Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	20 June 2018
Officer of Strategic Commissioning Board	Sarah Dobson, Assistant Director Policy, Performance and Communications.
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – PERFORMANCE UPDATE**
Report Summary:	This report provides the Strategic Commissioning Board with a Health and Care performance report for comment. This report provides the Strategic Commissioning Board (SCB) with a health & care performance update at June 2018 using the new approach agreed in November 2017. The report covers: • Health & Care Dashboard – including exception reporting for measures which are areas of concern, i.e. performance is declining and/or off target • Other intelligence / horizon scanning – including updates on issues raised by Strategic Commissioning Board (SCB) members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board (SCB) are asked to note, and any other data or performance issues that Strategic Commissioning Board (SCB) need to be made aware. • In-focus – a more detailed review of performance across a number of measures in a thematic area. This is based on the latest published data (at the time of preparing the report). This is as at the end of March 2018. The content of the report is based on ongoing analysis of a broader basket of measures and wider datasets, and looks to give the Strategic Commissioning Board (SCB) the key information they need to know in an accessible and added-value manner. The approach and dashboard are aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group (QPAG). The following have been highlighted as exceptions: • A&E Standards were failed at Tameside Hospital Foundation Trust; • Referral To Treatment- 18 weeks • Proportion of people using social care who receive self-directed support, and those receiving direct payments • Total number of Learning Disability service users in paid employment Attached is **Appendix 3** on Urgent care.

Recommendations:	The Strategic Commissioning Board are asked: • Note the contents of the report, in particular those areas of performance that are currently off track and the need for appropriate action to be taken by provider organisations which should be monitored by the relevant lead commissioner • Support ongoing development of the new approach to monitoring and reporting performance and quality across the Tameside & Glossop health and care economy
Financial Implications: **(Authorised by the statutory Section 151 Officer & Chief Finance Officer)**	The updated performance information in this report is presented for information and as such does not have any direct and immediate financial implications. However it must be noted that performance against the data reported here could potentially impact upon achievement of CQUIN and QPP targets, which would indirectly impact upon the financial position. It will be important that whole system delivers and performs within the allocated reducing budgets. Monitoring performance and obtaining system assurance particularly around budgets will be key to ensuring aggregate financial balance.
Legal Implications: **(Authorised by the Borough Solicitor)**	As the system restructures and the constituent parts are required to discharge statutory duties, assurance and quality monitoring will be key to managing the system and holding all part sot account and understanding best where to focus resources and oversight. This report and framework needs to be developed expediently to achieve this. It must include quality and this would include complaints and other indicators of quality.
How do proposals align with Health & Wellbeing Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning Strategy?	Should provide check & balance and assurances as to whether meeting strategy.
Recommendations / views of the Professional Reference Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients. The performance is monitored to ensure there is no impact relating to patient care.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities. This report will be further developed to help us understand the impact.

What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the performance as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	Delivery of NHS Tameside and Glossop's Operating Framework commitments 2017/18
Access to Information :	• **Appendix 1** – Health & Care Dashboard; • **Appendix 2** – Exception reports; • **Appendix 3** – Urgent Care in-focus report. • **Appendix 4** – End of Life Dashboard The background papers relating to this report can be inspected by contacting Ali Rehman by:  Telephone: 01613425637  e-mail: alirehman@nhs.net

1.0 BACKGROUND

1.1 This report provides the Strategic Commissioning Board (SCB) with a health & care performance update at June 2018 using the new approach agreed in November 2017. The report covers:

- Health & Care Dashboard – including exception reporting for measures which are areas of concern, i.e. performance is declining and/or off target;

- Other intelligence / horizon scanning – including updates on issues raised by Strategic Commissioning Board (SCB) members from previous reports, any measures that are outside the dashboard but which Strategic Commissioning Board (SCB) are asked to note, and any other data or performance issues that Strategic Commissioning Board (SCB) need to be made aware;

- In-focus – a more detailed review of performance across a number of measures in a thematic area.

1.2 The content of the report is based on ongoing analysis of a broader basket of measures and wider datasets, and looks to give the Strategic Commissioning Board (SCB) the key information they need to know in an accessible and added-value manner. The approach and dashboard are aligned with both Greater Manchester and national frameworks. The development of the report is supported by the Quality and Performance Assurance Group (QPAG).

2.0 HEALTH & CARE DASHBOARD

2.1 The Health & Care Dashboard is attached at **Appendix 1**, and the table below highlights which measures are for exception reporting and which are on watch.

EXCEPTIONS (areas of concern)	1	A&E 4 hour wait
	3	Referral To Treatment-18 Weeks
	42	Direct Payments
	43	LD
ON WATCH (monitored)	7	Cancer 31 day wait
	11	Cancer 62 Day Wait
	47	65+ at home 91days

2.2 Further detail on the measures for exception reporting is given below and at **Appendix 2**.

A&E waits Total Time with 4 Hours at Tameside and Glossop Integrated Care Foundation Trust (ICFT)

2.3 The A&E performance for April was 89.2% for Type 1 & 3 which is below the target of 95% nationally, and the 90% target. The key issue is medical bed capacity which not only cause breaches due to waiting for beds but the congestion in A&E then delays first assessment. There is still medical cover and specialty delays when teams are in Theatres. The trust reports acuity is high which can lead to people needing more than 4 hours for a decision to be reached on their care need. T&G ICFT are ranked first in GM for the month of April 2018.

18 Weeks Referral to Treatment

2.4 Performance for April is below the Standard for the Referral to Treatment 18 weeks (92%) achieving 91.69%. This is an improvement in performance compared to the previous month, March which also failed to achieve the standard at 91.5%. The national directive to cancel elective activity was expected to reduce performance from January. The impact for Tameside and Glossop was expected to be greatest at Manchester Foundation Trust (MFT) and the recovery plan submitted to GM reflected that fact that failure at MFT could mean T&G performance would be below the required standard. MFT is failing to achieve the RTT national standard. MFT (formerly UHSM) revised its improvement trajectory and is currently on track. MFT (formerly CMFT) is slightly below target although there have been improvements in children's services. We will discuss with lead commissioners the need for comprehensive recovery plans.

Proportion of people using social care who receive self directed support, and those receiving Direct Payments

2.5 Performance for Quarter 4 is below the threshold for total proportion of people using social care who receive self-directed support, and those receiving direct payments (28.1%) achieving 13.19%. This is a deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 13.48%. Tameside performance in 2016/2017 was 12.47%, this is a decrease on 2015/2016 and is below the regional average of 23.8% for 2016/2017. Nationally the performance is 28.3% which is above the Tameside 2016/17 outturn. Additional Capacity to be provided within the Neighbourhood teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the ASC transformation funding. The project post was not successfully recruited too therefore in order to increase capacity a different approach has been implemented. We use to have 2 Direct Payment workers this has now been increased to 4 Direct Payment Workers, one in each neighbourhood. A publicity campaign will now be developed to increase numbers over the coming months

Total number of Learning Disability service users in paid employment

2.6 Performance for Q4 is below the threshold for total number of learning disability users in paid employment (5.7 %) achieving 4.17%. This is deterioration in performance compared to the previous quarter, which also failed to achieve the standard at 4.39%. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. In order to improve performance, additional resource is required to increase capacity. An additional post has been funded through the ASC transformation funding and a vacant post that was held in the team has also been released to increase capacity in the team with an expectation that more people will be supported into paid employment. Work has been undertaken with Routes to Work to strengthen their recording of Supported Employment services and to clarify the links with this indicator.

3.0 OTHER INTELLIGENCE / HORIZON SCANNING

3.1 Below are updates on issues raised by Strategic Commissioning Board members from previous presented reports, any measures that are outside the Health and Care Dashboard but which Strategic Commissioning Board are asked to note, and any other data or performance issues that Strategic Commissioning Board need to be made aware.

'Winter crisis'

Influenza

3.2 The provisional February 2018 Tameside and Glossop CCG vaccine uptake for this period was 76.2% against a target of 75% meaning that the CCG has met the target set by NHS

England (NHSE). There were 39 GP practices participating in the 2017-18 seasonal flu campaign. Of these, 25 GP practices (64%) either met or exceeded the target set by NHSE and 14 GP practices (36%) were below the target. We are currently performing better than GM and England averages and ranked 3rd amongst GM CCGs for data up to Week 52. (as at January 2018)

Children aged 2,3 &4

3.3 Performance in February 2018 has shown an increase in all preschool age groups compared to January last year. The CCG has achieved the 40% ambition in children aged 2, 3 and 4 year old. This has been a national and local focus of the 17/18 flu campaign.

For data up to Week 52 we have been performing better than GM and England averages; and are ranked against other GM CCGs as 4th for 2 year olds and 3rd for 3 year olds. (as at January 2018)

Under 65 (at risk only), Pregnant Women and Carers

3.4 The national ambition is 55% for under 65s at risk. A downward trend is observed from last year's performance; however, the absolute number of patients vaccinated has increased during 17/18. To achieve the 75% target 6,649. We have achieved the interim ambition of 55%.

We are ranked 2nd against other GM CCGs (week 52). (as at January 2018)

3.5 The latest flu surveillance report for influenza like illness at upper tier local authority level shows that there is an increasing trend in Tameside over the last 10 weeks. Currently ranked sixth in GM for the rate per 100,000 population. (as at January 2018)

NHS 111

3.6 The North West NHS 111 service performance has improved in all of the key KPIs for March but none of the KPIs achieved the performance standards:

- Calls Answered (95% in 60 seconds) = 67.03%
- Calls abandoned (<5%) = 11.77%
- Warm transfer (75%) = 25.38%
- Call back in 10 minutes (75%) = 54.40%

Average call pick up for the month was 3 minutes 26 seconds. Performance was particularly difficult to achieve over the weekend periods. There is a remedial action plan in place with Commissioners.

3.7 52 Week waiters.

The CCG has had a number of 52 week waiters over the last few months. The table below shows the numbers waiting by month, which provider it relates to and the specialty.

		Better is...	Threshold	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
CCG	Patients waiting 52+ weeks on an incomplete pathway	L	Zero Tolerance	0	1	2	3	2	1	4	4
Provider	Manchester Foundation Trust	L	Zero Tolerance	0	1	2	3	2	1	4	4
Specialty	Plastic Surgery	L	Zero Tolerance	0	1	2	3	2	1	4	4

All of the breaches have occurred at Manchester Foundation Trust and in the specialty of Plastic Surgery which has had capacity pressures.

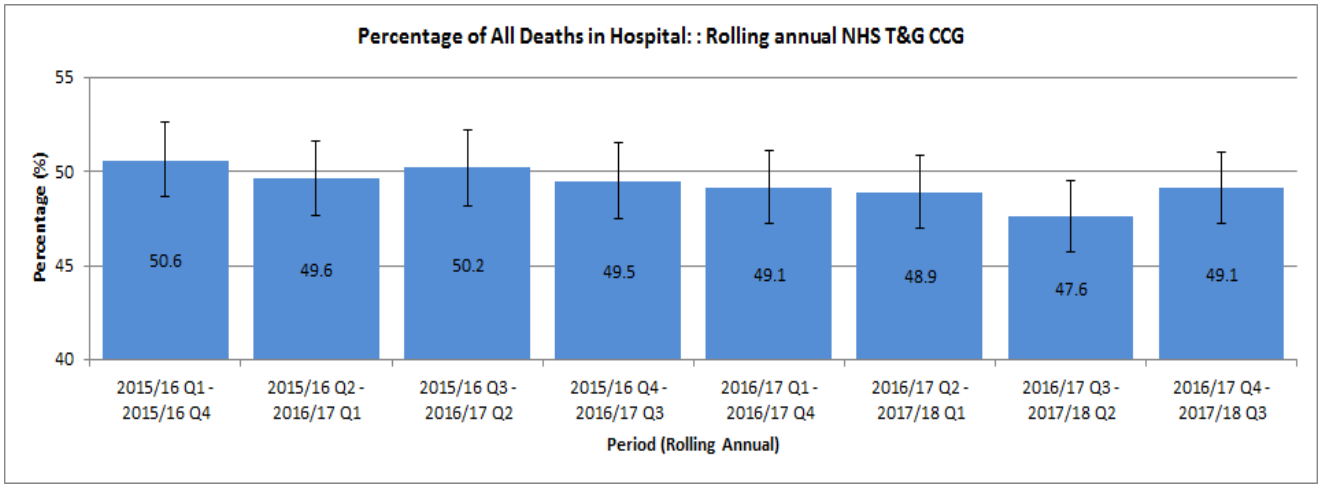
A significant increase in demand for the highly-specialised DIEP (deep inferior epigastric perforator) flap reconstructive surgery procedure at Wythenshawe Hospital (part of Manchester University NHS FT) has resulted in patients waiting in excess of 18 weeks (and in some cases over 52 weeks) for treatment.

The following actions are being undertaken by the Trust, working closely with the lead CCG, to address the current long waiting times for DIEP flap reconstructive surgery and develop a sustainable future service model.

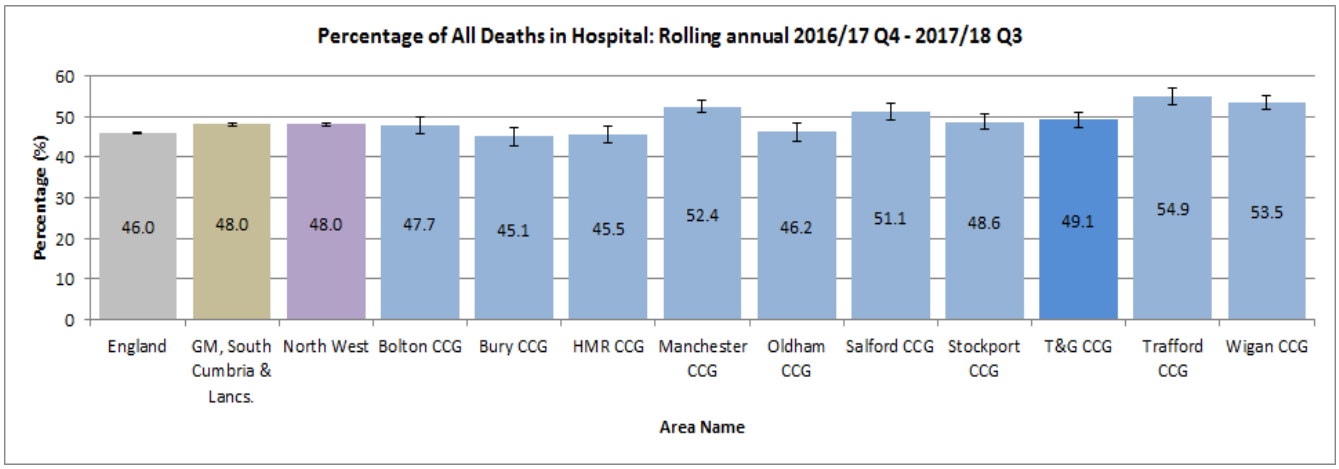
- Manchester Health and Care Commissioning has agreed a local tariff with the Trust in late 2017;
- The Trust has since undertaken extensive demand and capacity modelling to better understand the infrastructure requirements moving forward to ensure women are seen and treated in this service within national waiting time standards;
- A business case is in the final stages of development that outlines the expansion requirements to meet current and likely future demands;
- All women who have waited in excess of 52 weeks are being clinical validated and choice discussions taking place;
- A proposed recovery action plan is being developed, outlining the plans to see and treat existing patients and assurances on future service provision;
  Fortnightly assurance meetings are held with representatives for the Lead CCG (NHS Manchester) and performance is reported to CCGs at the monthly (formal) Finance & Performance meeting.

