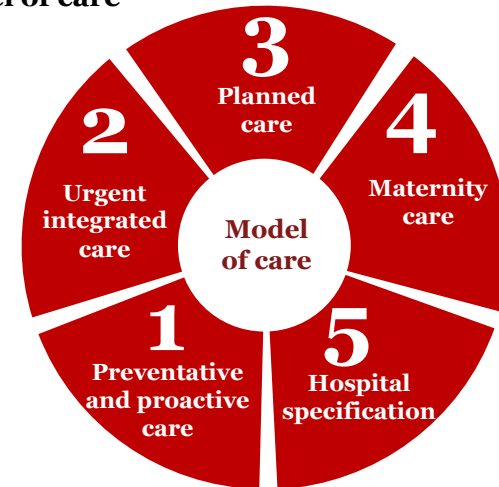
How the model of care was developed

- The model of care was jointly developed with care professionals, patient representatives and the CPT:
 - The model of care was developed taking into account national and international best practice which was used to inform a cost and activity model which details the benefits of the new model of care;
 - The CPT has run workshops on patient scenarios and the role of mental health in the new model of care;
 - An evening event was held with GPs and the CPT has attended primary care locality meetings; and
 - The Primary care strategy developed by the CCG is aligned with the incentives of the model of care.

The key elements of the model of care

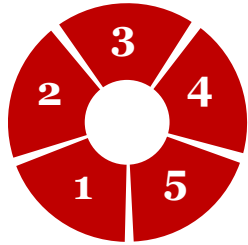
- The CPT undertook design work around the key elements of the model of care – as patients and citizens experience and interact with them. The 5 areas where specific design work was focussed are noted below and elaborated on over the next few pages.
- Planned care, urgent care, maternity and preventative and proactive care where designed through Care Design Groups ('CDGs').

The key elements of the newly designed model of care



- The structuring of the services into the key elements allowed local professionals to engage in how they could best work together.
- The key elements are also driving the development of detailed service specifications as part of the implementation governance. This will be used to inform the design and commissioning of services going forward.

Introduction to the model of care



CPT key points:

- *The patient centred model of care combines the currently disparate services into an integrated model of providing the health and social care for the population of Tameside and Glossop.*

The model of care has been designed with the person / patient being at the centre and aims to deliver better patient outcomes for the population of Tameside and Glossop within an affordable financial envelope.

The model of care focuses on four key areas:

- Preventative and proactive care;
- Urgent care;
- Elective care; and
- Specialist input.

The key features of these areas are described below.

Preventative and proactive care

- The whole system has a responsibility to keep people well and independent as long as possible with care being delivered in the lowest cost setting while maximising patient outcomes.
- A key principle in this emerging model of care is that community resources are developed and optimised so that there is a clear understanding of how they can help the individual.
- People and patients have a responsibility to maintain their own health and take an active role in managing their care.
- A key mechanism for delivering the proactive care approach is through LCCTs.
- The LCCTs bring together delivery across primary care, mental health, community care, social care, secondary care and the 3rd sector.
- The LCCTs coordinate care through actively managed care plans and share expertise across the teams.

- Risk stratification and early identification of potential issues are an important role of the LCCTs and GPs.
- The LCCTs can work with any individual but tailors services depending on level of need.

Urgent care

- In the event that there is a crisis, this is managed by one cross Tameside and Glossop Urgent Integrated Care Service (UICS).
- The UICS will have unequivocal responsibility for looking after local people who are in social crisis, or who are seriously unwell.
- The UICS acts as a single point of access and can mobilise all relevant assets and resources across the health and care system to help get the patient well and back in the lowest cost and most appropriate care setting as quickly as possible. There is clear accountability between the LCCTs and the UICS.
- There is a range of services sitting under the UICS including A&E, rapid response team, discharge team and intermediate care.

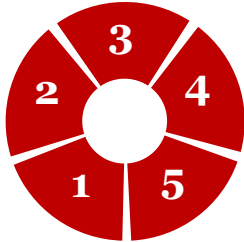
Elective care

Elective care is delivered in the most efficient way possible, with non-surgical interventions being considered where appropriate and timely interventions made to keep levels of acuity as low as possible.

Specialist input

- Access to specialist input is managed at a T&G level rather than specialists being allocated to individual LCCTs.
- Specialist input needs to feature early in care pathways, rather than only “at the end”.

Key elements of the model of care



CPT key points:

- The structuring of the services into the key elements allowed local professionals to engage in how they could best work together.
- Through the new governance structure, the CDGs' workstreams will work together to determine relationships and links between the 5 interrelated elements of the model of care. This will be used to inform the design and commissioning of services going forward.
- Specific efficiencies from the model of care were identified through CDGs in which care professionals and local public and patient representatives gave their views on how care could be improved.

The key elements of the model of care

- As described previously, the CPT undertook design work around 5 key elements of the model of care – as patients and citizens experience and interact with them.
- The table below describes some of the features of the 5 key elements of the model of care.
- Further detail on these is provided on the following pages.

Key element	Features of this element of the model of care	Benefits
1 Preventative & proactive care	<ul style="list-style-type: none"> • Currently, responsibility for the proactive and preventative care is diffused, and most care provided is reactive (responding to crisis or urgent need, rather than managing a condition to obviate or minimise crises or urgent need). • In the new model, 5 fully integrated LCCTs will have clear and unequivocal responsibility for the long term outcomes of the populations they serve. This multi-disciplinary team will proactively engage with patients with long term conditions, to help them manage their conditions in their own homes. 	<ul style="list-style-type: none"> • Proactively managed health for at risk parts of the population. • Earlier interventions reducing downstream crises and costs.
2 Urgent integrated care	<ul style="list-style-type: none"> • All of the urgent care resources will be managed as a single operational unit – including A&E, out of hours primary care and the aspects of community healthcare, mental healthcare and social care that need to be able to respond to a crisis (Urgent Integrated Care Services). • Response will be co-ordinated and increasingly in people's own homes. • Care professionals able to access key care services – e.g. A&E and CCU doctors able to “admit” patients to an urgent social care home package. 	<ul style="list-style-type: none"> • Simplified services – reducing complexity and duplication in expensive 24/7 services. • Unnecessary hospital stays avoided.
3 Planned care	<ul style="list-style-type: none"> • Alignment of community and hospital services, as well as appropriate referral management, through single management and capitated budgets • Networked provision – with access to greater specialist expertise and critical mass. 	<ul style="list-style-type: none"> • Access to improved networked services. • More defined and efficient portfolio.
4 Maternity care	<ul style="list-style-type: none"> • Maintain the excellent ante-natal services provided for mothers in deprived areas in T&G. • Maintain obstetrics-led maternity pending The Cumberlege Review findings. 	<ul style="list-style-type: none"> • Local services protected.
5 Hospital specification	<ul style="list-style-type: none"> • In the model of care every resource, including the hospital, is brought together around the elements of care above. We consider the following factors: <ol style="list-style-type: none"> 1. Key services have significant fixed and stepped costs (such as the need to have 24/7 consultant cover, PFI estates and diagnostic services); and 2. Critical mass is required to deliver services safely and affordably. 3. Tameside Hospital as an elective surgical centre with an A&E (as part of the UICS), maternity services and a reduction in medical beds and overall activity by c18%. 	<ul style="list-style-type: none"> • Efficient use of healthcare assets. • Local hospital services.

Benefits of the model of care



CPT key points:

- *This model of care is not a “soft” aspiration or intention – it represents a radical restructuring of how all of the resources and assets in the system are deployed.*

Benefits for the population

- We believe that there are a number of benefits within this model of care, including:
 - Less fragmented care, with fewer handovers and greater continuity whether in hospital, at home or in the community.
 - Services structured to be able to look after people with multiple physical and mental health, and social care needs.
 - A far greater focus on preventing ill health, and proactively keeping people as healthy and well as possible.
 - A provider structured and incentivised to promote and protect their long term health and social outcomes.

Benefits for the Trust

- The Trust would have control over a sufficiently broad range of resources to be able to plan end-to-end care, prioritise resources and ultimately be best placed to accept population demand risk.
- The model of care is compatible with Healthier Together and Manchester Devolution.
- The organisation will have a clear sustainable model for the future and will improve the ability to retain and attract staff.

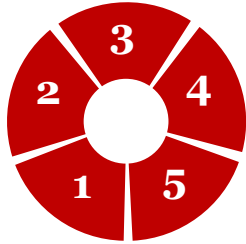
System benefit

- The impact of the model of care through better preventative and proactive care, a more efficient and joined up approach to dealing with crises, a networked approach to planned care and effective use of system resources will deliver a range of benefits outlined below:
 - Based on the KHO3 quarterly collection of beds available/occupied, the Trust has 449 general and acute

beds, 41 day case beds and 29 maternity beds.

- Over the period, the CPT is forecasting a 'do nothing' need for 92 additional general and acute beds, 3 additional day case beds and 4 additional maternity beds.
- The impact of the changes (net of the demand increase) is a 246 bed reduction in general and acute beds and 30 bed increase in day case beds (no change in maternity beds). This bed reduction represents a significant part of the financial savings associated with this model of care.
- Therefore the hospital will reduce in size to 203 general and acute beds, 71 day case beds and 33 maternity beds.

Model of care: Primary care involvement



CPT key points:

- *The continued engagement of primary care in the new model of care is crucial to its delivery.*
- *GPs have been engaged throughout the CPT and the CCG has developed its Primary Care Strategy that aligns incentives with the model of care.*
- *Use of Extensivist roles to manage the needs of high-risk cohort of patients can help to ensure the benefits of general practice inclusion.*

Primary care involvement

- The newly designed model of care will require substantial doctor time to be focussed on the 5% highest risk patients in the region (c10,000 adults in T&G).
- This would require working with 35-40 doctor WTEs to be dedicated to this role which would equate to 2 sessions per week focused on these high risk patients.
- Some GP practices already employ GPs whose time is dedicated on working with high risk patients such as those in nursing homes.
- Moving to this new way of working for GPs would require a new approach.
- The CCG has developed the new primary care strategy which from 2016/17 will incentivise GPs to deliver the new model of care. This means GPs would be working in ways that align with the model of care and as such all benefits would be delivered.
- After 2016/17 GPs may join the Trust as salaried staff with further increase in organisational and operational alignment.

Extensivist model

- The CPT considered the employment of Extensivists and has designed a way forward as it believes it to be innovative. Extensivists are hospital-based specialists who would focus on a cohort of high-risk patients. Extensivists would be trained and experienced in looking after patients with complex medical conditions which may exceed GP's expertise.
- CPT analysis indicates that managing c10,000 high-risk patient cohort would require 40 WTEs Extensivists.
- This would by far exceed the supply of suitable doctors (currently the Trust employs 6 consultant general

physicians and geriatricians) and would cost c£3m.

- Therefore, an Extensivist model alone is not deemed sustainable and the CPT proposes a combination of GPs and hospital physicians (Extensivists) to cover the needs of the high-risk patient cohort.
- This will comprise of 12 WTE Extensivists in addition to the GP staffing in the model of care. This would allow Extensivists to review the cohort of c10,000 patients once every quarter for half an hour, supplementing and supporting existing primary care activities.
- The extensivist model would be subject to availability of personnel in the market as well as suitable working arrangements being put in place with GPs.

Model of care: Preventative and proactive care



CPT key points:

- In order to reduce complexity and ensure clear responsibility, the CPT has developed a model of preventative and proactive care based on geographic populations (rather than a disease specific or population subset approach).*
- The LCCTs draw in both core primary care and resources such as diagnostics and consultant skills that are currently focused on Tameside Hospital.*
- Clinical accountability will reside with either the GP or consultant. Bringing all providers together under one structure will tighten clinical accountability.*

The current model of preventative and proactive care

- Currently, responsibility for the proactive and preventative care is diffused amongst a range of different organisations between TMBC, the CCG, the Trust and other care providers.
- The overwhelming majority of care provided, including primary care, is reactive – responding to crisis or urgent need, rather than managing a condition to obviate or minimise crises or urgent need, and the services provided are complex, duplicated and unevenly distributed.

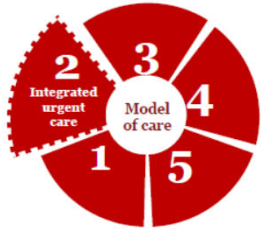
We recommend 5 Locality Community Care Teams (LCCTs)

- The 5 LCCTs will be responsible for:
 - Identifying people who would most benefit from preventative and proactive care (risk stratification);
 - Using multi-disciplinary teams to develop care plans, share these across the system and maintain them so they reflect current status; and
 - Assigning care co-ordinators.
- With primary care at the very centre, these teams will empower citizens and patients to better manage their own care and remove the boundaries between services and care professionals.
- Geographically, the localities are coterminous with the TMBC localities and Glossop, which will be supported by Derbyshire County Council from a social care perspective.
- The 5 localities have differing populations with different needs. Consistency and simplicity in LCCT structures are also key – so LCCTs will have the same operating model – however, the level of resourcing in different specialist roles will vary in response to different population needs.



- The LCCTs will draw together all of the care resources that support preventative and proactive care – including primary care, community nurses, drug and alcohol teams, mental health practitioners and others – into single operational units across each LCCT area.
- LCCTs will have clear and unequivocal responsibility for the long term outcomes of the defined populations they serve. In order to achieve this they will have:
 - Control over all of the health and care resources so they can be directly deployed, co-ordinated and focussed on those who would most benefit; and
 - Shared risk and incentives across every constituent part of the LCCT.
- Our modelling indicates that the LCCTs will be staffed by 478 WTE (in comparison to the current establishment of 477 WTE). This includes:
 - New locality management roles;
 - New care coordinator roles; and
 - A restructured and retained workforce based in localities and focused around multidisciplinary ways of working.

Model of care: Urgent Integrated Care



CPT key points:

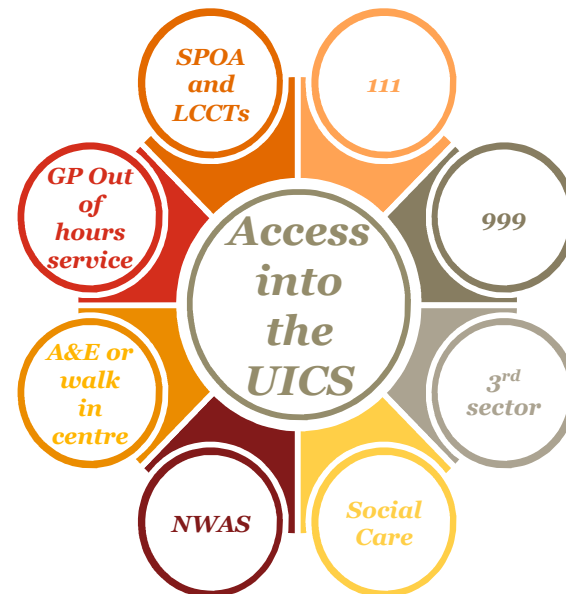
- *In the event that there is an unplanned decline in a person's health it will be managed by a single T&G UICS.*
- *The UICS will have unequivocal responsibility for looking after local people who are in social crisis, or who are acutely unwell.*
- *The UICS acts as a single point of access and can mobilise all relevant assets and resources across the health and care system to help get the patient well and back in the lowest cost and most appropriate care setting as quickly as possible.*
- *There is clear accountability between the LCCTs and the UICS.*

The current model of urgent care provision

- Various different services are run separately, with A&E, out of hours primary care and other key elements of urgent care response run by different organisations.

The new UICS

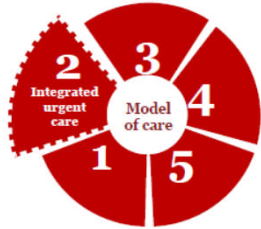
- The proposed UICS will draw together all of the resources that need to be able to respond to urgent needs under a single operational management – including A&E, MAU, urgent primary care as well as some key mental health, social care and other support that needs to be deployed rapidly. These services are noted in the diagram below.
- The UICS will have unequivocal responsibility for looking after local people who experience a crisis (whether medical or social). They will look after people from the moment they report their difficulties, until they have undergone diagnosis, treatment, support and rehabilitation in order to be able to live independently or with the help of the LCCT.



Accessing the UICS

- Access into the UICS could be through different routes as shown in the diagram below.
- Specific details of how 111 and 999 will link in with the UICS will build on existing local plans and include:
 - Pilots are in place with NWAS to identify “alternatives to transport”; and
 - Community Risk Intervention Teams (CRIT) led by Greater Manchester Fire and Rescue Service respond to low-priority calls from NWAS to falls in the home, where they can help people to stay in their own homes rather than going to hospital. They will also attend calls from Greater Manchester Police involving low level mental health crises.
- Mental health crises are dealt with in the UICS through a range of services including the access and crisis team, RAID, street triage, the home intervention team and the home treatment team. Access is as shown in the diagram opposite although some patients may directly access the LCCT (i.e 999 / 111 to LCCT rather than UICS if most appropriate).
- The UICS would be staffed by 326 WTE (in comparison to the current establishment of 378 WTE). This includes:
 - Urgent care village / triage;
 - Urgent Assessment Response Team; and
 - Delivery of intermediate care.

Model of care: Urgent Integrated Care



CPT key points:

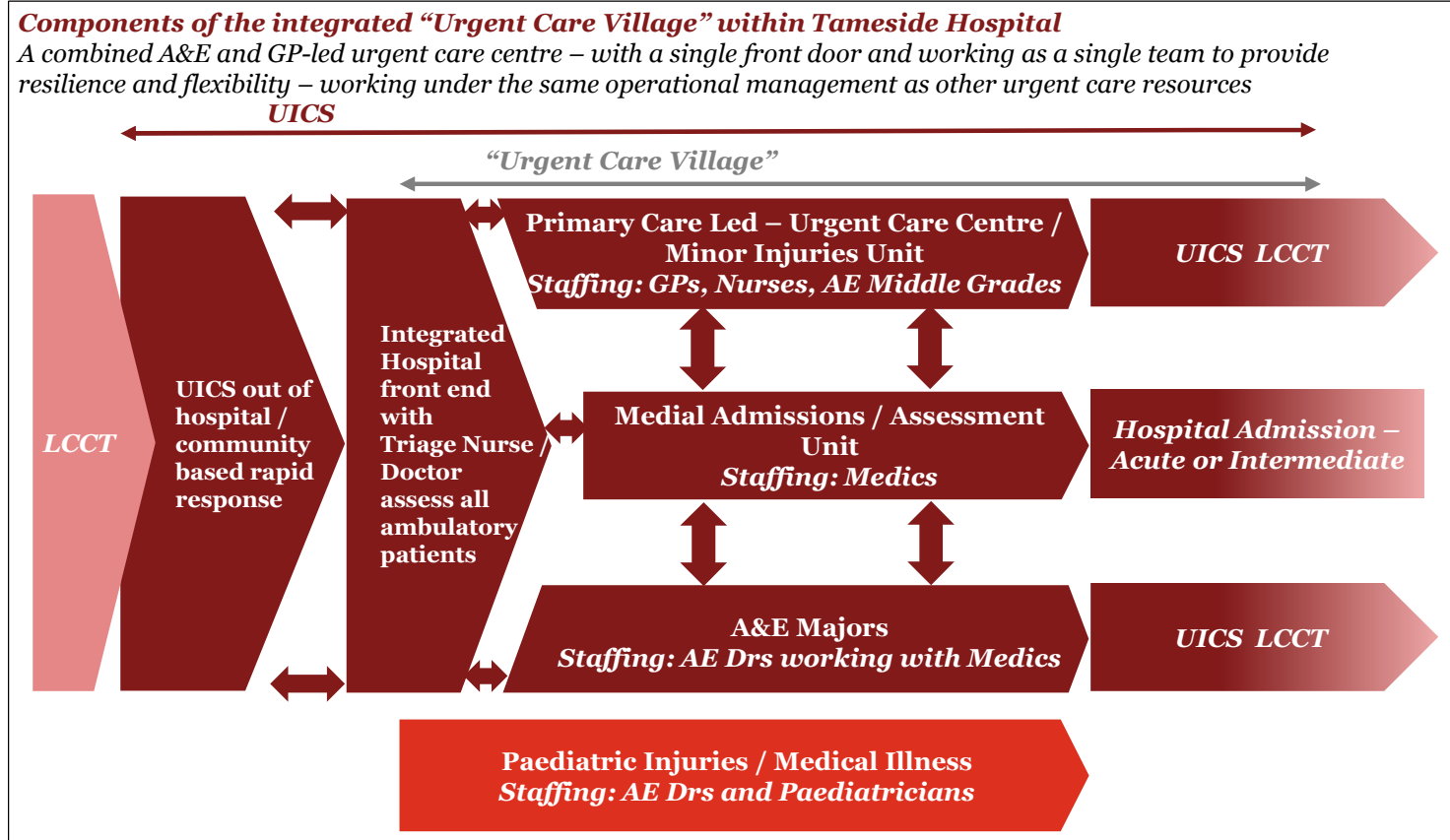
- The CPT model of care retains an A&E as part of the UICS.
- The retention of local A&E services – in addition to being no more expensive than sending A&E activity out of area – provides key resources and expertise to support urgent care response throughout the community as an integrated part of the UICS. It also smooths discharge routes as well as avoiding additional travel for patients.
- Key urgent care services that require scale to be effective and efficient – such as emergency surgery and complex medical patients – will be centralised at larger A&Es outside of T&G.