3.8 Deaths In Hospital

The table below shows the rolling annual percentage of all deaths in hospital by quarter for Tameside and Glossop CCG. The latest rolling annual period (2016/17 Q4 – 2017/18 Q3) shows the percentage at 49.1%, this is an increase from the previous rolling annual period (2016/17 Q3 – 2017/18 Q3) at 47.6%.



The chart below shows the Tameside and Glossop CCG percentage of all deaths in hospital for the rolling annual period as at 2017/18 Q3 benchmarked against GM, North West and England. This shows that Tameside and Glossop CCG has the 5th highest percentage of all deaths in GM. It is also higher than the Northwest figure (48.0%) and higher than the England figure (46.0%).



Attached at **Appendix 4** is an end of life dashboard for info.

4.0 IN-FOCUS – Urgent Care

4.1 The thematic in-focus area for this report is Urgent Care. The full report is attached at **Appendix 3**.

5.0 RECOMMENDATIONS

5.1 As set out on the front of the report.

Health and Care Improvement Dashboard

June 2018

	Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
1	Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95%	Apr-18	83.9%	84.8%	89.2%	p	
2	* Delayed Transfers of Care - Bed Days	3.5%	Mar-18	3.2%	3.2%	2.9%	q	
3	* Referral To Treatment - 18 Weeks	92%	Apr-18	91.7%	91.3%	91.7%	p	
4	* Diagnostics Tests Waiting Times	1%	Apr-18	0.7%	1.3%	1.0%	p	
5	Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93%	Feb-18	96.7%	95.9%	96.5%	p	
6	Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93%	Feb-18	94.9%	90.1%	96.3%	p	
7	Cancer - 31-Day Wait From Decision To Treat To First Treatment	96%	Feb-18	100.0%	98.8%	96.2%	q	
8	Cancer - 31-Day Wait For Subsequent Surgery	94%	Feb-18	100.0%	100.0%	100.0%	tu	
9	Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98%	Feb-18	100.0%	100.0%	100.0%	tu	
10	Cancer - 31-Day Wait For Subsequent Radiotherapy	94%	Feb-18	100.0%	95.5%	100.0%	p	
11	Cancer - 62-Day Wait From Referral To Treatment	85%	Feb-18	88.6%	86.1%	83.9%	q	
12	Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90%	Feb-18	100.0%	100.0%	80.0%	q	
13	Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade		Feb-18	83.3%	73.1%	68.2%	q	
14	MRSA	0	Mar-18	0	1	3	q	
15	C.Difficile (Ytd Var To Plan)	0%	Mar-18	-1.0%	-4.4%	-8.2%	q	
16	Estimated Diagnosis Rate For People With Dementia	66.7%	Apr-18	81.2%	81.0%	80.5%	q	
17	Improving Access to Psychological Therapies Access Rate	1.25%	Jan-18	4.0%	4.1%	4.1%	q	
18	Improving Access to Psychological Therapies Recovery Rate	50%	Jan-18	37.0%	35.7%	38.4%	p	
19	Improving Access to Psychological Therapies Seen Within 6 Weeks	75%	Jan-18	83.3%	84.6%	89.6%	p	
20	Improving Access to Psychological Therapies Seen Within 18 Weeks	95%	Jan-18	100.0%	96.2%	97.9%	p	
21	Early Intervention in Psychosis - Treated Within 2 Weeks Of Referral	50%	Feb-18	50.0%	50.0%	66.7%	p	
22	Mixed Sex Accommodation	0	Mar-18	0.38	0.13	0.12	p	
23	Cancelled Operations		17/18 Q3		1.0%	1.1%	p	
24	Ambulance: Red 1 Calls Responded to in 8 Minutes	75%	Jul-17	62.0%	57.1%	63.3%	p	
25	Ambulance: Red 2 Calls Responded to in 8 Minutes	75%	Jul-17	64.9%	60.6%	62.9%	p	
26	Ambulance: Category A Calls Responded to in 19 Minutes	95%	Jul-17	91.6%	88.2%	89.7%	p	
27	Cancer Patient Experience		2016	9.10	8.70	8.77	p	
28	Cancer Diagnosed At An Early Stage		16/17 Q3	43.7%	54.2%	54.6%	p	
29	General Practice Extended Access		Mar-18		82.1%	92.3%	p	
30	Patient Satisfaction With GP Practice Opening Times		Mar-17		74.4%	76.0%	p	

* data for this indicator is provisional and subject to change

31	111 Dispositions- - % Recommended to speak to primary and community care (Ranking out of 40, 38 from March onwards)		Mar-18	12% (29th)	11% (31st)	12% (31st)	tu	
32	111 Dispositions- - % Recommended to dental (Ranking out of 40, 38 from March onwards)		Mar-18	2% (38th)	2% (38th)	2% (37th)	p	

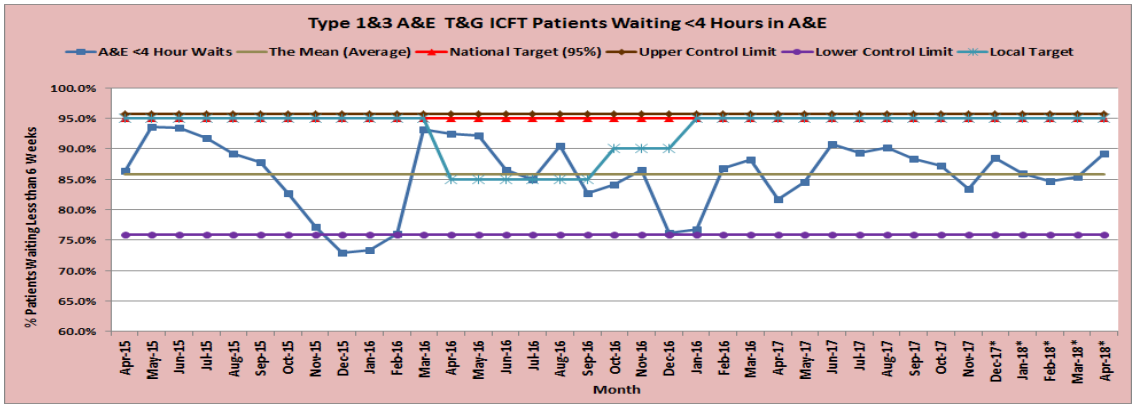
	Indicator	Standard	Latest	Previous 2 data points		Latest	Direction of Travel	Trend
33	111 Dispositions- - % Recommended home care (Ranking out of 40, 38 from March onwards)		Mar-18	3% (37th)	3% (34th)	3% (35th)	q	
34	Maternal Smoking at delivery		17/18 Q3	15.1%	14.6%	16.7%	p	
35	%10-11 classified overwieight or obese		2013/14 to 2015/16	33.3%	33.6%	33.6%	tu	
36	Personal health budgets		17/18 Q1	3.60	4.50	5.30	p	
37	% of deaths in hospital		16/17 Q2	47.60	49.80	50.40	p	
38	LTC feeling supported		2016 03	62.90	62.40	61.40	q	
39	Quality of life of carers		2016 03	0.80	0.77	0.78	p	
40	Emergency admissions for urgent care sensitive conditions (UCS)		16/17 Q4	2906	3212	3066	p	
41	Patient experience of GP services		Jul-05	81.2%	83.2%	83.5%	p	
	Adult Social Care Indicators							
42	Part 2a - % of service users who are in receipt of direct payments	28.1%	17/18 Q4	13.65%	13.48%	13.19%	q	
43	Total number of Learning Disability service users in paid employment	5.7%	17/18 Q4	4.50%	4.39%	4.17%	q	
44	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 18-64	13.3	17/18 Q4	10.38 (14 Admissions	11.86 (16 Admissions)	16.33 (22 Admissions)	p	
45	Total number of permanent admissions to residential and nursing care homes per 100,000 aged 65+	628	17/18 Q4	77.27 (108 Admissior	454.42 (177 Admissions)	656.41 (256 Admissions)	p	
46	Total number of permanent admissions to residential and nursing care homes aged 18+		17/18 Q4	122	193	278	p	
47	Proportion of older people (65 and over) who were still at home 91 days after discharge from Hospital	82.7%	17/18 Q4	81.8%	81.8%	77.4%	q	
48	% Nursing and residential care homes CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	50%	49%	55%	p	
49	% supported accomodation CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	80%	80%	80%	tu	
50	% Help to live at homes CQC rated as Good or Outstanding (Tameside and Glossop)		Mar-18	67%	53%	53%	tu	

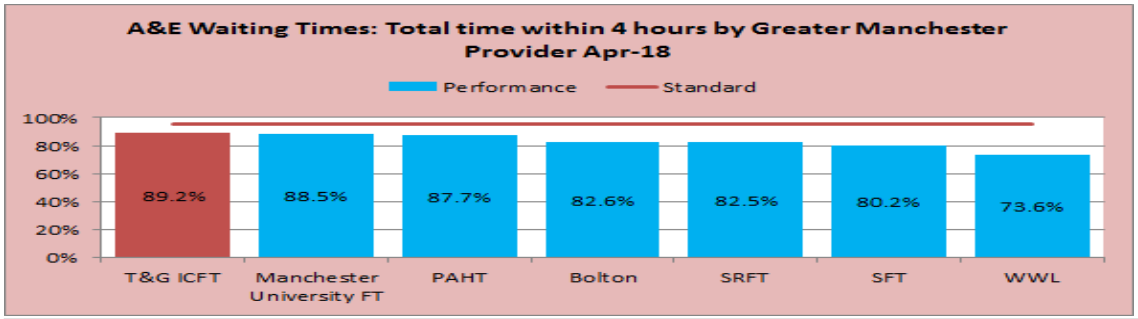
q	Performance detiorating and failing standard
p	Performance improvinging and failing standard
p	Performance improving and achieving standard
q	Performance detiorating and achieving standard
q	Performance detiorating no standard
p	Performance improving no standard
tu	No change in Performance and achievingstandard
tu	No change in Performance and failing standard
tu	No change in Performance and no standard

Exception Report

Health and Care Improvement- June

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





April Performance: 89.2%

17/18 ytd: 81.65%

18/19 ytd: 89.2%

Key Risks and Issues:

The A&E Type1 and type 3 performance for April was 89.2% which is below the National Standard of 95% and below the GM agreed target of 90%.
Late assessment due to lack of capacity in the department is the main reason for breaches. Surges of attendance particularly in the evenings leading to lengthened NWAS handover times. • Lack of timely exit flow from ED leading to reduced physical capacity in the ED to see patients safely. • Patients often bedded down in ED overnight. • High risk of 12 hour breaches• Increased numbers of complex patients requiring longer lengths of hospital stay reducing flow
• High acuity of patients on AMU and IAU leading to reduced discharges from the unit and increased need for patients to be transferred to the wider wards.

Overall the system has little resilience and so increased demand or reduced capacity in any one of the component Health and Social Care services can quickly reduce the A&E performance.
A&E Streaming is in place but staffing of rotas challenging at times.

Actions:

Hourly reviews of patients in ED by lead nurse and consultant. • Live SMART board with predicted attendance visible to plan for surges and escalate in a timely manner • ED Dr supporting triage of patients arriving by ambulance and undertaking see and treat where appropriate • ED streaming to AEC using "push pull model" from triage. • REACT underway in ED when staffing resource and physical capacity permits. • Second triage nurse in times of surge • Helicopter nurse supporting coordinator as trouble shooter to enable internal flow • Medical in reach to ED in the evenings • Reverse queueing of patients waiting for a bed in area at the back of ED with nurse support to free up capacity in main ED area to see patients • Acute medicine consultants working weekends. • Escalation beds in use to prevent 12 hour breaches • Fit to sit project operational in ED and on wards prior to discharge • Golden ticket for next day discharges and Ticket Home project operational on wards to support flow • Roll out of Electronic Casualty Card (eCAS) progressing from minors to paediatrics • Digital Health supporting GPs to refer to appropriate areas of the hospital ie AEC/ED
We are working on a GM level recovery plan to achieve 90% by Q1.

Operational and Financial implications:

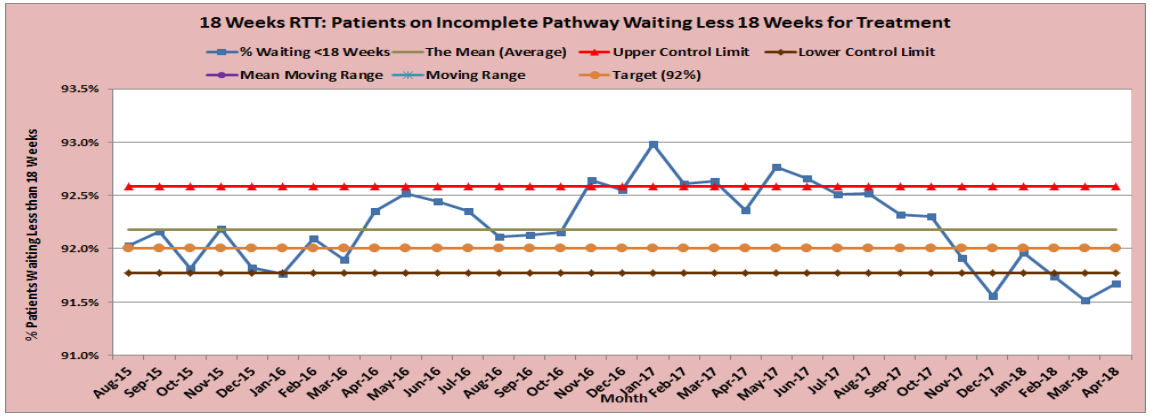
Failure of the standard will negatively impact on the CCG assurance rating. However regular contact is maintained with GMHSCP and the local work being undertaken is recognised.

The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Unvalidated-Next month FORECAST

* Please note that Tameside Trust local trajectory for 18/19 is Q1, Q2 and Q3 90%, and Q4 95%.
* Type 1 & 3 attendances included from July 2017.