Urgent care within Tameside Hospital

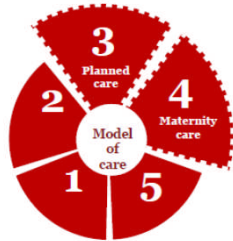
- Unlike the 5 LCCTs, the high cost and variable demand mean that a single service UICS model will be available for all of T&G.
- Wherever possible, the UICS will respond to urgent needs in community settings.
- Within the Tameside Hospital site, all physical urgent care services (A&E, Walk-In Centre, emergency primary care, etc.) will be co-located as an “Urgent Care Village”.

Flow of patients into and out of hospital

- The model will support the effective flow of patients through the health and social care system.
- With access to alternative care options within direct control, individuals are only admitted to hospital when absolutely required.
- The discharge team as part of the UICS would take an integrated team approach to supporting discharge from bed based care back to the person’s home.

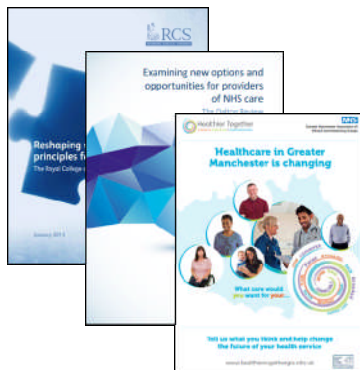


Model of care: Planned and maternity care



CPT key points:

- *Retention of key services is contingent upon agreement of networking with other providers (although many such agreements are already in place and operating).*
- *Decisions on maternity services will need to be reviewed once The Cumberlege Review report is published.*



Planned care

There is building evidence of the need for scale in planned care, including:

- The **Royal College of Surgeons** recent analysis showed centres which undertake higher numbers of complex and emergency surgery, have better mortality and morbidity rates improving quality of care for patients;
- The **Dalton Review** suggested networked models of care between high performing larger organisations and smaller organisations to improve quality of care; and
- **Healthier Together** review for Greater Manchester has already suggested a networked model of care for surgical services with central hubs for complex surgery.

As part of Healthier Together, all planned care services will be delivered as part of wider clinical networks. The Trust already delivers a significant proportion of planned care through networks.

Building on the structured review of Location Specific Services performed by T&G CCG, the CPT applied criteria to assess the clinical sustainability and operational efficiency of delivering different planned care services at Tameside Hospital.

CPT recommendation for planned care

The portfolio of planned care surgery recommended in the model of care to be delivered at Tameside Hospital includes:

- Daycase surgery for simple cases for the population of T&G;
- Simple overnight surgery (e.g. joint replacements) where overnight cover can be provided by medical staff, rather than requiring dedicated overnight surgical support; and
- Daycase surgery for patients from outside of T&G as part of the Healthier Together review of hospital portfolios pending commissioning decisions such that providers can share access to assets and infrastructure.

Maternity care

The Trust currently provides an obstetrician-led maternity service at Tameside Hospital. This service incurs very high CNST (insurance) premium charges – primarily due to historical claims.

With approximately 2,500 births per year, and with complex births being transferred to other hospitals, the CPT looked closely at the quality, sustainability and economic viability of the service.

There is significant support for the ante-natal care provided in the community – particularly for mothers from deprived backgrounds. However, the link between the quality of this service and the location of the birth could not be firmly established.

Quality of outcomes and patient experience have improved. A range of options for the service has been considered.

CPT recommendation for maternity services

The CPT has determined that the financial savings of closing the unit – even without costs of building additional capacity elsewhere – are marginal.

Given the national review, it would seem inappropriate to make a decision to close the unit pending their findings which are likely to materially impact upon this decision.

Model of care: Hospital specification



CPT key points:

Under the CPT model of care, more local services are retained at Tameside Hospital than under the CCG's previous ICO plans. This reflects:

- *The benefits of integrated care rely upon having sufficient expertise focussed on the local population and working closely alongside local GPs and other community-based care professionals.*
- *The financial benefit of moving activity elsewhere is marginal or negative if local stranded costs and the cost of providing that care elsewhere are included.*

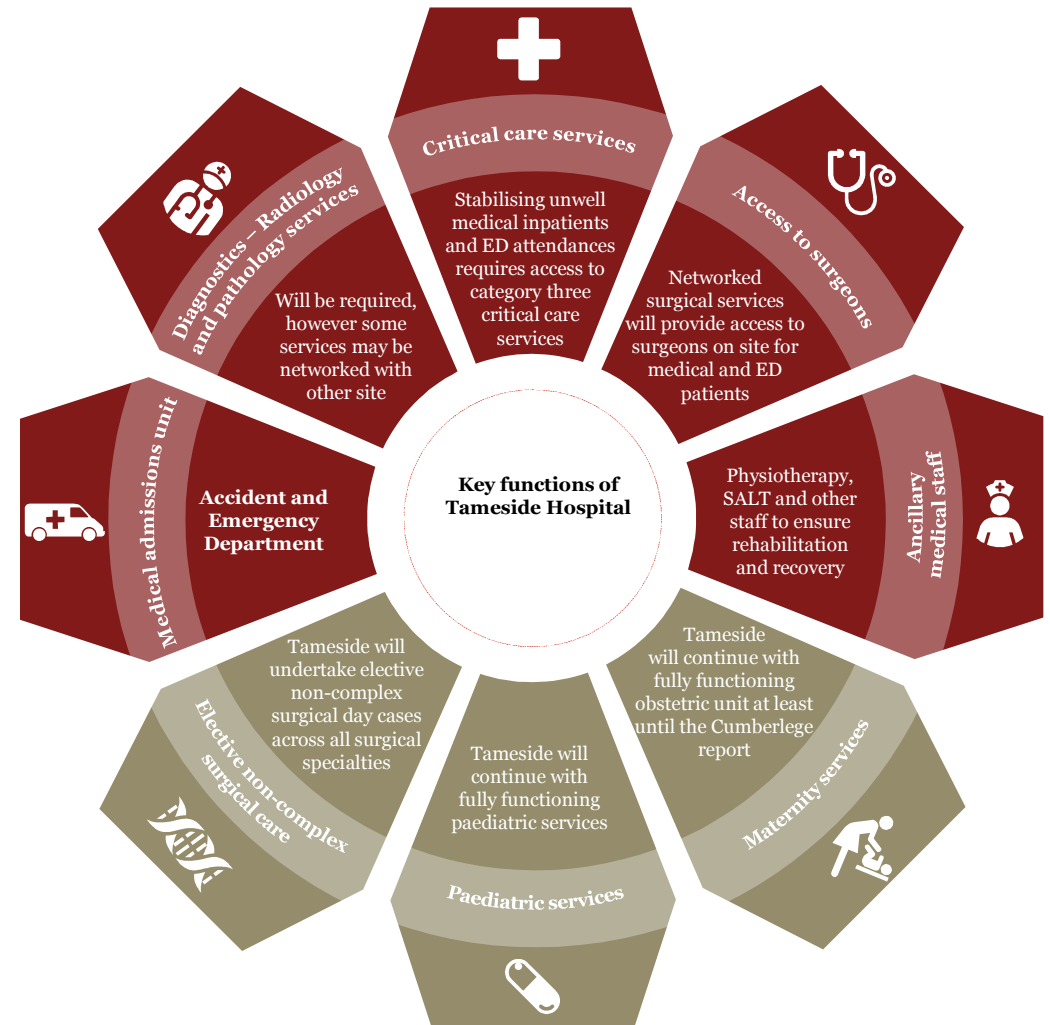
Description of Tameside Hospital

- The Trust will use Tameside Hospital site as a core inpatient medical unit with focus on acute medicine, non-interventional cardiology, respiratory, gastroenterology, geriatrics and stroke rehabilitation with associated required specialties.

Key functions of Tameside Hospital

- The diagram to the right shows the key functions that will be provided at Tameside Hospital.
- These functions have significant clinical and resource inter-dependencies.
- The hospital will be an asset to the community, with LCCTs, UICS both benefitting from access to local specialist expertise and diagnostic capabilities from Tameside Hospital.
- High acuity inpatient medical services will form the core function of the hospital.
- Surgical services consist of elective non-complex day case and simple overnight surgery where overnight cover can be provided by medical staff.
- Maternity services will continue at least until The Cumberlege Review reports.
- Paediatric services continue to be delivered in an integrated fashion.
- Critical care and diagnostic services are required for a safe functioning inpatient medical unit.

- Acute surgical services including; general surgery, gynaecology and orthopaedic trauma will be networked with other local services.
- This portfolio of services is clinically sustainable, and optimises the balance between localism and scale.



Model of care: Hospital specification



CPT key points:

- 6 core medical specialties will form the main function of the hospital. Other medical specialties will be provided by visiting consultants.
- All complex and emergency surgery will be networked across other acute providers.
- Maternity services will be maintained but should be re-assessed after the national review.

¹ Assumes continuation of current occupancy rates

² Assumes maintaining current theatre throughput, with similar weighting for inpatients and daycases in theatre times

³ 11 theatres with 6 in the PFI

Core elements of the Hospital Specification

Building on the overall specification on the previous page, the boxes below provide further detail on the function of Tameside Hospital.

Medicine

The majority of patients currently admitted as medical inpatients are in six core specialties: *non-interventional cardiology, respiratory medicine, gastroenterology, geriatrics, neurology (stroke) and acute medicine*. As part of the ICO, this will form the core medical services of the hospital albeit with a reduced number of medical inpatient beds.

For a clinically sustainable delivery of inpatient medical services – there is a requirement for access to diagnostics (radiology and pathology) and critical care access at level 3 for all patients across the hospital.

Supporting the entry of medical patients will be an integrated A&E function with Urgent Care and medical administrators working in an integrated ‘urgent care village’.

Hospital doctors will work in a much more integrated fashion with community colleagues in MDTs and ensure specialist expertise is available much more readily.

	Current	‘Do nothing’	‘Model of care’
Inpatient episodes	28,099	34,332	18,627
Inpatient bed requirement ¹	340	415	196

Maternity and Paediatrics

Tameside currently runs a good quality maternity service as assessed by CQC, but due to historic claims, it pays high negligence indemnity costs impacting profitability. There is currently a national review of maternity services being undertaken by Baroness Cumberlege. However, removing all maternity services from Tameside will have minimal financial impact to the whole health economy.

In the interim, whilst the national review is ongoing, we suggest to continue with an obstetrics led maternity unit. Coupled with this, Tameside will continue to provide an integrated paediatric unit which will further integrate with children’s social and community care.

	Current	‘Do nothing’	‘Model of care’
Deliveries	2,628	2,902	2,902
Other obstetrics episodes	6,087	6,749	6,757
Paediatric episodes	4,069	4,390	3,646
Inpatient bed requirement ¹	52	57	52

Emergency surgery and Gynaecology

In line with regional and national trends, complex and emergency surgical services will soon be centralised across Greater Manchester. The vast majority of all current activity at Tameside is non-complex day case for general surgery and gynae with relatively small numbers of emergency activity for both specialties. Running emergency theatres for small number of non-complex emergency patients would not be cost-effective.

Tameside would cease to undertake all emergency and longer stay complex general surgery. However, it has 11 theatres which would become an elective non-complex day case centre for all surgical specialties to increase operational efficiencies and reduce specific unit costs.

All surgical specialties would be networked with hospitals and surgical opinions available for all inpatients twice daily.

	Current	‘Do nothing’	‘Model of care’
Inpatient episodes	5,615	6,952	-
Inpatient bed requirement ¹	80	97	-
Theatre requirement ²	2	2	-

Planned care

As with general and gynae surgery – all sub-specialty services in both medicine and surgery will be provided on a networked basis as a single service specialty model across other hospitals. Specialties which are more currently conducted on an outpatient basis such as dermatology, rheumatology, breast surgery, ENT and ophthalmology will all be provided on a networking visiting basis from other organisations. For both inpatient opinions and outpatient clinics. All sub-specialty inpatient admissions will be at other organisations due to the small volume of patients and specialist requirements.

	Current	‘Do nothing’	‘Model of care’
Medical inpatient episodes	407	436	462
Surgical inpatient episodes	3,102	2,865	1,012
Medical day cases	5,368	6,178	5,216
Surgical day cases	11,123	11,325	20,563
Inpatient bed requirement	84	86	96
Theatre requirement	5	7	7

Model of care: Provider considerations

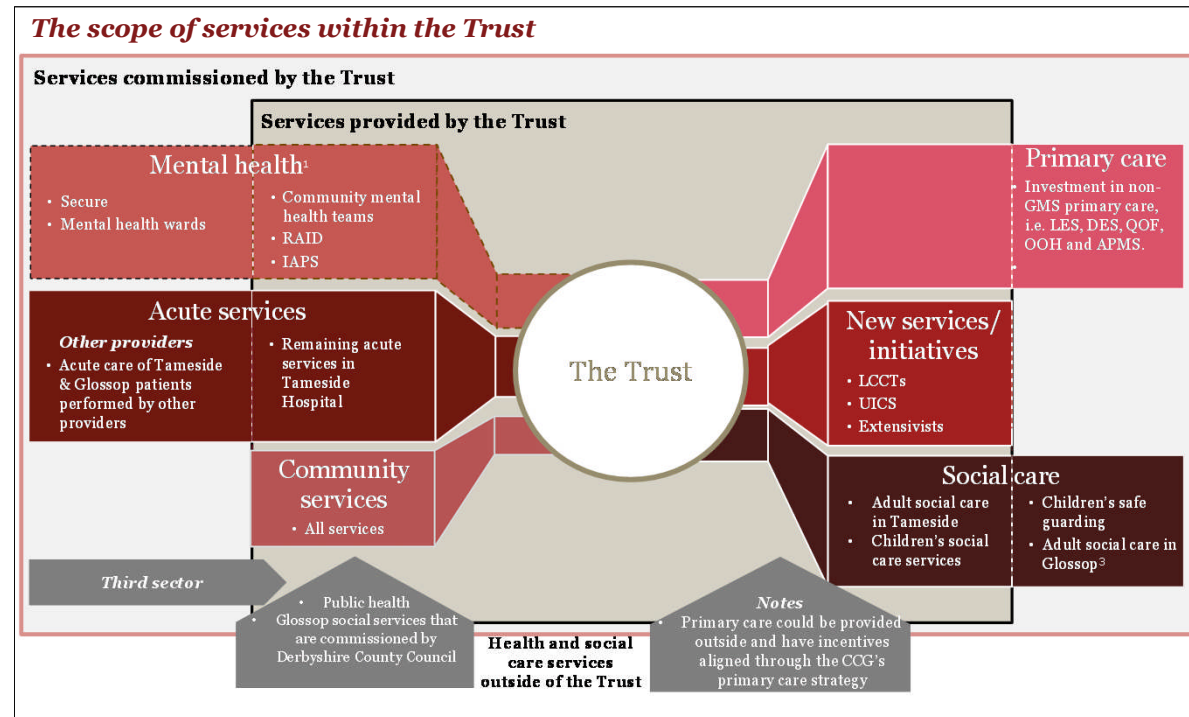
CPT key points:

- *In our view in order for the model of care to truly integrate services it requires single operational management, shared incentives and long term accountability for health outcomes. This is most simply delivered through a single provider where possible.*
- *Primary care will be incentivised through the new Primary Care Strategy which will influence GP involvement.*
- *The CPT's recommendation is that the main provider and prime contractor should be the Trust.*
- *A long term capitated contract would be an appropriate type of contract for the Trust.*

Provider scope and shape

- The model of care describes how the resources in Tameside and Glossop will be optimised by working as integrated functions.
- Currently these resources are held within multiple different organisations. The CPT recommends a single provider form with the scope laid out in the diagram below.
- The rationale follow these 3 criteria:
 - **Simplicity:** Minimising the need for complex alliance contracting or sub-contracting where possible;

- **Single operational management:** a single provider with operational management of staff etc can ensure services are fully integrated and deployed in the most effective way overall.
- **Ability to implement:** This form and scope recognises that it is easier to implement the changes as one organisation but implementing some options – such as employing all GPs directly – is more difficult.
- The diagram below sets out the CPT recommendations for the scope and shape of the integrated care provider.



Organisational form

The CPT has concluded that the Trust would be an appropriate vehicle to be the new integrated care organisation. There is strong (but not universal) informal support for this locally in Tameside and Glossop, but it is for the CCG to determine whether it wishes to select

the Trust as the 'delivery vehicle' or integrated care organisation. If the Trust were to take on this role, its leadership and management would need to have significant additional skills and capacity to enable the effective provision of services the Trust does not currently provide, such as community and social services across Tameside.

Clinical sustainability

Clinical sustainability	22
Clinical sustainability of the model of care	23
Improvements and risks associated with the model of care	24

We have assessed the clinical sustainability of the model of care. The reason for undertaking this assessment is to show that the services in the model of care are clinically sustainable. Without this, the services could not be provided safely. The proposed service changes should improve clinical sustainability.

Assessment by the implementation workstreams and the overall governance arrangements will need to continue through the implementation process.

Clinical sustainability

CPT key points:

- *We have assessed the clinical sustainability of the model of care assuming it is provided by the Trust as the future ICO.*
- *Our view is that the model of care is clinically sustainable.*
- *The proposed model of care improves almost all dimensions of clinical sustainability. Only travel times for patients with surgical emergencies and elective inpatient procedures could suffer due to larger distances. A recent review has found travel distances for such services acceptable, by not classifying them as Location Specific Services to Tameside Hospital.*
- *The report of the 2015 CQC inspection is pending and it remains to be confirmed that all issues raised in the 2014 report have been resolved.*

Clinical sustainability

- The CPT has assessed the clinical sustainability of the model of care, assuming that the Trust would provide these services as the future Integrated Care Organisation. Given that the Trust was rated inadequate in the 2014 CQC inspection, clinical sustainability has to be ensured beyond addressing the shortcomings in the CQC inspection.

Approach

The Trust was reviewed again by the CQC in April 2015 after a new senior management team had focussed on addressing the concerns in the 2014 report. The 2015 CQC report has not yet been published by the time of this report, however we have assumed that shortfalls identified in 2014 have been addressed.

Clinical sustainability has been the major consideration underpinning the entire process of designing the new model of care. Indeed, many specific features of the model of care have been shaped through iterations driven mainly by considerations of clinical sustainability. Our assessment focuses on clinical sustainability of the new model of care and the changes it would bring to clinical services. Our approach to the design and development of the model of care has had extensive clinical involvement and has included:

- Engagement with clinicians and patient representatives in Care Design workshops and other sessions;
- Discussions with a range of local and national clinicians including Monitor's Medical Director and clinicians in the Enforcement Team, clinicians in the CCG's Governing Body, GPs in all 5 localities, the Trust's Medical Director and Nursing Director and other Clinicians in the Trust;
- Reference to relevant national guidance such as from the Royal Colleges;
- Reference to the regional Clinical Senate who will review implementation plans for clinical services; and
- Clinicians in the CPT have undertaken the assessment.

Assessment and conclusion

We have concluded that the model of care is clinically sustainable. In reaching our conclusion, we note:

- **Safety, outcomes and patient experience (Quality)** will be improved compared to current services beyond addressing concerns of the 2014 CQC inspection (details on next page);
- **Workforce** challenges would reduce by networking hospital clinical teams with other providers to ensure adequate activity levels across provider sites for maintaining clinical skills, for training purposes, and to maintain on-call rotas; and
- **Clinical governance** will be improved by bringing currently diverse and fragmented provider teams under one integrated governance arrangement.