18 Weeks RTT: Patients on incomplete pathway waiting less than 18 weeks for treatment **Lead Officer:** Elaine Richardson **Lead Director:** Jess Williams **Governance:** Contracts



Key Risks and Issues:

The RTT 18 weeks performance for April was 91.67% which is below the National Standard of 92% .
Failing specialties are, Trauma & Orthopaedics (83.06%), Urology (91.53%), General Surgery (91.63%), Plastic Surgery (71.11%), Cardiology (91.78%), Neurology (83.33%), Rheumatology (87.65%), Gynaecology (90.64%).
The national directive to cancel elective activity was expected to reduce performance from January. The impact for T&G was expected to be greatest at MFT and the recovery plan submitted to GM reflected that fact that failure at MFT could mean T&G performance would be below the required standard.
The performance at MFT at 89.42% is the key reason for the failure in April with 323 people breaching. Stockport, Salford and Pennine trusts also contributed to the failure accounting for a further 253 breaches.
T&O continues to be a challenge across most providers. In MFT our biggest concerns are around plastics, cardio theracic, gyneocology and cardiology.
As lead Commissioner.
T&G ICFT as a provider are achieving the standard.

Actions:

MFT is failing to achieve the RTT national standard. MFT (formerly UHSM) revised its improvement trajectory and is currently on track. MFT (formerly CMFT) is slightly below target although there have been improvements in children's services.

We will discuss with lead commissioners the need for comprehensive recovery plans.

Operational and Financial implications:

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

The failure of this target will impact on the CCGs ability to obtain the money attached to this target for the Quality Premium Payment (QPP).

Monthly Referral to Treatment (RTT) waiting times for incomplete pathways.

	Mar-18			
CCG	**Total number of incomplete pathways**	**Total within 18 weeks**	**% within 18 weeks**	**Target**
NHS Wigan Borough CCG	19524	18247	93.46%	92%
NHS Salford CCG	23257	21518	92.52%	92%
NHS Tameside and Glossop CCG	17103	15624	91.35%	92%
NHS Trafford CCG	16106	14543	90.30%	92%
NHS Manchester CCG	37503	33718	89.91%	92%
NHS Oldham CCG	15125	13598	89.90%	92%
NHS Bolton CCG	22508	20121	89.39%	92%
NHS Stockport CCG	25213	22529	89.35%	92%
NHS Bury CCG	12979	11542	88.93%	92%
NHS Heywood, Middleton & Rochdale CCG	16680	14759	88.48%	92%
NHSE North of England	1036880	916463	88.39%	92%

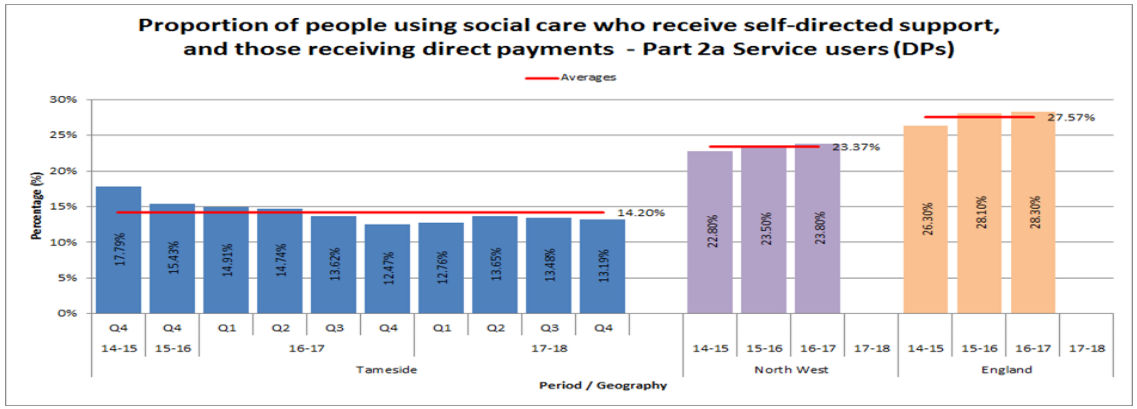
Unvalidated-Next month FORECAST

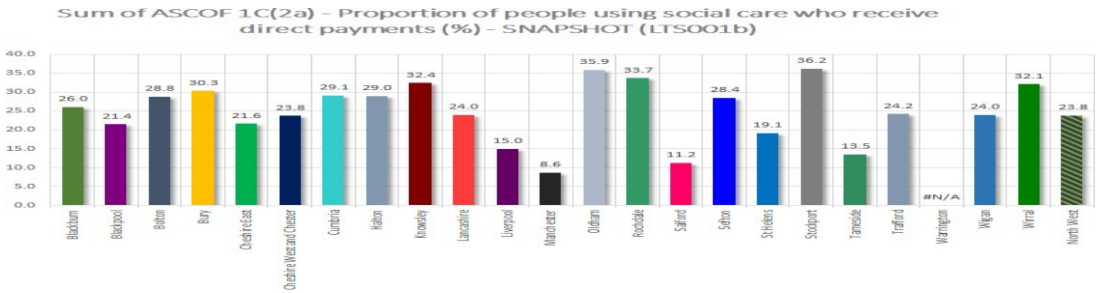
* Benchmaking data relates to March 2018

Exception Report

Health and Care Improvement- June

ASCOF 1C- Proportion of people using social care who receive self directed support, and those receiving Direct Payments **Lead Officer:** Sandra Whitehead **Lead Director:** Steph Butterworth **Governance**: Adults Management team





Key Risks and Issues:

This measure supports the drive towards personalisation outlined in the Vision for adult social care and Think Local, Act Personal, by demonstrating the success of councils in providing personal budgets and direct payments to individuals using services.

Actions:

Additional Capacity to be provided within the Neighbourhood teams over a 12-18 month period to carry out an intensive piece of work to promote Direct Payments. This post will be funded from the ASC transformation funding. The project post was not successfully recruited too therefore in order to increase capacity a different approach has been implemented. We use to have 2 Direct Payment workers this has now been increased to 4 Direct Payment Workers, one in each neighbourhood. A publicity campaign will now be developed to increase numbers over the coming months.

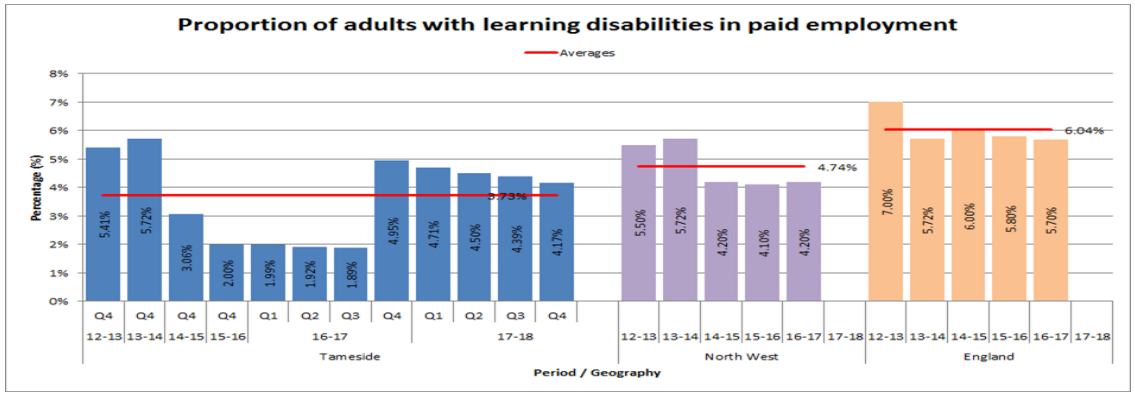
Operational and Financial implications:

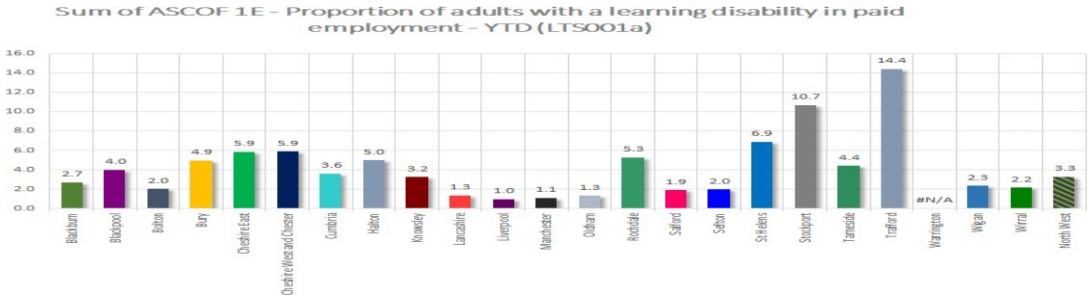
None

Unvalidated Next Quarter FORECAST

* Benchmarking data is as at Q3 17/18.

ASCOF 1E- Total number of Learning Disability service users in paid employment **Lead Officer:** Sandra Whitehead **Lead Director:** Steph Butterworth **Governance:** : Adult Management meeting





Key Risks and Issues:

The measure is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing and financial benefits. Tameside performance in 2016/2017 was 4.95%, this is an increase on 2015/2016 and brings us above the regional average of 4.2% for 2016/2017. Nationally the performance is 5.7% which is still above the Tameside 2016/17 outturn. 4th Quarter 2017/18 figure is 4.17%

Actions:

- We have moved the remaining Employment Support staff into the Employment and Skills corporate team to ensure a more focused approach to employment and access to wider resource and knowledge base
- In order to improve performance, additional resource is required to increase capacity. An additional post has been funded through the ASC transformation funding and a vacant post that was held in the team has also been released to increase capacity in the team with an expectation that more people will be supported into paid employment.
- Work has been undertaken with Routes to Work to strengthen their recording of Supported Employment services and to clarify the links with this indicator.
- The development of a new scheme focused on supporting people with pre-employment training and supporting people into paid employment including expansion of the Supported Internship Programme for 16-24 year olds.

Operational and Financial implications:

None

Unvalidated next Quarter FORECAST

* Benchmarking data is as at Q3 17/18

Appendix 3

Urgent Care In-Focus

Strategic Commissioning Board

1. Introduction

1.1. Over the years Tameside and Glossop have developed a range of services that meet the Urgent and Emergency Care needs of local people. Some services are commissioned at a local level either independently or jointly with other CCGs and some as part of Greater Manchester/North West arrangement.

1.2. Services have been implemented over time to embrace new ways of working or in response to national expectations and as result the Urgent and Emergency Care system has become complex with multiple access routes and significant levels of duplication and overlap.

1.3. The Strategic Commission approved the development of the Integrated Urgent Care Service in March 2018 to reduce duplication and improve efficiency. The implementation of the new arrangements autumn is planned for autumn 2018 onwards.

1.4. In April 2018 Greater Manchester Urgent and Emergency Board set out its Transformation programme involving four workstreams (shown below) with the expectation that change will happen rapidly in 2018/19.

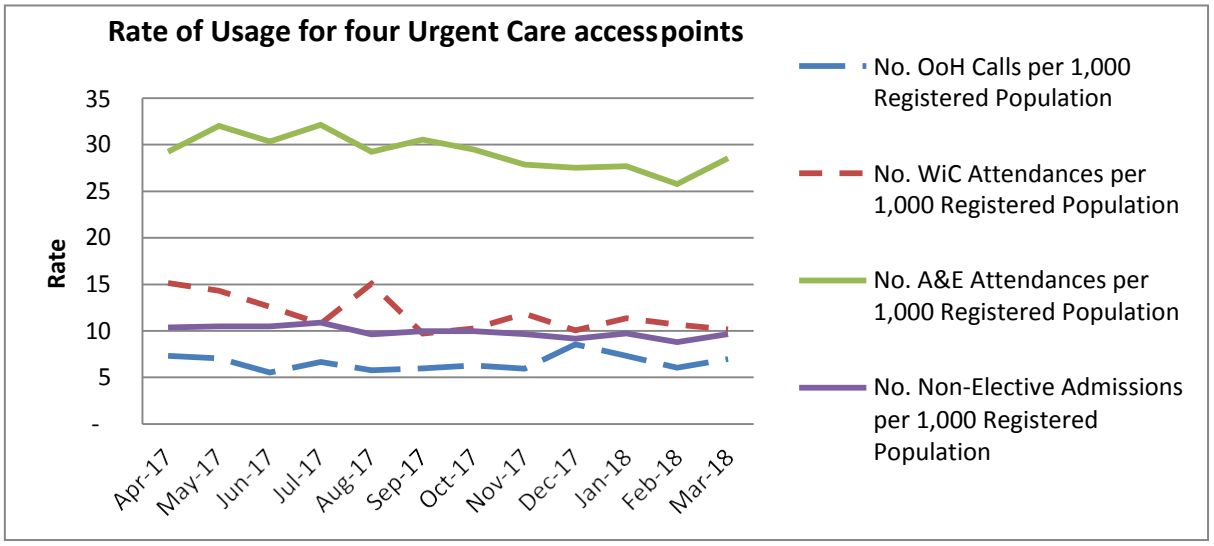
1. "Stay Well" – Early identification & Prevention
2. "Home First" – Attendance & Admission Avoidance
3. Patient Flow
4. Discharge & Recovery

1.5. In addition Tameside and Glossop are involved in the 2018/19 NHS Improvement Action on A&E programme focusing on support for Frail patients who develop an urgent care need. This area is also reflected in the local Q1 Improvement plan that was required by GM HSCP.

1.6. 2018/19 is therefore anticipated to be a year of significant change for urgent and emergency care. So this deep dive is based on the services currently in place and focuses on historic data whilst also signalling how these will change going forward as the Integrated Urgent Care Service and further Care Together developments are implemented.

2. Understanding Demand

2.1. The number of people who seek support when an emergency or urgent care need arises is not easily quantified due to the many access routes. Demand also tends to reflect the level of concern an individual has as much as clinical need with people presenting for a range of needs some of which are problems that would usually be manged through a routine service. However, when comparing the rate of use of four key access points per 1000 registered population there is slight trend toward reduced use particularly in the winter months when demand is generally higher.