It is important that the CCG and implementation work streams continue to assess the clinical impact of all proposed changes during the implementation process.

Risks to manage post implementation

We have noted the key risks to manage post implementation;

- **Travel times** could be adversely impacted when patients for emergency surgery or elective inpatient procedures need to be treated at other hospitals. Some patients may arrive directly at the Trust's A&E and require transfer. After surgery, patients may be repatriated back to the Trust if further post-operative hospital care is required, leading to another transfer. Additionally, while inpatient at another provider, it would be less convenient for visitors to reach those patients.
- **Maternity workforce** would become unsustainable if the Royal College of Obstetricians and Gynaecologists ("RCOG") were to recommend on birth units being covered by 168 hours weekly consultant obstetrician presence. Such a rota only becomes sustainable at centres with at least 6,000 births. It is expected that the RCOG publishes new guidelines within the next 1-2 years.

Clinical sustainability

CPT key points:

- *Clinical sustainability improves significantly in the new model of care.*

	Improvements	Challenges and risks
Safety	<ul style="list-style-type: none"> • The entire model of care was designed with safety concerns at the centre during the design phase. • Sub-scale services (e.g. emergency surgery) are diverted to larger providers, or networked (e.g. elective surgery). • Integration of care across care settings improves communications and care monitoring. 	<ul style="list-style-type: none"> • Diverting surgical emergencies to other providers adds travel time. However a recent analysis by the CCG has found that travel times for emergency surgery are acceptable.
Outcomes	<ul style="list-style-type: none"> • Consolidating surgical activity in larger units (also when networked) improves outcomes. • Integrated care model with early expert clinician input early in care pathways leads to better outcomes. 	<ul style="list-style-type: none"> • N/A
Patient experience	<ul style="list-style-type: none"> • More services will be provided closer to home, which is a key driver of better patient experience. • Care professionals act as one integrated team providing one cohesive service. 	<ul style="list-style-type: none"> • Diversion of emergency and inpatient elective surgery to other providers makes access less convenient for patients and their visitors.
Workforce	<ul style="list-style-type: none"> • Networked services ensure sufficient activity to maintain skills, achieve better training and sustain on-call rotas. • “One team” approach has been shown to lead to greater staff satisfaction, which should help with local recruitment and retention. • New model of care does not require material numbers of additional staff. 	<ul style="list-style-type: none"> • Maternity: If RCOG insists on 168 hours per week of obstetrician presence, the service may become unviable. • Many members of current staff would require additional support and retraining to new roles and ways of working.
Clinical governance	<ul style="list-style-type: none"> • Bringing governance from multiple separate teams together into one governance arrangement. This reduces risk of governance boundaries with gaps and conflicts. 	<ul style="list-style-type: none"> • New governance arrangements have to be designed and implemented.

Financial sustainability

Financial sustainability	26
Summary of the financial sustainability assessment	27
The affordability challenge if the system does nothing	28
Impact of the model of care	29
Residual deficit and allocation	30
Financial sustainability of the Trust	31
Investment monies required to implement the model of care	32

In this section we have considered the financial sustainability of the Trust within the Tameside and Glossop health and care system. To achieve this, we have looked at the system’s financial challenge, the benefits of the model of care, the residual deficit and then, how this could be apportioned to the Trust and its commissioners. This allows us to undertake a financial sustainability assessment on the Trust.

Summary of financial sustainability assessment

We have modelled the financial impact of the model of care with the Trust as the provider.

CPT key points:

- *There is a system deficit before the benefit of model of care in FY20 of c£69m pa.*
- *The financial benefit of the model of care is c£28m pa.*
- *The residual deficit is c£42m pa.*
- *The residual gap has been allocated to the commissioners, so the Trust is breakeven.*
- *We believe the Trust is financially sustainable.*

Financial sustainability assessment

The CPT has modelled the activity and financial impact of the new model of care. This includes:

- Reductions in in-patient demand from proactive and preventative care;
- The costs related to the new out of hospital model of care including the LCCTs, UICS; and
- Costing of the different options for maternity services.

Financial modelling

We have performed a financial modelling exercise, to estimate the financial impact of 2 scenarios:

- 1. The ‘do nothing’ scenario** is used as a comparison against integrated care. This scenario maintains the current structure of delivering health and social care across Tameside and Glossop and is forecast up to FY20.
- 2. Integrated care scenario** reflects the impact on activity levels and the cost of provision from the new model of care described elsewhere in this document.

The table below describes some of the features of the financial analysis undertaken by the CPT. Further details on these are provided on the following pages.

Financial analysis	Summary of findings
1 The affordability challenge if the system does nothing	<ul style="list-style-type: none"> • We have modelled a ‘do nothing’ scenario, which maintains the status quo of separate organisations delivering care, along with ‘normal’ efficiencies. • This results in a forecast deficit of c£69m pa in FY20.
2 What is the impact of the model of care?	<ul style="list-style-type: none"> • We have modelled the financial impact of the model of care across the health and care system. • The benefit of the model of care reduces the system wide deficit by c£28m. • The (c£69m) deficit in the do nothing scenario in FY20 improves but leaves a system deficit of (c£42m).
3 There remains a residual deficit. We have considered how it should be allocated	<ul style="list-style-type: none"> • There are a range of ways that the residual deficit can be attributed set out in this part of the report. • On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, the deficit should rest with the commissioners.
4 The financial sustainability of the Trust	<ul style="list-style-type: none"> • The Trust would be financially sustainable.
5 The investment required to implement the model of care	<ul style="list-style-type: none"> • The implementation of the model of care will need an element of transition costs, we identify the type and likely amount. • The combined deficit will also need addressing but we note that the need would have been c£299m in 5 years before integrated care and c£216m in 5 years after the model of care.

The affordability challenge if the system does nothing

The affordability gap is based on the assumptions and plans from the Trust, CCG and TMBC.

CPT key points:

- The system has a growing financial deficit driven largely by rising demand, cost inflation and the underfunding of social care costs.
- The combined system deficit in 5 years is c£69m, after 'normal' efficiencies of c3% pa, comprising of the Trust c£23m and TMBC c£46m.

Approach to financial modelling and the financial impact of the model of care

Our financial analysis has taken forward the work undertaken by the CCG, Trust and TMBC:

- We have applied financial planning and demand assumptions to update the deficit for the whole system, split by organisation;
- We have built an activity and finance model, to show the cost of providing existing services and then the impact of the model of care and linked this with income, demand and other assumptions;
- Our approach is organisation agnostic when we consider how the cost of provision changes with the impact of the model of care (changing demand, acute configuration, LCCTs etc.) as it looks at system costs; and
- With the Trust as the provider of the model of care, we have then considered the cost of the provision in the Trust and a contractual basis for receiving income.

1 The affordability gap in a do nothing scenario

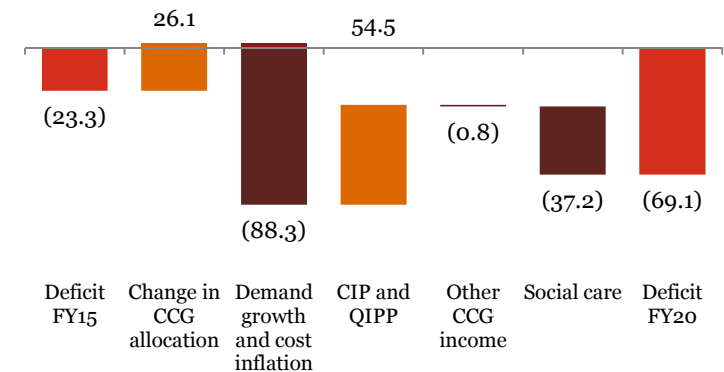
In FY15, the Trust finished the year with a c£15m deficit. Adding to this a small CCG surplus and a c£8m social care deficit of allocation against actual cost, gives a c£23m deficit for the health and care economy.

The key drivers of from the current deficit to the forecast deficit in 5 years are shown in the diagram opposite and include:

- Demographic demand growth;
- Non-demographic demand growth and cost inflation; and
- Benefits associated with QIPPs and CIPs of c3%.

Do nothing scenario £'m	FY15	FY20
System income		
T&G CCG allocation	332	358
Trust income from other CCGs	23	24
Other Trust income	13	11
Social care allocation	66	41
Total income	433	434
Cost of provision		
Trust expenditure	-173	-185
Commissioning of other services	-210	-231
Social care expenditure	-74	-87
Total expenditure	-456	-503
System deficit	-23	-69

Do nothing deficit (£m)



What is the impact of the model of care?

We have modelled the financial impact of the model of care with the Trust as the provider.

CPT key points:

- The financial benefit of the model of care is c£28m pa.
- This drives a significant reduction of the system affordability gap of £69m, but a system wide deficit of c£42m remains.
- The Trust, as the provider of integrated care, would have costs of c£414m pa, more than double the current costs.

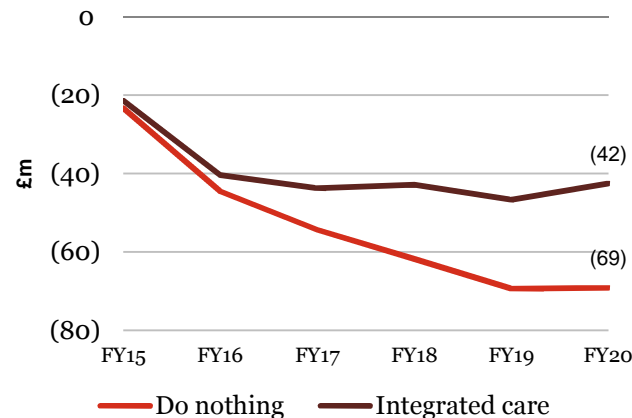
2 The model of care significantly improves the affordability gap within health and social care in Tameside and Glossop

The graph below shows our estimate of the 5 year deficit within the health and social care economy of a c£69m deficit. It also shows the benefit of integrated care in Tameside and Glossop, which reduces the deficit by c£28m, to c£42m. The table opposite details the split between income and costs.