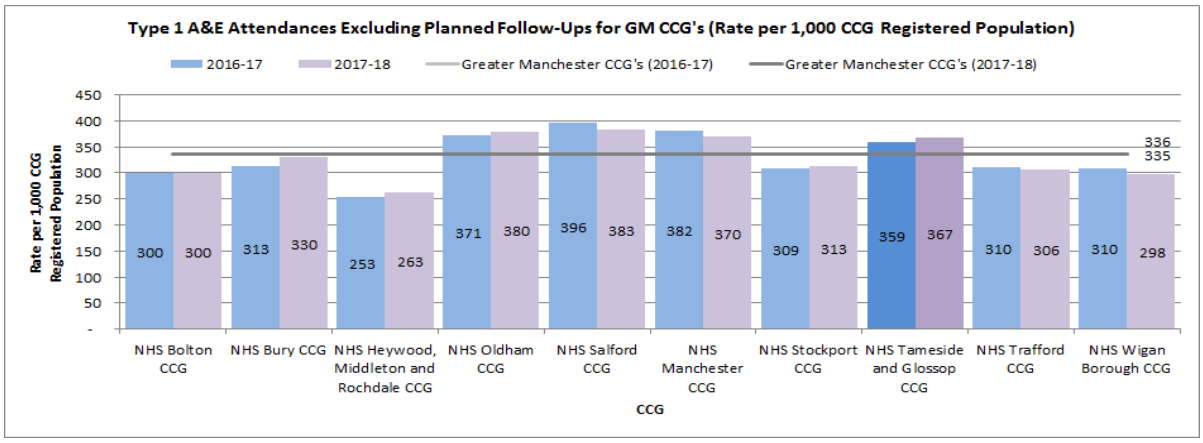


2.2. The level of usage varies across neighbourhoods and will not only reflect the profile of the neighbourhood population but also geography and ease of access as these particularly influence usage for the WIC and A&E.

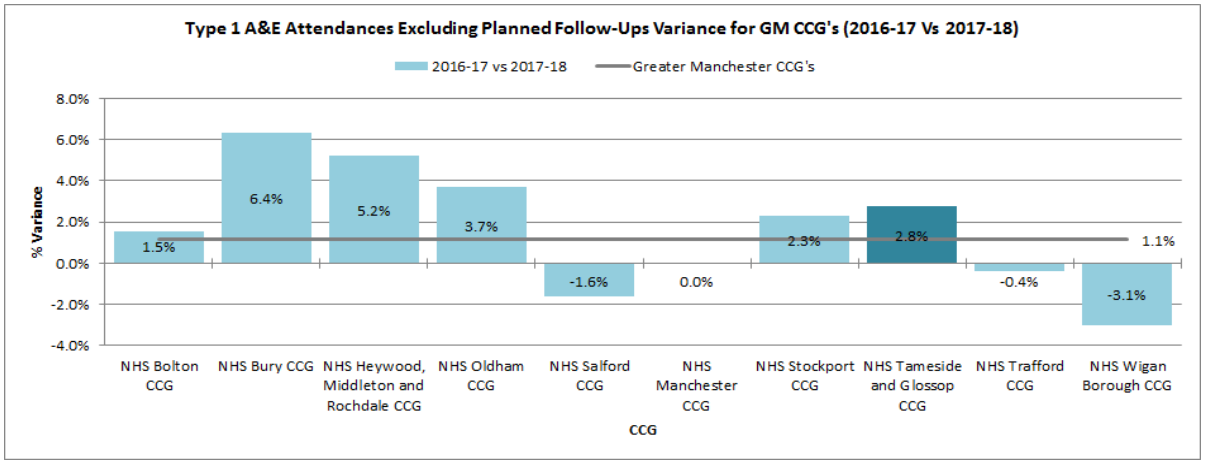
	Out of Hours GPs (OoH)	Walk-in Centre (WIC)	A&E	Non-elective Admissions
Neighbourhood	**17-18**	**17-18**	**17-18**	**17-18**
Ashton	83	228	402	128
Denton	85	157	352	121
Glossop	57	40	258	100
Hyde	93	121	369	127
Stalybridge	65	119	324	106
NHS T&G CCG	**79**	**142**	**350**	**119**

2.3. **A&E Attendances -** Attendance at A&E is frequently seen as the measure of demand for the emergency and urgent care system and whilst a good indicator of emergency need, for urgent need, it will equally reflect geography and ease of access to alternative support in the community. It remains however. the only indicator which can be used as a Greater Manchester comparison.

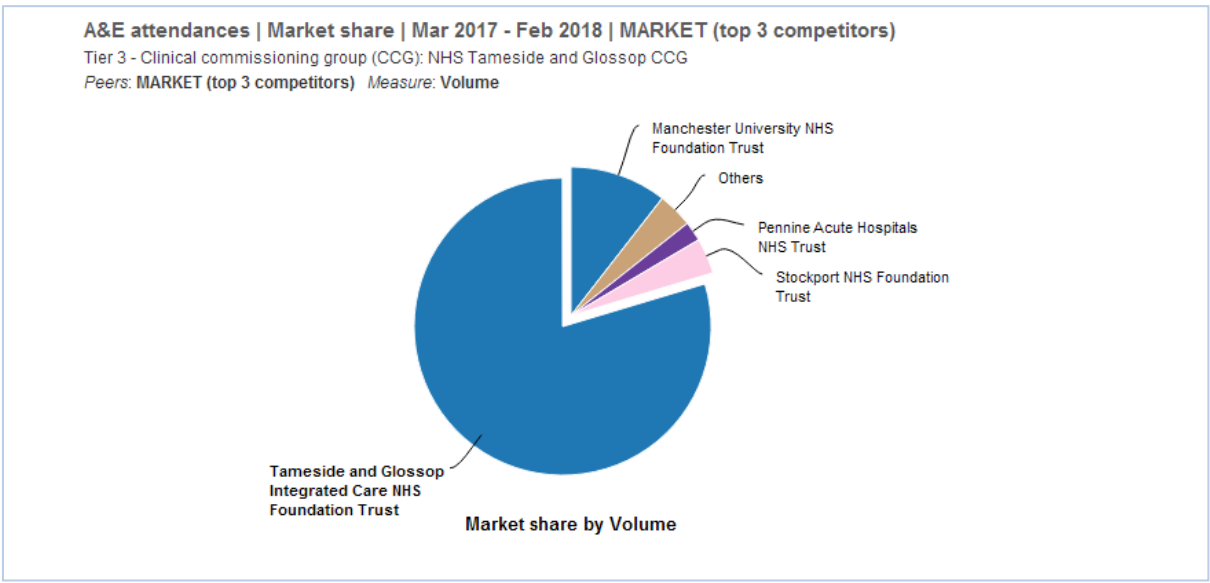
2.4. Comparing Tameside and Glossop registered patients with those of other CCGs shows that overall we have seen an increase in rate of A&E attendances in 2017/18 and we remain above the Greater Manchester rate.



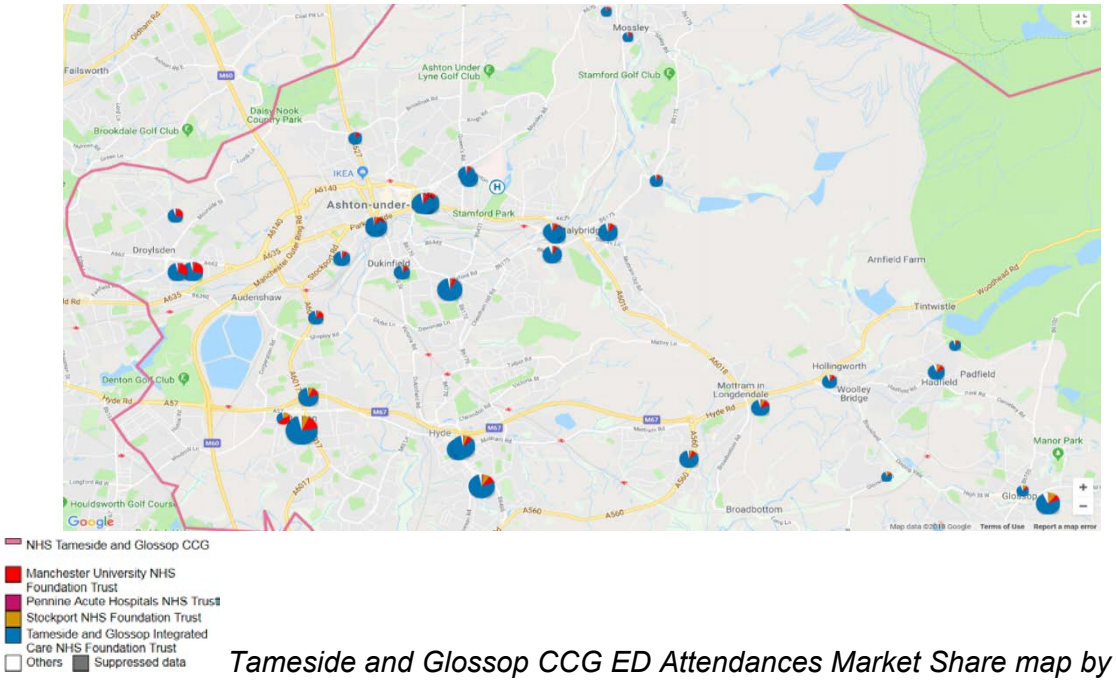
2.5. The growth is however, lower than some CCGs but above GM average.



2.6. The majority, 80%, of Tameside and Glossop patients who attended A&E between March 2017 and Feb 2018 went to the ICFT with 10% attending Manchester University FT 4% Stockport FT and 2% Pennine Acute.



2.7. The map below shows where people attend by GP Practice and as can be seen a higher proportion of residents migrate to Manchester rather than Tameside from the Denton/Droylsden Neighbourhood where the M60 motorway acts like a natural barrier.



Tameside and Glossop CCG ED Attendances Market Share map by GP Practice

2.8. Analysis by age band of attendances at the ICFT (85% of which are T&G patients) shows fairly steady year on year growth overall (between 1.6% and 2.4%). The growth is mainly across the 65+ range and whilst the percentage is affected by the cohort size the difference is significant enough that statistically this is an increase not accounted for by cohort size. The 19 to 64 age range has increased by 799 attendances between 16/17 and 17/18 whereas the 75+ age range has increased by 755 attendances over the same period and is only a quarter of the cohort size.

Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	20449	20401	-0.2%	20595	1.0%	0.7%
19 to 64	44709	45266	1.2%	46065	1.8%	2.9%
65 to 74	7159	7491	4.6%	7821	4.4%	8.5%
75 to 84	7236	7490	3.5%	7868	5.0%	8.0%
85+	4748	4990	5.1%	5367	7.6%	11.5%
Grand Total	**84301**	**85638**	**1.6%**	**87716**	**2.4%**	**3.9%**

2.9. **Non-Elective Admissions –** When a patient needs ongoing support in a hospital setting they will be admitted as a non-elective patient. More patients are admitted to Medical specialties than Surgical specialities with the majority of admissions being at the ICFT. Almost 87% of Medical admissions and 54% of Surgical admissions are at Tameside and Glossop ICFT.

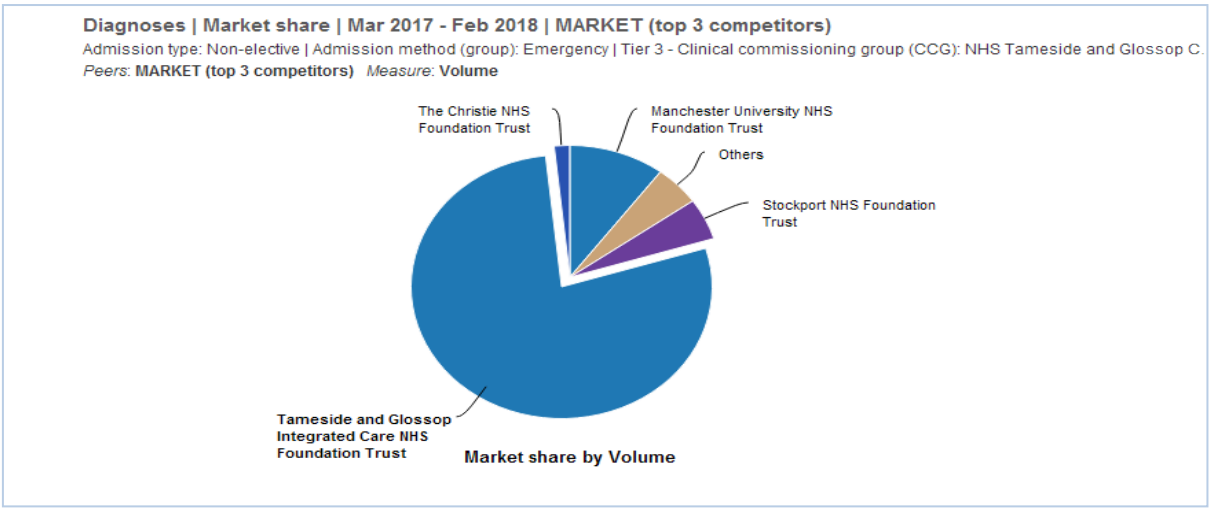
Diagnoses | Market share | Mar 2017 - Feb 2018 | Specialty chapter (of discharge) by MARKET (top 3 competitors)

Admission type: Non-elective | Admission method (group): Emergency | Tier 3 - Clinical commissioning group (CCG): NHS Tameside and Glossop CCG

Analyse by: Specialty chapter (of disc ▾ | Peers: MARKET (top 3 competit ▾ | Measure: Volume ▾

	MARKET (to...	Tameside and Glossop Integr...		Manchester University NHS F...		Stockport NHS Foundation Tr...		The Christie NHS Foundation ...		Others	
Specialty chapter (of discharge)	Total	Volume	%	Volume	%	Volume	%	Volume	%	Volume	%
All	27,180	21,211	78.0%	2,794	10.3%	1,383	5.1%	457	1.7%	1,335	4.9%
Medical Specialties	20,421	17,698	86.7%	1,050	5.1%	737	3.6%	306	1.5%	630	3.1%
Surgical Specialties	5,447	2,920	53.6%	1,330	24.4%	532	9.8%	7	0.1%	658	12.1%
Obstetrics & Gynaecology	751	510	67.9%	91	12.1%	114	15.2%	****	****	****	****
Other Children's Specialties	412	83	20.1%	321	77.9%	0	0.0%	0	0.0%	8	1.9%
Psychiatry	****	0	0.0%	0	0.0%	0	0.0%	0	0.0%	4	****
Radiology	****	0	0.0%	****	****	0	0.0%	****	****	0	0.0%

2.10. As with A&E attendances about 10% of Tameside and Glossop admissions are at Manchester FT with a higher proportion of people from the west of the Tameside and Glossop footprint being admitted at Manchester FT.