The reasons why benefits for the model of care are greater in FY20 are:

- The model of care takes time to implement; and
- Once implemented, the benefits from preventative and pro-active care do not occur immediately.

System-wide affordability challenge



We have considered the phasing of the benefits of the model of care shown in the diagram opposite in line with the implementation plans described later in this document.

£'m	Do nothing		IC
	FY15	FY20	FY20
System income			
T&G CCG allocation	332	358	358
Trust income from other CCGs	23	24	20
Other Trust income	13	11	11
Social care income	66	41	41
Total income	433	434	430
Cost of provision			
Trust expenditure	-173	-185	-414
Commissioning of other services	-210	-231	-58
Social care expenditure (moves into Trust expenditure in the model of care)	-74	-87	-
Total expenditure	-456	-503	-472
System deficit	-23	-69	-42

The financial benefits from the model of care come mainly from the following:

- A reduction in demand for relatively expensive in-patient services;
- A resulting reduction in estate use at the Trust; and
- Managing the demand increase with the same financial envelope of community, social care and mental health services that operate in a new integrated model.

Contracting basis

We have considered the most appropriate contracting basis for the Trust as the provider of the model of care. Following workshops on this topic and discussions in the local OFG, there is a common view that this is the most appropriate contracting basis.

- Key features of the contract and its phased introduction are:
- A long term capitated contract with outcome based measures;
- Operating the contract in shadow form in FY17 following development and discussion of the outcome based elements between the commissioners and Trust in FY16;
- FY18 as the first year when the contract is in effect; and
- The commissioners and Trust may want to increase the impact that the outcome based measures have beyond FY18.

There remains a residual deficit. We have considered how it should be allocated.

CPT key points:

- *We have considered different bases for allocating the deficit and recommend an approach we believe is most appropriate.*
- *On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, our recommendation is that the deficit should rest with the commissioners.*
- *Whilst we have suggested ways that the deficit could be allocated, the system leaders are set on maintaining this residual gap as a system wide issue for resolving as a system.*

3 Allocating the residual deficit

In order to assess the financial sustainability of the Trust, the CPT has had to allocate the system’s residual deficit at an organisation level.

We have set out in the table below 4 ways in which the deficit could be allocated.

The CPT recommended basis for allocating the deficit

We have considered the 4 options below.

On the basis that the model of care costs what the CPT has estimated and it is what the commissioners wish to commission, it is our view that the deficit should rest with the commissioners. As a result, we are assuming that the cost of provision is covered by income and the Trust breaks even.

However, with a long term capitated contract, the Trust would bear the downside risk if the cost of provision was greater than the level of the contract.

The CEOs of the Trust, CCG and Council consider the residual deficit as a shared issue and this is consistent with TMBC and the CCG’s co-commission where they are pooling budgets. The Greater Manchester Devolution likely position will be to pool budgets across social care and health care as well. Nevertheless, the CPT’s recommended basis is supported locally but not yet fully ratified.

Further addressing the residual gap

The CPT has been asked to take a high level review of the likely opportunities for further reducing the gap. We have considered these through the Ops and Finance Group, compared the opportunities to the potential CIP opportunities at the Trust and across the system and our experience of the type of efficiencies from system wide change programmes. Outside of productivity and efficiency opportunities, which we have assumed will be part of the normal CIPs for the organisations, there are several further potential areas for reducing the residual gap identified by the system including:

- Estates reconfiguration – c£5m. The system believes that there are further opportunities to rationalise the estate and make revenue savings on estate running costs;
- Back office function consolidation. Joint commissioning and integration of services provides further efficiency opportunity – c£5m;
- A culture of continuous financial and operational improvement. Whilst difficult to quantify, lessons learnt from other economies overseas indicates this culture to be the single biggest contributor to improved financial and clinical performance; and
- Procedures of lower clinical value– limited opportunity in reviewing referral criteria for services.

Potential basis of allocating deficit (£m)	Trust	CCG	TMBC	Total
① All to commissioners	-	Combined deficit of 42		42
② All to TMBC	-	-	42	42
③ Pro-rata the benefits in proportion to the deficits in the do nothing scenario.	14	-	28	42
④ Shared equally	14	14	14	42

The financial sustainability of the Trust

We have undertaken the financial sustainability assessment assuming the Trust provided the model of care at a capitated payment set at a level at the cost of provision.

CPT key points:

- *It is our view that the Trust (as the primary provider of services under the new model of care) would be financially sustainable against the definitions described opposite.*
- *However, the capitated payment means that the financial risk for delivering the model of care on or under the level of the capitated contract rests with the Trust.*

Financial sustainability assessment

The tests for financial sustainability commonly used by Monitor are as follows:

- Ability of the Trust to pay its debts when due;
- Ability of the Trust to generate cash; and
- Ability to make a surplus.

The forecast system deficit comprises TMBC c£46m, the Trust c£23m and the CCG breakeven.

Applying basis 1 for allocating the deficit described on the previous page, the deficit is moved to the commissioners and the Trust is breakeven.

The Trust is therefore on the margin of being financially sustainable, however, we believe it will generate cash and pay its debts when due.

The Trust

The new model of care will see the size of the Trust grow as it takes on new services but the income from acute activity will reduce by 18%. The Trust transitions to a model where the majority of its income (62%) and costs (67%) relate to non-acute health and social care activities.

Our financial modelling of the Trust's future position assumes that all of the system wide deficit lies with the Commissioners. The deficit is driven almost entirely by the difference between the allocation for social care from TMBC £41m and the cost of provision of social care services £87m.

An alternative method of assessing financial sustainability

If only the NHS aspect of the forecast deficit in FY20 of £23m is compared against the benefit of the model of care of c£28m, there would be a surplus in the NHS of c£5m.

On the basis the capitated contract is set at breakeven for the Trust, the surplus would move to the CCG.

Whilst we do not believe that this alternative method is more appropriate, it does help to illustrate the impact that the size of TMBC's deficit has on the system.

Trust position £'m	Do nothing		IC
	FY15	FY20	FY20
Trust income			
Income from T&G joint commissioners (TMBC and CCG)	121	127	383
Income from other CCGs	23	24	20
Other Trust income	13	11	11
Total income	157	162	414
Cost of provision			
Trust acute costs	-154	-169	-122
Trust community care costs	-	-	-24
Trust mental health costs	-	-	-25
Trust social care costs	-	-	-87
Trust commissioning of other care services	-	-	-139
Trust other costs	-18	-16	-16
Total expenditure	-173	-185	-414
Trust deficit	-16	-23	0

Investment monies required to implement the model of care

CPT key points:

- *Implementation costs have been considered through the Operations and Finance Group as well as identified individually in the implementation plans.*
- *We believe the one-off implementation costs will be c£48m.*
- *The majority of the implementation costs will be incurred in the first 2 years of implementation.*
- *We also think that there could be further investment beyond the implementation stage to drive further benefits of integrated care, such as alignment of IT systems and further technological solutions.*
- *Ways to address and sources of funding need to be explored and agreed as soon as possible.*

The type of costs needed to implement integrated care in Tameside and Glossop have been identified through the development of the implementation plans, via workstreams owned by clinical and executive leads in Tameside and Glossop.

We believe the implementation costs will be c£48m.

The majority of these costs are expected to be incurred in the first 2 years of implementation.

Following discussions with the Ops and Finance Group, further costs have been added as follows:

- Provision for legal fees has increased to £0.5m;
- Provision for investment in IT – the implementation plans incorporate the costs that would be needed to get to day 1 of an integrated provider. In the future, it may be possible to drive further benefits from integrated care with more investment in common systems across all points of care that can be accessed remotely, create

paperless working, and link to each other (e.g. EPR, SLAM, SUS, PLICS, ESR). This would mean further capital costs but a potential reduction in the cost of provision;

- Contract terminations – no provision has been made in the implementation plans for existing contracts that may need to be terminated, amended or transferred; and
- Contingency – given the level of uncertainty and risk associated with the programme of work a higher provision would be appropriate, estimated at a total of £8m.

Ways to address the gap and sources of funding will be needed. In discussions with the Tameside Ops and Finance Group, several potential sources of funding have been identified, including:

- NHS funding routes, such as PDC, and DH lending; and
- Greater Manchester Devolution funding.

Area	Description	Costs per workstream plans £m	Additional cost to drive full benefits of integrated care £m
Estate reconfiguration costs	Reconfiguration of the Trust's estate – assessment, planning and design of the new estates, moving services within the estate, development of new LIFT buildings for LCCTs, relocating services currently provided outside hospital, building work around the new front end of the hospital, and demolition costs associated with Charlesworth building.	6.5	
Workforce costs	Requirements for changes to workforce regarding: training, re-deployment costs, redundancy, recruitment and contractual/pay-scale changes between social care and healthcare.	5.8	
Implementation management and professional costs	External/temporary support for: – Implementation support, programme management, communications/engagement and contracting; and – Due diligence, actuarial advice, legal advice and other transaction costs.	4.9	0.6
Double running costs	Where services are to be replaced with services in alternative settings, or where facilities are closed to new patients but need to retain staffing for a period while existing bedded patients are cared for until discharge/transfer, there will be some need for overlap of services.	1.2	
Organisational / leadership development	Cultural change support within ICO organisations and development of ICO leadership team.	0.5	
Investment in integrated IT and comms systems	Set up cost and capital investment in new IT including community migration, equipment to support community diagnostics, gap modelling, and infrastructure investment.	5.5	14.0
Contract terminations	Transfers of services between organisations or changes to where and how services are delivered may mean that some support contracts need to be terminated, modified or transferred. There could be financial costs and penalties associated.		1.2
Contingency		1.9	6.1
Total		26.2	21.9

Engagement

This section outlines our work on communications and engagement as part of developing the model of care. We have also considered if public consultation will be needed and recommended how this is addressed in the implementation plans.

Engagement **CPT key points:**

- *We have created a strong spirit of collaboration between communications and engagement leads from partner organisations through the formation of the local Communications Working Group (CWG).*
- *We recommend the Tameside and Derbyshire scrutiny panels consider whether a public consultation is needed.*
- *We have included public consultation in the implementation plans.*

Summary of communications and engagement in Phase 3 and 4

Throughout the CPT process we have engaged with a broad range of stakeholders across the health and care economy to:

- Involve the people delivering services on the ground in the design process;
- Build support for the proposed changes; and
- Establish a clear and consistent understanding of a best-practice approach to public consultation.