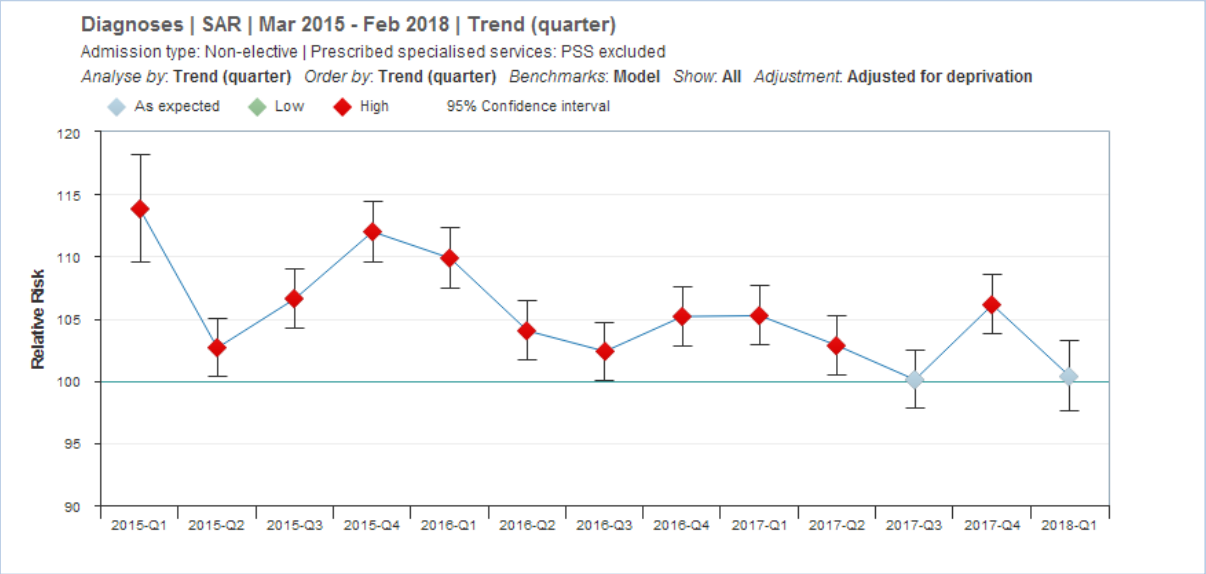
2.11. Analysis by age band at the ICFT shows that although non-elective admissions have been fairly stable (a 537 increase over two years) there was a 1.4% decrease in in 16/17 but 17/18 saw a 4.1% increase against previous year resulting in a 2.6% increase over the two years. However the change in age cohort admissions show this is not a consistent increase and does not necessarily mirror the A&E attendance.

2.12. The increase in the 85+ does correlate to A&E attendances whereas the increase in 65 to 85 is much lower than the increase in attendances and the increase in 0-18 is being much higher. The reason for this would require further analysis to understand if this reflects improved access to alternative support out of hospital, reduced risk appetite to discharge or increased clinical need.

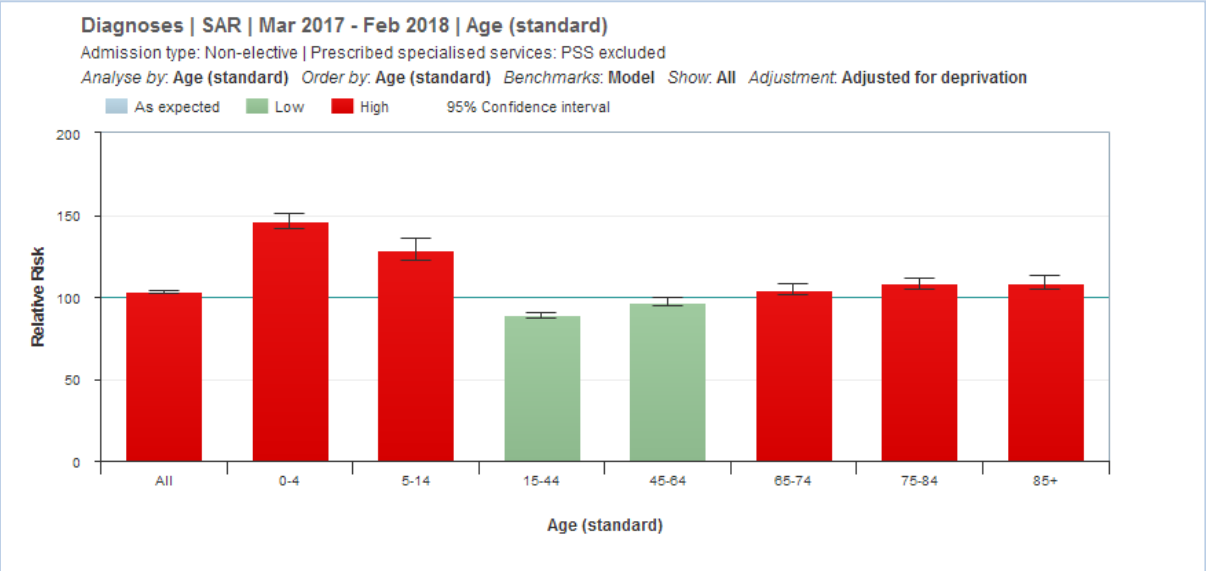
Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	2861	3074	7.4%	3249	5.7%	11.9%
19 to 64	7912	7345	-7.2%	7481	1.9%	-5.8%
65 to 74	3003	3069	2.2%	3102	1.1%	3.2%
75 to 84	3779	3694	-2.2%	3925	6.3%	3.7%
85+	2754	2852	3.6%	3089	8.3%	10.8%

Grand Total	**20309**	**20034**	**-1.4%**	**20846**	**4.1%**	**2.6%**

2.13. The **Non-Elective Standardised Admission ratio (SAR)** is a tool used by Dr Foster to show the ratio of observed number of non-elective admissions to expected number of non-elective admissions, standardised by age, sex deprivation and year. The graph below shows the trend by quarter of SAR for T&G CCG from 2015 to 2018 Q1. When the SAR = 100 that means that there are as many NEL Admissions as would be expected and anything above means there are more etc. As can be seen there has been an improving picture and in two of the last 3 quarters T&G CCG were having as many non-elective admissions as would be expected given their case mix.

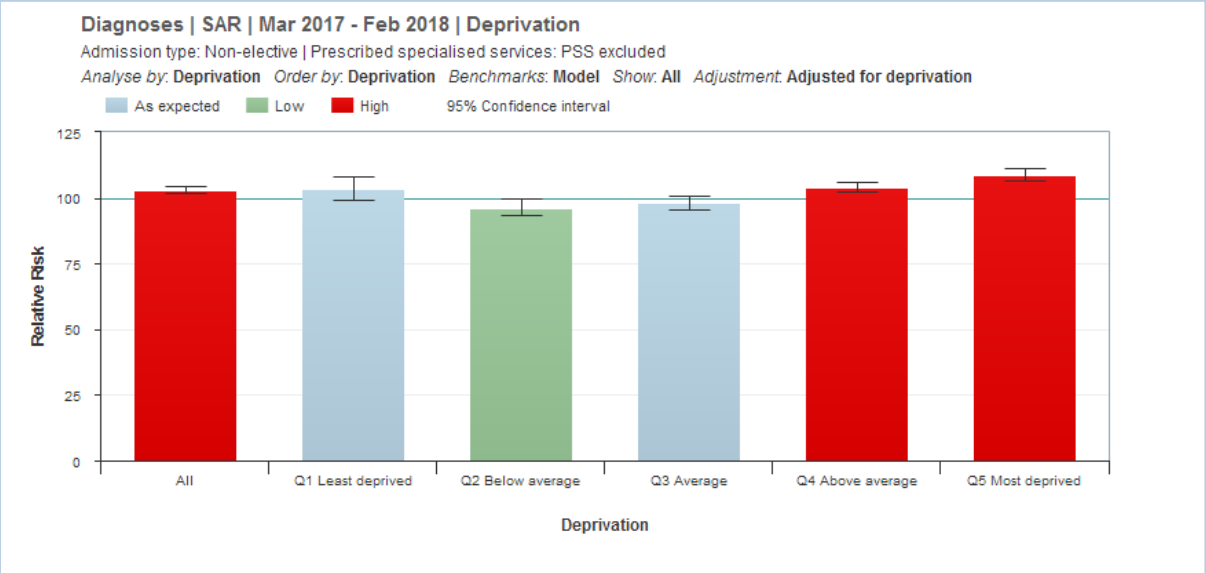


2.14. Comparing age bands shows the 65+ and younger cohorts having slightly higher non-elective Admissions than expected given their supporting factors. The younger cohort will be affected by the fact admissions are made to the Children's Observation and Assessment unit so may not be an accurate comparison.



2.15. Comparing deprivation quintile the least 3 deprived quintiles are below or not significantly above the expected range. However the two most deprived quintiles are

above expected ranges with confidence intervals also above the expected range resulting in them being RAG rated red. This is despite the fact they have been adjusted for deprivation as one of the key supporting factors of the risk model.



2.16. Our Commitment to improving Healthy Life Expectancy and embedding proactive and preventative management into our neighbourhoods will increase the number of people who are able to manage their condition and prevent a crisis or urgent care need arising. However, whilst this should reduce demand with respect to numbers of people who need emergency and urgent care other more social and cultural factors may increase the number of people who expect same day responses.

3. Managing Demand

3.1. There will always be circumstances where people need access to emergency or urgent care and ensuring people are assessed and treated by the right person first time improves both clinical outcomes and patient experience. Tameside and Glossop are committed to delivering the right care in the right place first time and use a variety of services to facilitate this.

3.2. Primary Care Services

3.3. All our **General Practices** see patients with urgent care needs using either telephone or face to face same day consultations. The level of same day access varies practice by practice with most utilising the extended access service when the practice does not have capacity themselves. Practices, Out of Hours service and NHS 111 can all book patients into extended access slots where available.

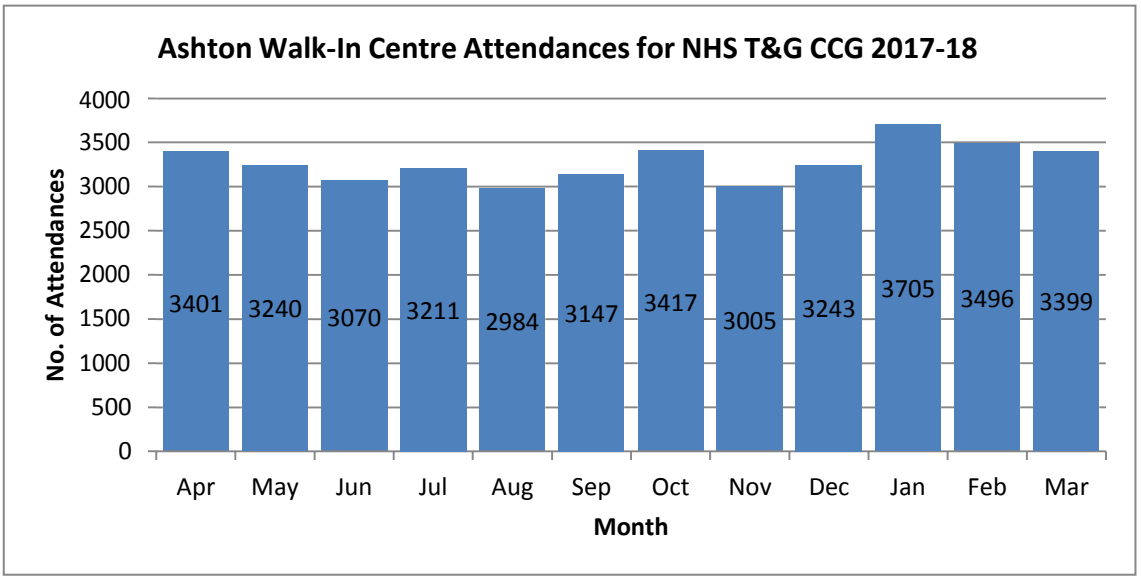
3.4. Practices will also direct patients to other appropriate services such as the **Minor Aliments Service** delivered by pharmacies. This is well used locally as people are able to walk in to any pharmacy in Tameside and Glossop for support. Around 9,200 people with minor aliments are supported by pharmacies each year.

3.5. The **Minor Eye Conditions Service** delivered by a range of optometrists in Tameside and Glossop is equally well used with 2337 people receiving an urgent appointment (within 24 hours) in 2017/18. In addition 1433 people were seen as routine (within 5

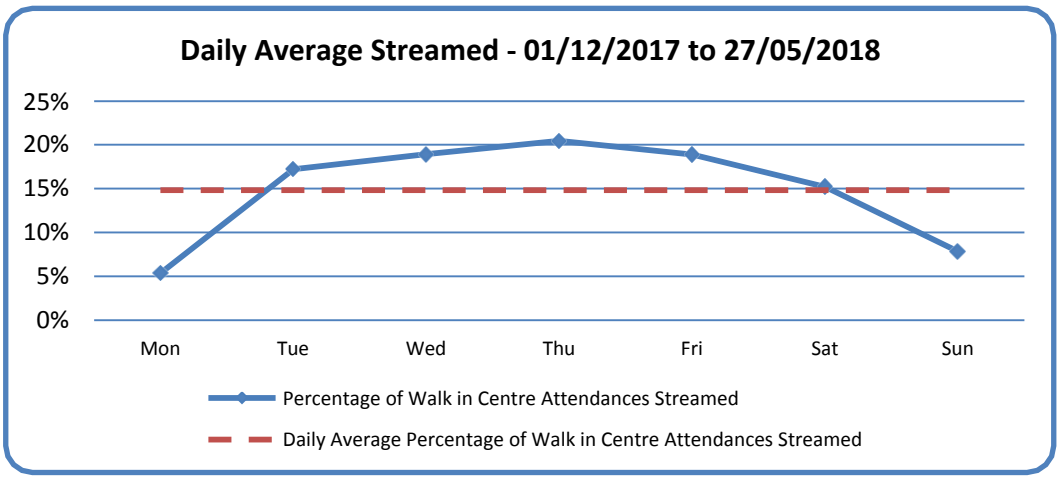
days). In total 324 people were onward referred urgently to Ophthalmology and 169 as a routine referral. Referrals are received through other services as well as patients self-presenting.

Source of Referral	2017/18	
	No. of referrals	%
NHS 111	3	0.08%
A&E	7	0.19%
GP (after seeing GP)	437	11.62%
GP staff (not seen GP)	735	19.55%
Hospital eye clinic	16	0.43%
Other	94	2.50%
Other optometrist	204	5.43%
Pharmacist	186	4.95%
Px self-referral	2028	53.94%
GP out of hours	9	0.24%
Referral following a GOS sight test	41	1.09%

3.6. People can also walk-in to primary care services at the **Walk-In-Centre** in Ashton Primary Care Centre between the hours of 08:00 to 20:00 seven days a week.



3.7. In addition since October 2018 **A&E Streaming** has been in place. This is a further primary care service supporting people who walk-in to A&E 12 hours a day in line with the national mandate. This service sees people who on initial assessment in A&E are identified as appropriate for primary care. The number of people currently recorded as streamed varies and is believed to be underreported which will be addressed as the new eCAS electronic system is implemented. The percentage of A&E attendances streamed to primary care is lower than nationally hoped but this will be due to the underreporting and the fact the other primary care walk-in service is available in the same township and only 1.5 miles away.



3.8. The role of primary care in supporting people with urgent care needs will be strengthen in 2018 as the Integrated Urgent Care Services is centred around the General Practice and the trust patients have in their own practice. Patients will be encouraged to contact their practice initially to maximise the opportunities for people to be supported through Primary Care. The ability to book into appointments at an Urgent Treatment Centre based on the hospital site or in a Neighbourhood Care hub should help the system manage demand and see people more quickly. Increased appointments along with walk-in access at the Urgent Treatment Centre should also free up A&E clinicians to support those people who need emergency support.

3.9. In addition several Practices are considering offering additional services such as Minor Injuries which will enable people to be treated at their own practice rather than having to attend A&E.

3.10. NHS 111

3.11. NHS 111 is a national service available 24/7 via the telephone as a free call. It is designed to support people by assessing symptoms and, depending on the situation, the NHS 111 team will give self-care advice, direct an individual to the most appropriate service, connect someone to a nurse, emergency dentist or GP, book a face-to-face appointment or if necessary send an ambulance directly.

3.12. Usage in Tameside and Glossop CCG has increased in 2017/18 by 4.16% with 43,144 calls being made by a total of 26,796 different patients. The outcome of those calls is summarised in the table below with 24% of calls identified as emergencies or urgent, 15.2% being sent an ambulance and 8.5% recommended to attend A&E or urgent care centre.

3.13. For those who were sent an ambulance 74.6% were conveyed to A&E and on further assessment 23.4% of these were admitted. Others were supported at home. Not all of those recommended to attend A&E or an urgent care centre follow that recommendation but of the 67% that did attend 8.1% were admitted on further assessment.

3.14. 15.3% of callers recommended to attend another service presented at A&E within 24hrs and of these 20.7% were admitted when assessed further. Some of these will have been assessed by the Out of Hours or Extended Access services and been advised to attend on further clinical assessment. Others will self-present because their concerns have not been allayed; or they are unable to get an appointment in the

alternative service in a timeframe acceptable to themselves or because the condition worsens over time.

CCG Level Selected	Time period	Cohort of calls	Distinct Patients
NHS TAMESIDE AND GLOSSOP CCG	Selected 2017/18 Financial Year	43,144	26,796

Ambulance			Other Service			Not Recommended to attend			Unknown / Not Triaged			A&E Dept or UCC		
No. / %	6,556	15.2%	No. / %	25,874	60.0%	No. / %	5,483	12.7%	No. / %	1,552	3.6%	No. / %	3,679	8.5%
No A&E in 24 Hours			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**			**No A&E in 24 Hours**		
No. / %	1,664	25.4%	No. / %	21,919	84.7%	No. / %	4,852	88.5%	No. / %	1,232	79.4%	No. / %	1,208	32.8%
A&E in 24 Hours			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**			**A&E in 24 Hours**		
No. / %	4,892	74.6%	No. / %	3,955	15.3%	No. / %	631	11.5%	No. / %	320	20.6%	No. / %	2,471	67.2%
Admitted			**Admitted**			**Admitted**			**Admitted**			**Admitted**		
No. / %	1,144	23.4%	No. / %	820	20.7%	No. / %	113	17.9%	No. / %	76	23.8%	No. / %	200	8.1%
Not Admitted			**Not Admitted**			**Not Admitted**			**Not Admitted**			**Not Admitted**		
No. / %	3,748	76.6%	No. / %	3,135	79.3%	No. / %	518	82.1%	No. / %	244	76.3%	No. / %	2,271	91.9%

3.15. The alternative services are identified through the Directory of Services (DOS) and Tameside and Glossop have a range of alternative services which people can be directed to as self-referrals e.g. Minor Eye Conditions Service. Where services require a Health Care Professional referral callers will usually need to be advised to attend a GP service.

3.16. NHS 111 can book people directly into appointments in the extended access service and the expectation is that this will increase over time and extend to booking into the Integrated Urgent Care Service and GP surgery appointments.

3.17. 11.5% of the callers not recommended to attend any service also presented at A&E within 24hrs with 17.9% being admitted. Reasons for attending A&E will be similar to above.

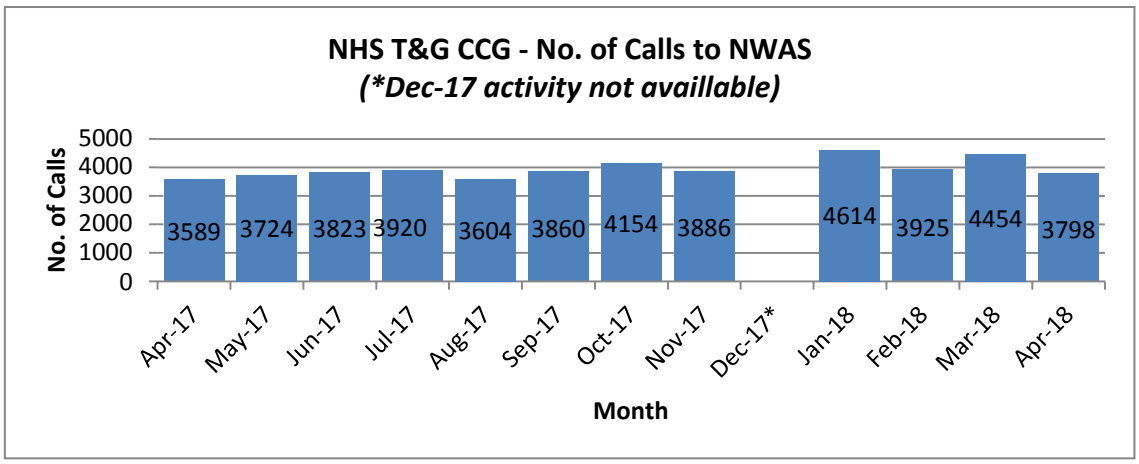
3.18. NHS 111 online is due to go live in Greater Manchester in July 2018 and will enable people to get medical help or advice from NHS 111 online using their smartphone, laptop or other digital device. The service is free to use and helps to direct patients to the right care, first time. Patients can use the online service to:

- find out where to get the right healthcare in their area
- get advice on self care
- get further advice from a nurse or doctor on the phone or during a consultation

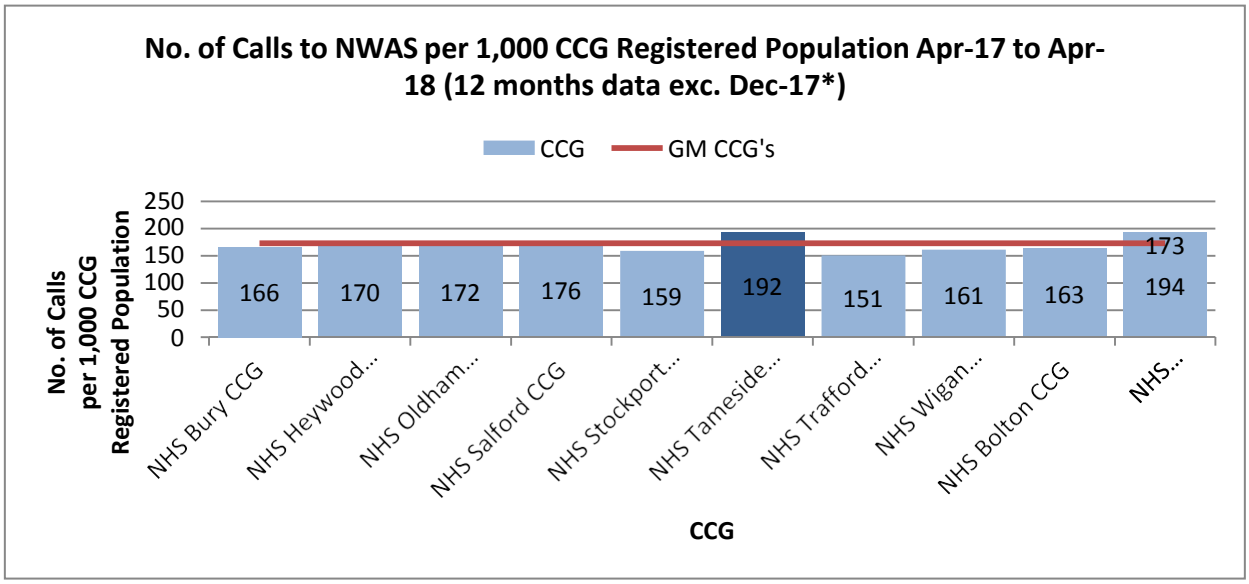
3.19. The services on the DOS are regularly reviewed to ensure that all alternatives are identified. In 2018/19 more social care and social prescribing services are likely to be included in the DOS.

3.20. 999 – Ambulance Services

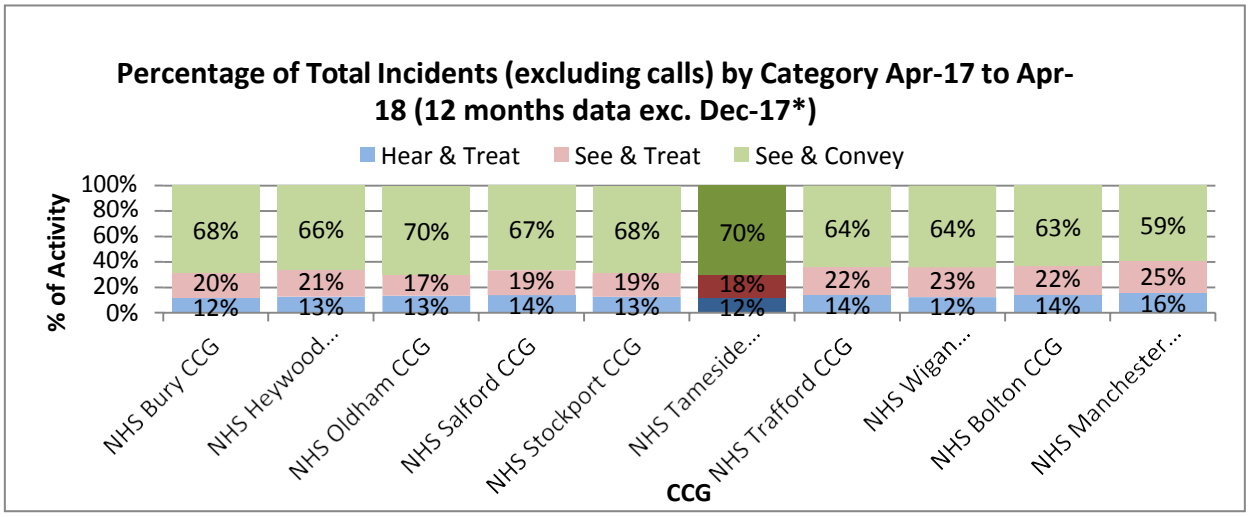
3.21. Between 3500 and 4650 calls are made to 999 by Tameside and Glossop patients every month.



3.22. The rate of calls is higher than most CCGs.



3.23. Nationally 999 ambulance services are encouraged to increase the support they can give over the telephone (Hear and Treat) or within the home (See and Treat) to reduce the level of conveyance to hospital and for Tameside and Glossop around 30% of callers are supported to stay at home. This is slightly less than most other CCGs.

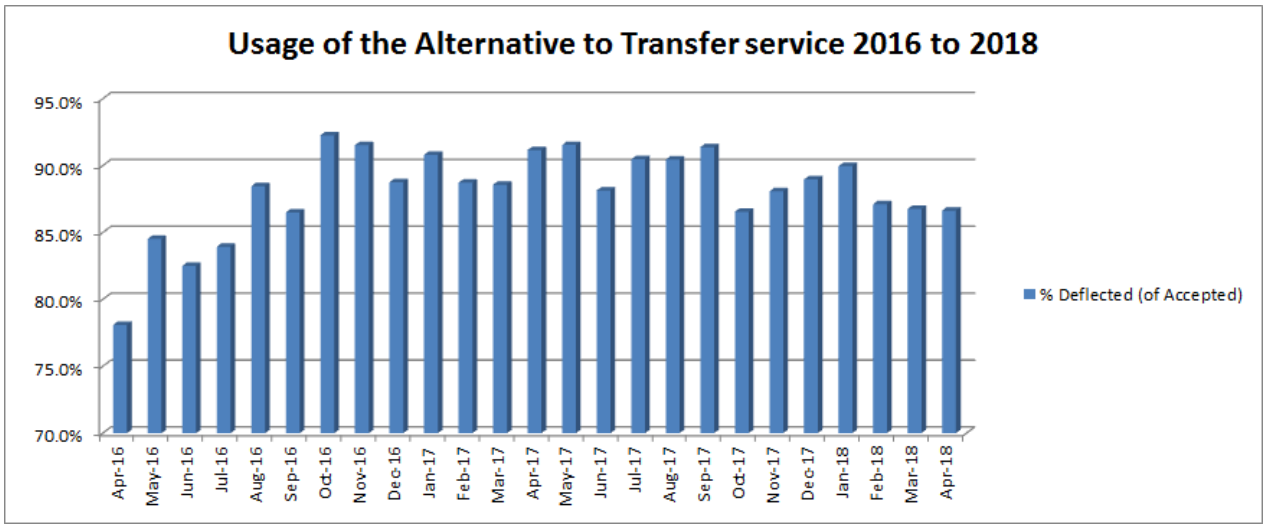


3.24. The **Community Paramedic** operating in Glossop is a key support to See and Treat and has worked with local care homes to implement the Care Home Triage Tool that helps care home staff to identify the most appropriate service to contact in any situation.

3.25. 2018/19 will see additional support through Digital Health that can respond to 999 calls directly to avoid ambulance dispatches wrapping care around the patient in their own home rather than transferring them to hospital.

3.26. Alternative To Transfer (ATT)

3.27. The **Alternative to Transfer service** is another key service that supports Hear and Treat and See and Treat as it enables paramedics to transfer the clinical care of a patient to a GP when appropriate. Use of the Alternative to Transfer service is good with an average of 8 or 9 referrals per day above 80% of which are maintained at home.



3.28. The service also ensures people who refuse to be transferred to hospital even when clinically indicated receive ongoing support.

3.29. The Primary Care Access Service will incorporate Primary Care support for Alternative To Transfer and continue the Health Care Practitioner Advice line that also reduces 999 calls

3.30. Digital Health Service

3.31. The **Digital Health Service** was initially developed to support patients in care homes and reduce the need for people to attend A&E when they could be appropriately managed in the home. Forty Care Homes are able to contact the Digital Health hub via Skpe and discuss a patient's symptoms and clinical observations with an appropriate clinician in order to agree the most appropriate treatment plan.