Through these interactions we have developed a view of the local health economy from a communications perspective.

Examples of local engagement

- Running Care Design Groups across the 4 care areas as referenced in the model of care section of this report:
 1. Preventative and proactive;
 2. Urgent Integrated Care;
 3. Planned care; and
 4. Maternity care.
- This helped design the model of care with a range of local clinical, patient and management input;
- The CPT attended over 400 local meetings;
- Working closely with local leadership with over 25 CEO meetings and over 50 attendances at 'Exec' meetings across the Trust, CCG and TMBC;
- Meeting a range of local stakeholder groups from Trust staff groups, CVAT (represents the third sector in part of T&G), leaders from nearby providers etc.;
- Chairing and supporting the local Communications and Working Group;

- Running dozens of workshops on a range of CPT related topics; and
- Running sessions with local GPs from an all GP session to meeting GPs in each locality.

Building a strong foundation

The Communications Working Group (CWG) will need to be well resourced and well supported to ensure that the ongoing engagement and consultation period maintains public and media support for the proposed changes.

During the CPT we focused on planning and preparing for pre-consultation engagement and consultation - building the knowledge and capability of the local organisations to deliver it effectively. Throughout the process we have made sure that there was a transfer of knowledge to the CCG and partners so that they are well prepared to continue the work going forward through a CCG led CWG.

Consideration of public consultation

With the latest model of care and advice the CPT has received, public consultation may be needed due to the extent of service change and proposing such significant change in the 'provider'.

We recommend that to help the CCG determine whether public consultation is needed, the local scrutiny panels for Tameside and Glossop should be consulted. This has been built into the implementation plans.

Whilst our implementation plans reflect public consultation, in the event that public consultation is not required the overall length of the implementation plans could be reduced by up to 3 months.

Engagement **CPT key points:**

- *Under CCG leadership, the CWG should look to bring in additional resource to deliver the plan.*

Stakeholder status

The CPT has worked in the local system extensively in the development of the model of care, implementation plans etc. and set out below our understanding of the status of each stakeholder. In summarising the status, we have sought to take the overall position from each group but note that individuals within each group may have different views. Also, some groups represent a large number of individuals that again, may have different views.

Overall, the CPT's experience engaging with local stakeholders has been encouraging.

CEOs and board level leaders: The CEOs and board level leaders of the Trust, CCG and TMBC have been closely involved throughout the CPT and are supportive of the proposed model of care. Each organisation has been involved with the development of implementation plans and the new governance arrangements (see page 36). Maintaining this support will be critical in the next few years. A series of meetings has been held with senior councillors and officers of Derbyshire County Council, who are supportive of the direction of travel and wish to have extensive operational engagement in the new model, but without transferring staff or budgets into the ICO.

GPs: There are a number of GPs that have been engaged on developing the model of care and there is a common view that more integrated care would be beneficial to patients. The role of primary care and GPs in particular within an ICO will need continued engagement in coming months and years.

Clinicians: Clinicians from several providers have actively participated in the development of the mode of care. Clinicians from the Trust and CCG's Governing Body have also been involved with the development of the Hospital Specification. We note that there will be many individual clinicians in the Trust who we did not meet and the Trust will need to engage further with their clinicians in the short term.

Trust staff: During the CPT, representatives of the CPT attended a number of internal meetings for staff at the hospital and there were updates the Trust communicated as well. We believe that awareness of the CPT was high but details of the Hospital Specification set out in this report will be low, as this was finalised towards the end of the CPT. Also relevant to Trust staff, will be how their roles will change (i.e. in an LCCT) and the co-working arrangements with staff that are currently employed by other organisations.

Trade Unions: The CPT met Trade Union and staff representatives at the Trust several times. Awareness and understanding of the CPT was high but they are not aware of the details of the new model of care (as Trust staff above).

MPs/Councillors: Generally the engagement with Tameside MPs was undertaken by leaders of the Trust, CCG and TMBC, although the CPT did have one meeting. The CPT worked with or presented to councillors within several groups, such as Tameside's Scrutiny Panel, within TMBC's Cabinet or in Derbyshire County Council in meetings with some senior leaders and councillors. There is a good understanding of the model of care and many of the councillors will have a critical role in considering whether public consultation is undertaken. The CPT has not engaged directly with the High Peak MP.

Public, patients and voluntary sector: Public and patient representatives (including Tameside Healthwatch and voluntary sector organisations) were involved in designing the model of care. Continued public and patient engagement is planned by the CCG (even if no public consultation is required) and the public and patients have not been notified of the model of care or other aspects of the CPT's recommendations, such as on the form and identify of the provider of the model of care. The CPT met and briefed the CEO of Healthwatch Derbyshire.

Healthier Together and neighbouring trusts: The CPT has engaged with senior officers of Healthier Together and neighbouring trusts, including Stockport FT, Pennine Care FT, Pennine Acute Hospitals, CMUH and UHSM. NWAS, PCFT and SFT clinical and managerial staff were involved in the CDGs.

Engagement **CPT key points:**

- *Under CCG leadership, the CWG should look to bring in additional resource to deliver the plan.*

Next steps: Immediate priorities

- Public rules prohibiting stakeholder engagement by public bodies during purdah meant that no public and patient engagement has taken place around options development in Phase 3 and 4 so this needs to be driven forward at pace by the CCG with the tools we have provided.
- The responses received from planned engagement work (CVAT/CVS) need to be fed into the design workstream, and a 'You Said' report published.
- The pre-consultation and consultation strategy and implementation plan will need to be ratified by the Programme Board and appropriate resourcing will need to be agreed.
- The CWG will need to work together to implement the detailed communications and engagement plan.
- An Equalities Impact Assessment should be commissioned.
- Care Together ambassadors must be identified and briefed to front messages before and during consultation.
- A dedicated plan for staff engagement and subsequent consultation should be developed for each of the 3 organisations and tailored according to impact.
- Staff and trade unions will need to be engaged/consulted on any potential changes to roles or services as employees of the organisations, but also encouraged to respond as residents and service users to the consultation itself.
- Advance briefings should be planned key stakeholders.

Implementation

Implementation	37
Delivering an integrated care solution	38
Implementation (Programme) Governance	39
Implementation plan	40

The CPT believes that the proposed model of care can be delivered successfully in Tameside and Glossop, but this will require an implementation programme which is large, complex and pioneering.

The programme will need to be well-planned and well-led, and it will only succeed if several major risks are managed effectively.

To this end, the CPT has worked closely with the local CEOs and their teams to develop a summary implementation plan and 11 supporting workstream plans, to devise and introduce a tight programme governance structure. This is ‘owned’ locally, with key roles already filled.

Implementation

The CPT has worked closely with the CEOs and their teams to develop a summary implementation plan and supporting governance structure to deliver the integrated care solution.

CPT key points:

- *This plan conservatively assumes full Public Consultation. If this is not required, launch of new models can be accelerated by up to 3 months.*
- *The plan assumes that the Trust is the delivery vehicle (integrated care organisation). More details on this can be found on page 39.*
- *Enabling workstreams (notably Workforce and IM&T) are critical to launch dates.*
- *We believe new services could be launched in summer and autumn of 2016.*
- *c£48m is estimated to be required to implement this programme. This needs to be found urgently or the programme will be delayed.*

Implementation - summary

The CPT has worked closely with the CEOs and their teams to develop an implementation plan and underpinned by 11 supporting workstream plans, to devise and introduce an effective programme governance structure to drive implementation, and to identify key risks to delivery (with mitigations). These are outlined over the next 4 pages.

Governance and delivery

Establishing the right governance structures will introduce the drive and accountability necessary to implement the service reconfiguration, something which the CPT has noted has been lacking to date. This is now well advanced (see overleaf).

The plan assumes that the Trust is the ‘delivery vehicle’ (see overleaf) and that a procurement is not required.

Consultation

The summary plan assumes full Public Consultation will be required for all service changes.

However, the plan also assumes that Public Consultation will not be required either for formal agreement on the proposed ‘delivery vehicle’ (the future provider or ‘integrated care organisation’) or the proposed transfer of services and staff from other NHS organisations to the delivery vehicle, because neither involves service change.

Launch of new services

The core elements of integrated care (LCCTs and UICS) can be launched safely between July and November 2016.

If full Public Consultation is not required, the new services can be launched earlier, between April and September 2016.

Some ‘early wins’ and some new services (e.g. drug and alcohol) may be introduced earlier.

Elective and surgical changes commence post-Consultation with introduction in late 2016 or 2017.

No plans are being made for changes in maternity services. Any consideration of this will follow the national review.

Resources

Partner organisations acknowledge that substantial additional resource capacity and capability will be needed. This requirement is estimated to be £48 million. A business case is being prepared locally for this.

Enabling workstreams

The implementation of a new service model is dependent upon a number of enabling projects including workforce, estates, IM&T and transport. The outputs of these workstreams need to be in place to enable the model of care to be launched safely and sustainably.

Implementation plans have been produced for each enabling workstream. These plans identify key activities, with milestones, accountabilities, risks, mitigations, resource requirements.

These plans have then been reconciled against the 4 model of care workstreams to ensure that the appropriate infrastructure will be in place in time for the launch of key elements of the model of care.

Work across a number of these enablers has already begun including, identification of new models for outcome based commissioning, identification of the IM&T systems necessary to enable cross-network working across a number of service areas, identification of the estate requirements for the new service and modelling of the workforce needed to put LCCTs and the UICS in place.

The new model of care will involve the transfer of services and staff from other organisations. A dedicated workstream will be created to engage with staff and manage this complex process.

Risks to delivery

A programme as pioneering, large and complex as this carries several critical delivery risks.

Implementation

New programme governance arrangements have been designed by the CPT, and agreed and introduced by the CEOs to provide backbone, accountability and drive to implementation of Care Together.

CPT key points:

- A tight Programme Board with delegated authority will drive implementation, under the leadership of an independent chair.
- Monitor, NHS England and DCC will have observer seats on the Programme Board.
- Liaison with 'DevoManc' and Healthier Together is essential.
- Delivery will be driven and integrated with 'daily business' by 'backfilled' workstream director leads who hold substantive posts in the CCG, TMBC and the Trust.
- The CPT recommends that the Trust becomes the 'delivery vehicle'. A decision on this must be made by the CCG urgently.