3.32. By the end of the November 2017 Digital Health had received 1300 calls, avoiding 907 unnecessary A&E attendances, 510 GP call outs, over 350 nursing call outs and saved approximately 1452 hospital bed days or 6.8 beds.

3.33. The service incorporates the Tameside Community Response Service (CRS) has managed 190 CRS calls with 95 avoiding attendance at A&E and 43 avoiding GP involvement. CRS is able to attend people who have fallen and use lifting equipment to help them up with only those who clinically need support having to attend A&E of the 1,200 falls supported April to September 2017 only 93 ambulance where required to transfer people to hospital.

3.34. The support available will continue to develop as mechanisms for supporting more people living in their own residences are explored.

3.35. Mental Health Support

3.36. The need for increased urgent access to Mental Health support is recognised and two pilots were established in 2017/18 to facilitate rapid access to mental health support and divert pressure away from A&E.

3.37. **A&E Pilot -** A mental health practitioner working alongside the triage practitioner within A&E to facilitate early identification of those presenting with mental health difficulties, and increasing diversion. Early findings suggest this has reduced the numbers of people entering the department, and the duration of stay. In the first 4 weeks of the project the following outcomes were noted

Outcome	Numbers of patients	%
direct to MHA Assessment	3	2.8%
deflected to urgent outpatient clinic	3	2.8%
direct for informal inpatient admission	4	3.8%
assessed by triage practitioner due to high demand on both ED and RAID	11	10.7%
referred directly to OPHTT	2	1.9%
signposted to support services as no need for RAID at time of present'n	38	37%
seen by RAID	43	41%

3.38. **The Anthony Seddon Fund Pilot -** Practitioners from the Pennine Care NHSFT Home Treatment Team working alongside a community voluntary organisation (The Anthony Seddon Fund) providing an afternoon drop in to access professional advice and support. In the first 23 days of Drop Ins

- At least 70 people took up appointments with CMHT nurse
- At least 50 different people have seen CMHT nurse
- 3 – 8 appointments per day

3.39. It is hoped to extend these pilots and use the learning to inform future service arrangements that provide mental health support within the most appropriate setting.

3.40. Admissions Avoidance support in the community

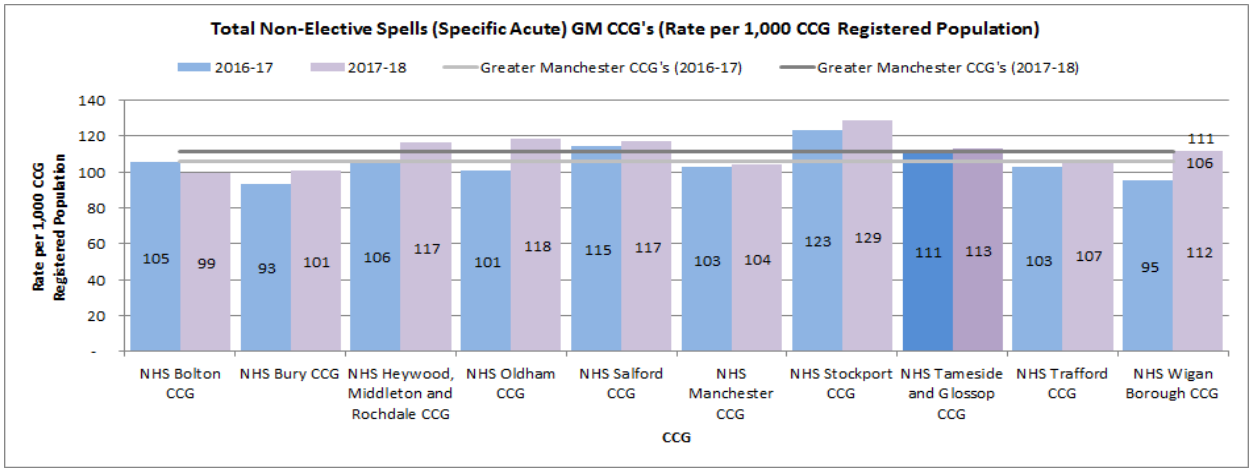
3.41. The Integrated Urgent Care Team (IUCT) supports people in their own home when wrap around care can avoid an admission. The table below shows a comparison of three months of IUCT activity which includes both admissions avoidance and discharge support and shows an increase in activity.

IUCT Activity	Jan	Feb	Mar	Average	Total
2017/18	2368	2527	2266	**2387**	**7161**
2018/19	4102	3285	3335	**3574**	**10722**
			Diff	**1187**	**3561**

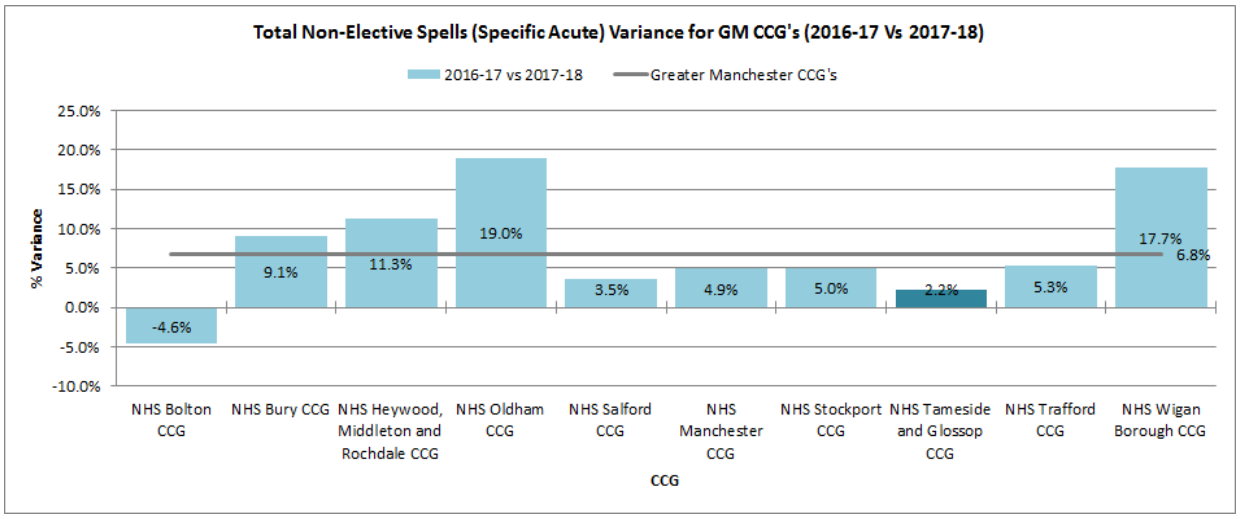
3.42. IUCT working with Integrated Neighbourhood Teams are key to maintaining people in their own homes and it is expected increasing numbers of people will remain at home receiving the care they need to support a prompt recovery.

3.43. Non-elective Admissions

3.44. There will always be a need for some people to receive more hospital based care than can be delivered in A&E and in these situations a non-elective admission will take place. The rate of non-elective admissions is just below the GM average for 2017/18.

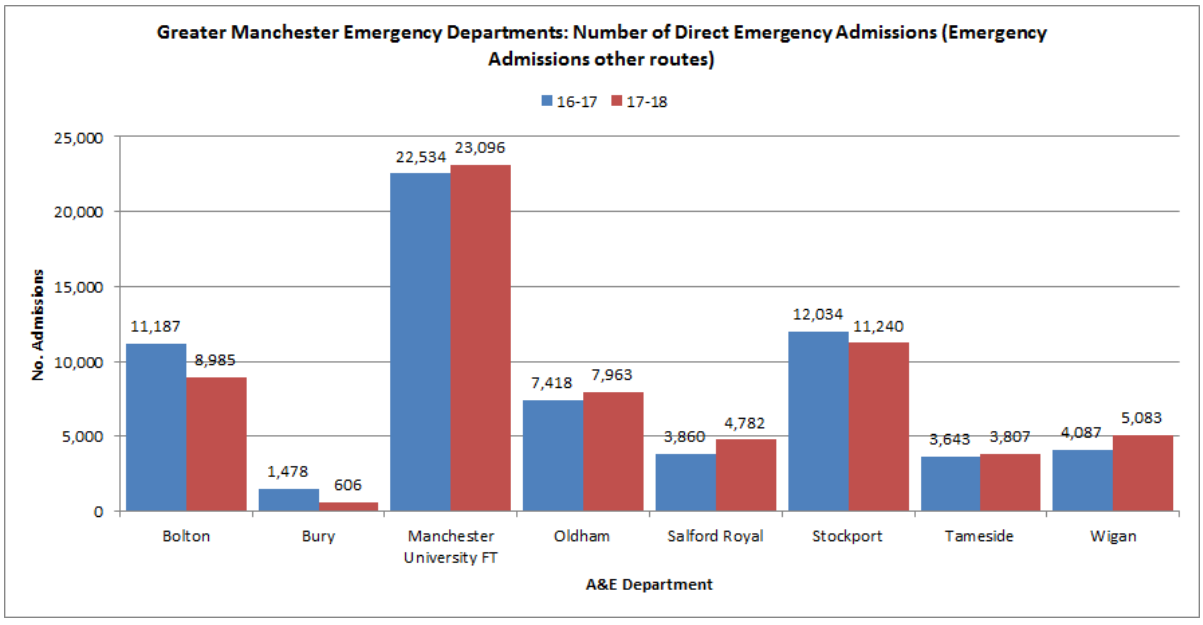


3.45. However, the level of growth is one of the lowest in GM.



3.46. Not all patients admitted attend A&E as some patients seen by a GP or other Health Care Professional in the community are identified as needing an admission but not needing A&E care in these situations a direct admission can take place.

3.47. The amount of **direct admissions** will vary by hospital as it is affected by total bed capacity, the medical/surgical split and the case mix of the Trust. The ICFT has increased the amount of people admitted directly which is likely to have improved the experience for that patient as well as reducing unnecessary activity in A&E.



3.48. The level of patients admitted from A&E can be seen as a conversion rate. As would be expected the older the patient the higher the conversion rate so 0-18 year olds are admitted 15.8% of the time in 17/18 whereas 85+ cohort are admitted 57.6% of the time.

Age Bands	2015/16	2016/17	% change 15/16 vs 16/17	2017/18	% change 16/17 vs 17/18	% change 15/16 vs 17/18
0 to 18	14.0%	15.1%	7.7%	15.8%	4.7%	11.3%

19 to 64	17.7%	16.2%	-8.3%	16.2%	0.1%	-9.0%
65 to 74	41.9%	41.0%	-2.3%	39.7%	-3.2%	-5.8%
75 to 84	52.2%	49.3%	-5.6%	49.9%	1.1%	-4.7%
85+	58.0%	57.2%	-1.5%	57.6%	0.7%	-0.8%
Grand Total	**24.1%**	**23.4%**	**-2.9%**	**23.8%**	**1.6%**	**-1.4%**

3.49. The table also shows the change in conversion rate over the last two years with a reduced percentage being admitted across all age ranges except the 0-18 cohort. However, this increase may be due to usage of Children's Observation and Assessment Unit which are short stay observation units that are important parts of a pathway for many youngsters and so may skew the data as they are reported as Non-elective admissions. Further analysis would be needed to verify this.

3.50. **Ambulatory Care Pathways** admissions are also recorded as non-elective admissions (with the exception of the Outpatient DVT pathway) but involve attendance at a short stay unit rather than admission to a bed overnight.

3.51. There are eight Ambulatory Care Pathways at the ICFT as shown below but this is not the entirety of activity on Ambulatory Care as all ambulatory sensitive conditions can be seen on the Unit. The table only shows first presentation and does not include where patients come back for follow up as these are then treated as ward attenders.

Month	Pneumonia	Cellulitis	IPDVT	UTI	Chest Pain	PE	TIA	DVT	Grand Total
Q1 16/17	20	56	216	5	393	183	107	417	1397
Q2 16/17	21	72	179	7	329	162	91	402	1263
Q3 16/17	21	28	135	4	284	165	87	347	1071
Q4 16/17	30	29	145	2	490	166	100	369	1331
Q1 17/18	22	56	142	5	474	165	89	404	1357
Q2 17/18	21	64	163	10	415	131	91	389	1284
Q3 17/18	19	49	161	14	492	154	107	404	1400
Q4 17/18	34	76	179	3	416	151	96	380	1335

3.52. Patients may attend the Ambulatory Care Unit directly following a GP or other Health Care professional assessment or may be streamed from triage in A&E.

3.53. As services that can support people at home increase the numbers of non-elective admissions is likely to decrease and through increased use of the Digital Health Hub where possible opportunities for direct admissions will be maximised.

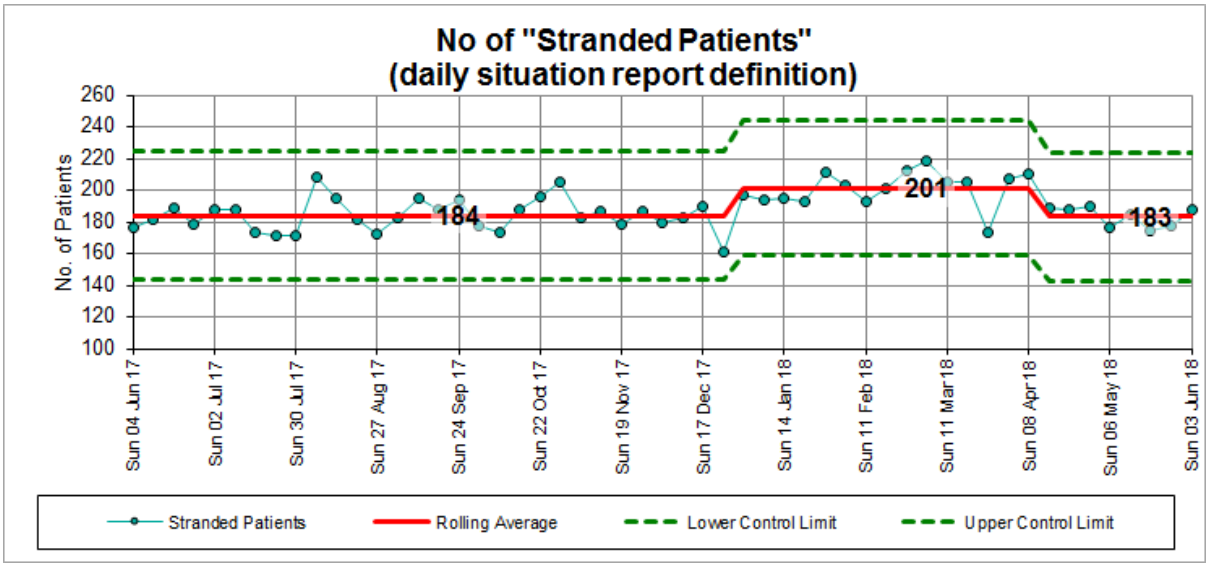
3.54. The development of frailty beds is likely to increase zero day length of stay admissions in a similar way to Children's Observation and Assessment Unit enabling people to be fully assessed out of A&E but reducing the need to admit someone to a ward.