New implementation structure

The CPT supported the CCG, TMBC and the Trust to devise and introduce a new implementation (programme) governance structure for Care Together. This was built on simple principles of accountability and effective decision-making, whilst reflecting the complexity and inter-agency nature of the overall programme. Senior appointments have been made to this new structure. This structure is explained in detail in the CPT's Working Papers.

Programme Board

The Programme Board will comprise 7 local leaders led by an independent chair.

Workstream Director Leads

A newly appointed Programme Director will be supported by 11 workstream director leads, each with clear accountability for delivering their workstream.

These director leads have all been appointed from director posts in the CCG, TMBC or the Trust, and will be 'backfilled' to enable them to fulfil their 'day job' and their workstream role effectively.

National oversight and Greater Manchester

Monitor and NHS England will have Observer seats on Programme Board. Liaison with 'DevoManc' and Healthier Together will be tight.

Derbyshire County Council

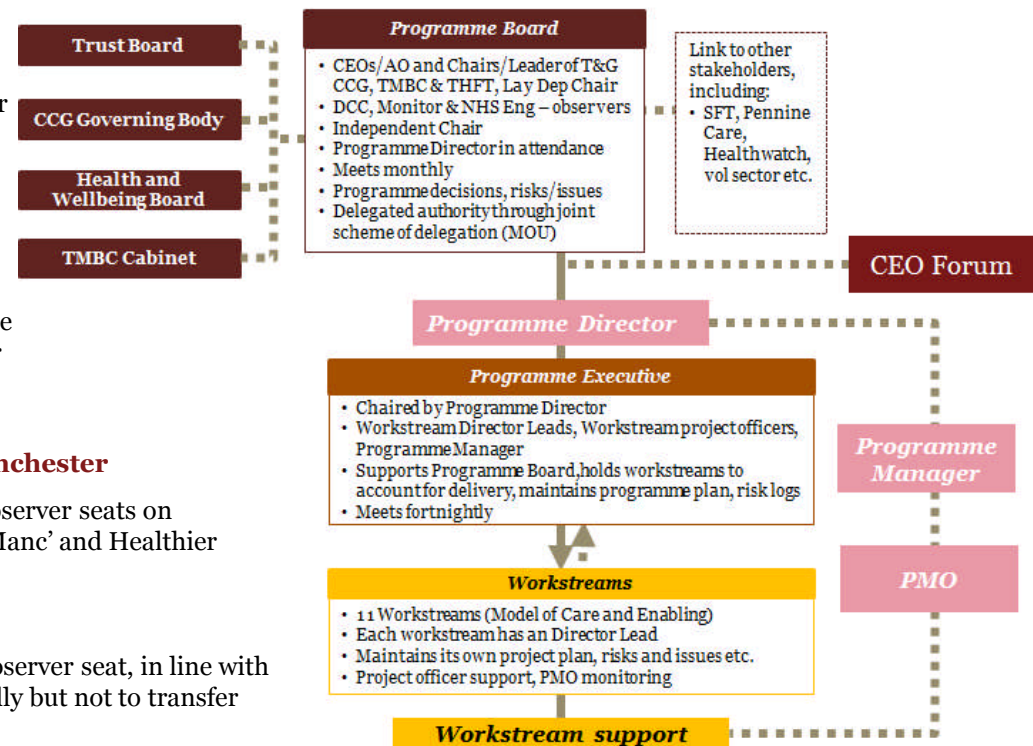
Derbyshire County Council will have Observer seat, in line with its agreement to collaborate operationally but not to transfer staff of budget into the new model.

Delivery vehicle

The programme is designed by commissioners but delivery and operation will need to be by a single 'integrated care organisation' or 'delivery vehicle'.

The CPT recommends that the Trust becomes this 'delivery vehicle'.

Decision on this is the prerogative of the CCG, which needs urgently to determine whether or not this will be the case. If it is not, a procurement exercise may be required, which may delay implementation by up to 12 months.



Implementation

This summary implementation plan captures the key activities and identifies how the delivery timelines interact in delivering the new model of care.

CPT key points:

- This plan assumes Public Consultation. If this is not needed, timelines could shorten by up to 3 months.
- Launch of the main new services (LCCTs and UICS) commences after Consultation in late summer and autumn 2016.
- Some 'early wins' and some new services (e.g. drug and alcohol) may be introduced earlier.
- Elective and surgical changes commence post-Consultation and with introduction in late 2016 or 2017.
- This plan involves multiple inter-dependencies and substantial enabling activity (e.g. Workforce).

Workstream	Key milestone description	Calendar years																		
		Q2 2015	Q3 2015	Q4 2015	Q1 2016	Q2 2016	Q3 2016	Q4 2016	Q1 2017	Q2 2017										
Implementation Governance & Organisational Form	Second wave key appointments (Project Manager, PMO, Project Officers)																			
	MOU, Scheme of Delegation and escalation routes drafted and agreed by Gov Body, Cabinet, Board																			
	CCG option appraisal and recommendation about Delivery Vehicle																			
	Enhanced capability/structure for Delivery Vehicle designed and agreed																			
	Formal agreement, by CCG and Board of nominated organisation, on Delivery Vehicle																			
	New appointments/restructuring of Delivery Vehicle																			
	Business case development																			
Model of Care	Interim agreement on model of care, with final agreement reached after consultation																			
	Detailed planning of new teams and pathways (policies, staffing, enabling requirements, GP input)																			
	Pre-operational mobilisation of new teams and pathways (staff appointments, patient profiling, communications)																			
	LCCTs go live (phased)																			
	UICS goes live																			
	Wellness offer, drugs and alcohol and primary care extended access procured																			
	Implementation of elective and surgical changes																			
	Agree mental health relationship to ICO																			
	GP and extensivist model planning within the ICO																			
	CCG and HT, post Cumberlege, review of Maternity options																			
Comms & Engagement	Agree budget, plan and resources																			
	Undertake pre consultation engagement (PCE) activities and quality																			
	Evaluate PCE activities and decide on consultation																			
	Clinical Senate review and assurance																			
	Full Public Consultation on service changes																			
	Post consultation and decision																			
Workforce & OD	Agree need for consultation around Maternity options																			
	Planning phase (OD, TUPE, role mapping, workforce design)																			
	OD, new appointments, new teams formed																			
Other enabling workstreams	Staff consultation and TUPE of staff																			
	Publication of CCG commissioning intentions																			
	Stockport services and staff transfer planned and executed																			
	Identify and resolve issues around joint commissioning																			
	Development of capitation and outcome based commissioning																			
	Operation and testing of shadow commissioning model																			
	Go live with new commissioning model																			
	Formal decision around application for transition funding																			
	IM&T solutions (Accordant, community clinical IT and secondcare systems) tested and implemented																			
	Go live with shared intelligence database																			
	All patient, visitor, staff & goods transport arrangements in place and tested																			
	Community estate plan agreed and estate in place (phased)																			
	UICS estate building and opening																			
Identification of potential quick wins																				
Implementation of identified quick wins																				

Glossary of key terms

Term	Definition
'Care Together'	The programme of work aimed at delivering an integrated care solution for T&G.
'Cost and activity model'	The model for the service specification and the hospital specification that shows the cost and activity in the health economy. This includes the operational assumptions that convert the service specification and hospital configuration into assumptions that can be modelled.
'CPT'	Contingency Planning Team.
'CVAT'	Community Voluntary Action Tameside
'CVS'	Community Voluntary Support
'Delivery vehicle'	The organisation responsible for delivering the new model of care.
'Extensivist'	Hospital-based specialists who would focus on cohort of high-risk patients.
'Health economy'	The health economy of Tameside and Glossop.
'Hospital Specification or configuration'	The part of the model of care and service specification that covers the proposed configuration of services at TH, flowing from many factors including the impact of integrated care.
'ICO / integrated care organisation'	The proposed model of integrated care in Tameside and Glossop.
'IC'	Integrated care.
'LCCTs / Locality Community Care Teams'	5 multidisciplinary, local community care teams focused on keeping people well and out of hospital.
'LIFT'	Local Improvement Finance Trust
'LSS'	Location Specific Services
'MDT / Multi Disciplinary Team'	A team composed of members from different healthcare professions with specialised skills and expertise working collaboratively to make treatment recommendations that facilitate quality patient care..
'Model of care'	The way the health economy works, that spans health and social care and covers what is to be provided within an ICO and the services outside an ICO.
'NWAS'	North West Ambulance Service,

Glossary of key terms

Term	Definition
‘OFG’	<ul style="list-style-type: none"> • Operations and Finance Group.
‘PACS / Primary and Acute Care System’	<ul style="list-style-type: none"> • A whole system integration of hospital, community, social and primary care within a single outcomes-based capitation contract.
‘SPOA’	<ul style="list-style-type: none"> • Single Point of Access.
‘Service specification’	<ul style="list-style-type: none"> • What is being delivered, where and by whom. This describes the model of care.
‘TH’	<ul style="list-style-type: none"> • Tameside Hospital.
‘the Trust’	<ul style="list-style-type: none"> • Tameside Hospital NHS Foundation Trust.
‘T&G / Tameside and Glossop’	<ul style="list-style-type: none"> • The geography of Tameside and Glossop.
‘CDG / Care Design Group’	<ul style="list-style-type: none"> • Model of care design sessions bringing together inputs from health and care professionals, third sector patient and public representation.
‘UICS / Urgent Integrated Care Service’	<ul style="list-style-type: none"> • Multi disciplinary team responsible for dealing with urgent care patient needs under a single operational management structure.



This publication has been prepared for general guidance on matters of interest only, and does not constitute professional advice. You should not act upon the information contained in this publication without obtaining specific professional advice. No representation or warranty (express or implied) is given as to the accuracy or completeness of the information contained in this publication, and, to the extent permitted by law, PricewaterhouseCoopers LLP, its members, employees and agents do not accept or assume any liability, responsibility or duty of care for any consequences of you or anyone else acting, or refraining to act, in reliance on the information contained in this publication or for any decision based on it.

© 2015 PricewaterhouseCoopers LLP. All rights reserved. In this document, "PwC" refers to PricewaterhouseCoopers LLP which is a member firm of PricewaterhouseCoopers International Limited, each member firm of which is a separate legal entity.