4. Managing Bed Capacity

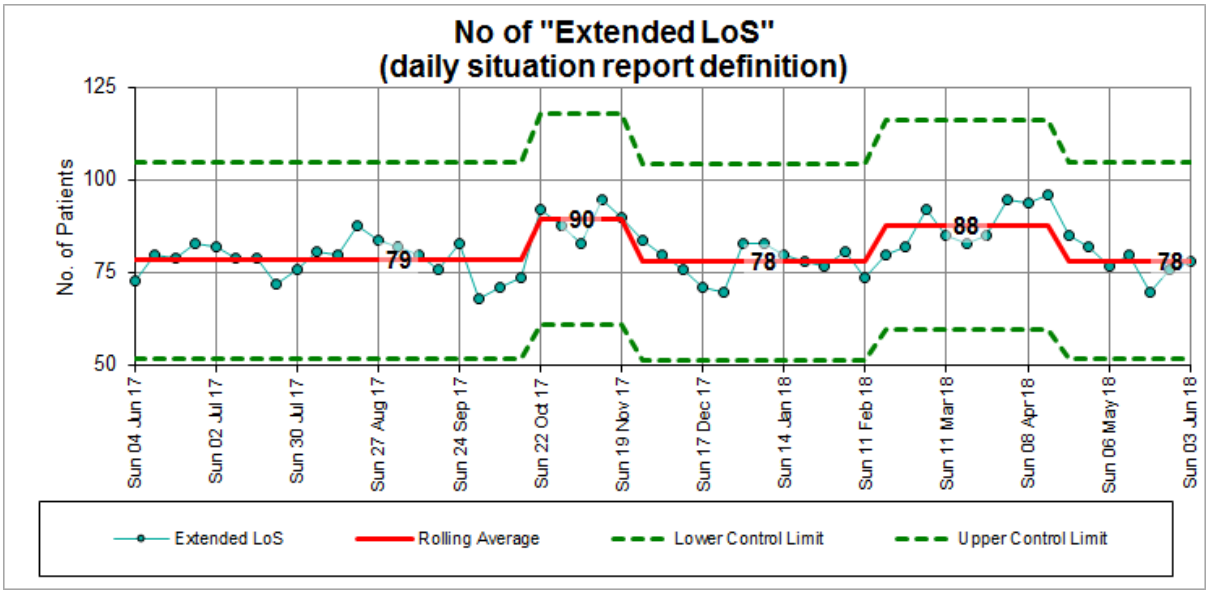
4.1. When patients are admitted the treatment plan aims to discharge them as promptly as possible. Nationally people who remain in a hospital bed for seven days or more are classed as a **Stranded Patient.** Patients may have been admitted through an elective or non-elective route and some would be normally be expected to have a seven-day or longer stay e.g. patients who have had a stroke, myocardial infarction, fractured neck of femur, or need neurorehabilitation. The measure is a snapshot taken at either midnight or 8am. Whilst comparisons are made across hospitals it is

usually not a true comparison because different hospitals provide significantly different services.

4.2. The numbers of stranded patients for Tameside and Glossop CCG have been fairly consistent between June and December 2017 when numbers increased over the winter period resulting in an increase in the moving average from 184 patients to 201 patients, however since April the numbers have reduced enough to reduce the moving average back down to just below levels prior to Winter.



4.3. Patients with stays of 21+ days are classed as **Super Stranded Patients** (Extended LoS). The graph below shows Super Stranded/Extended Length of Stay (LoS) patients for Tameside and Glossop CCG and is fairly cyclical with peaks over the Winter period and then recovery through the Summer Period.

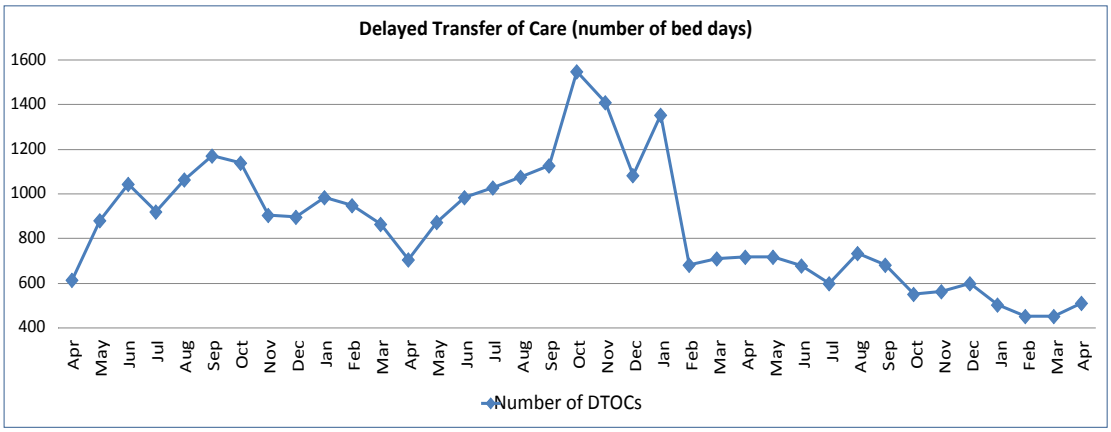


4.4. Within the ICFT there have been similar reductions in Stranded and Super Stranded patients with Stranded patients moving average reducing by 18 since April which matches the CCG reduction and Super Stranded moving average reducing by 14 which is higher than the CCG reduction. Very long LoS have also been reduced at the ICFT through some targeted work and reductions over the last two years are shown in the table below:

Very Long Los at T&G ICFT

LoS	Apr-16	Apr-17	Apr-18
50-99	31	24	24
100+	15	10	4
Total	**46**	**34**	**28**

4.5. When patients are well and should have been discharged but are still in a hospital bed they are classed as a **Delayed Transfer of Care (DTOC).** There has been a significant improvement in DTOCs over the past 3 years at the ICFT. This has been supported by many of the Early Supported discharge schemes and the collaborative working between health and Social Care.



Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	**511**											
2017/18	716	716	678	600	734	681	550	561	598	504	453	453
2016/17	705	871	985	1027	1076	1126	1547	1407	1084	1354	682	710
2015/16	613	880	1044	920	1064	1169	1139	903	896	984	946	863

4.6. DTOC is generally reported on a trust or Local Authority basis, however, GM have been producing some acute DTOC analysis locally which shows that typically most of the CCG DTOCs happen at the ICFT and Manchester Foundation Trust.

Delayed Transfers of Care

Trust	Daily - 31/05/18			DTOC Monthly			DTOC 12 Months Rolling ****	
	¥ DTOC - Delayed Days per Occupied Bed	Occupied Beds		Mar-18 Published	Feb-18 Published	Jan-18 Published	Previous 12 Months	Current 12 Months
Greater Manchester	**3.1%**	**90.7%**		**3.8%**	**4.1%**	**4.0%**	**4.8%**	**3.9%**
Bolton	4.0%	91.9%		3.4%	6.1%	8.2%	6.3%	5.6%
MFT	4.8%	91.3%		4.2%	4.5%	4.6%	-	-
PAHT	1.7%	89.0%		4.3%	8.7%	3.3%	2.0%	3.4%
SRFT	1.5%	89.3%		2.7%	3.4%	3.3%	5.1%	3.4%
Stockport	1.6%	89.6%		5.7%	4.8%	4.2%	8.9%	4.6%
Tameside	3.8%	94.3%		2.9%	3.2%	3.2%	7.8%	4.1%
WWL	1.0%	90.9%		1.5%	2.1%	1.5%	0.4%	1.4%

4.7. Pennine Care Trust have recently reviewed the guidance around the recording or DTOCs and have now changed the way the record the information to ensure that the information is more accurate. This has resulted in the numbers of DTOCs recorded to increase.

4.8. IUCT and the Integrated Neighbourhood Teams are key to reducing the level of Stranded patients and DTOCs ensuring that discharge planning starts on admission and arranging care in the home as soon as possible. Effective utilisation of Intermediate Care in a patient's own homes or if needed a community bed will reduce length of stays and improve recovery.

4.9. The use of Discharge to Assess beds will support recovery and help ensure that people return to their own home wherever possible rather than to a long term residential bed.

5. Conclusion

5.1. The commitment to keeping people well and providing effective alternatives to hospital based care will support improvements in clinical outcomes and patient experience.

5.2. For those people who need hospital based support there will be focus on effective recovery and a Home First approach on discharge.

5.3. However as the system develops and only the very sick people attend A&E the current performance standards that are based on time to discharge from A&E may no longer be appropriate as the clinical level of need will determine the time needed to fully assess the patient's need and agree an appropriate care pathway and this may exceed the current 4 hour standard.

5.4. Likewise the increased use of LOS of zero days and home based care will result in only the sickest people being admitted overnight and these may need a LOS of greater than 7 days before they are well enough to be discharged.

End Of Life Dashboard

Dates

Q2 (2016/17)	Q3 (2016/17)	Q4 (2016/17)	Q1 (2017/18)	Q2(2017/18)
July to Sept	Oct-Dec	Jan to March	April to June	July to Sept
1st July to 30th Sept	1st Oct-31st Dec	Jan 1st -32st March	1st April -30th June	1st July-30th Sept

* each quarter contains a complete years worth of data for data quality reasons

Notes

* Usual Place of Residence includes Nursing and Residential Home

** Although the report is produced Quarterly, this data is for a full *rolling* 12 month period due to small numbers

RAG rating boundaries

Green = 10% lower than the T&G average
Amber= within 10% each way of the T&G average
Red = 10% higher than the T&G average

Conditions		
Cancer		C00- D48
Dementia and Alzheimer Disease		F03, F019, G309
Chronic Lower Respiratory Disease		J40-J47
Chronic Heart Failure		I25, I50
Neurological conditions		
	Parkinson Disease	G20
	Huntington Disease	G10
	Motor Neurone	G12.2
	Multiple Sclerosis	G35
	progressive supranuclear palsy	G23.1
	multiple-system atrophy	
	Muscular Dystrophy	G71

Sources:

PCMD dates for relevant quarter
(nww.openexeter.nhs.uk)

Practice level mortality by place of death

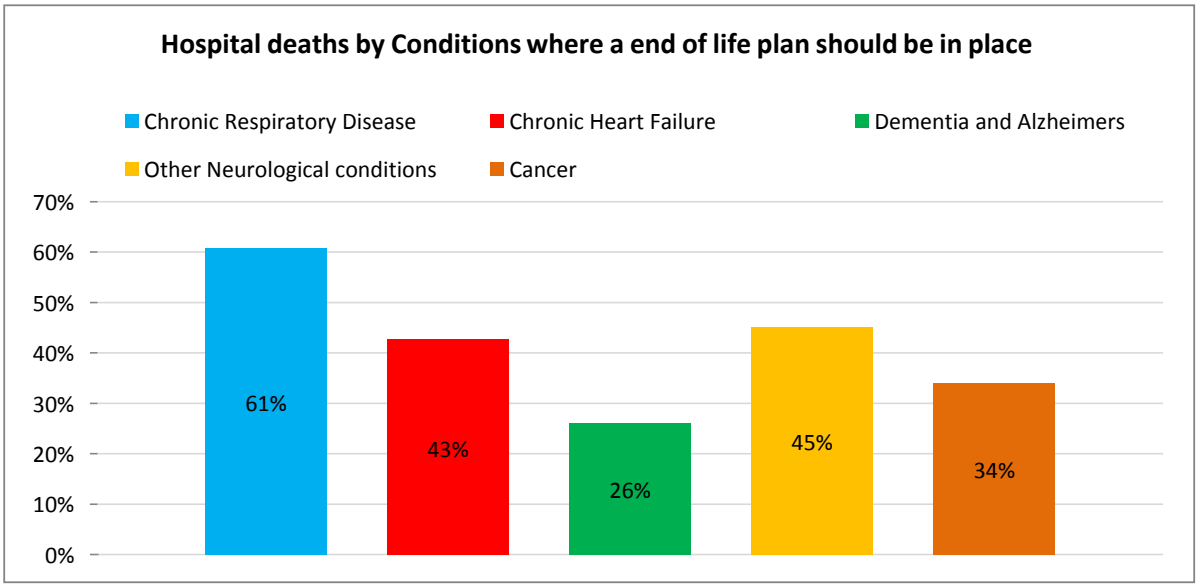
GP practice code	Prac Name	Ward	Community Neighbourhood	Health Neighbourhood	Total Observe ddeaths	Hospital		Usual place of residence*		Residential/Nursing home		Hospice		Other	
						number	%	number	%	number	%	number	%	number	%
P89003	Albion	St Peter's	North	Ashton	**99**	47	47%	37	37%	2	2%	13	13%	0	0%
Y02586	Ashton GP Service	St Peter's	North	Ashton	**15**	8	53%	5	33%	0	0%	2	13%	0	0%
P89008	Bedford House	St Peter's	North	Ashton	**74**	36	49%	24	32%	3	4%	11	15%	0	0%
P89017	Chapel Street	St Peter's	North	Ashton	**38**	23	61%	11	29%	0	0%	4	11%	0	0%
P89011	Gordon Street	Ashton St Michael's	North	Ashton	**33**	15	45%	11	33%	2	6%	5	15%	0	0%
Y02713	Guide Bridge	St Peter's	North	Ashton	**23**	10	43%	11	48%	0	0%	2	9%	0	0%
P89609	Stamford	Ashton St Michael's	North	Ashton	**24**	12	50%	10	42%	0	0%	2	8%	0	0%
P89033	Tame Valley	St Peter's	North	Ashton	**60**	23	38%	23	38%	3	5%	11	18%	0	0%
P89020	The Highlands	St Peter's	North	Ashton	**65**	31	48%	26	40%	0	0%	8	12%	0	0%
P89613	Waterloo	Ashton Waterloo	North	Ashton	**24**	11	46%	6	25%	1	4%	6	25%	0	0%
P89030	West End	St Peter's	North	Ashton	**40**	26	65%	11	28%	0	0%	3	8%	0	0%
P89616	Ashton Road	Droylsden East	West	Denton	**1**	0	0%	0	0%	0	0%	0	0%	1	100%
P89015	Millgate	Denton West	West	Denton	**236**	127	54%	67	28%	6	3%	36	15%	0	0%
P89018	Denton	Denton North East	West	Denton	**107**	58	54%	31	29%	0	0%	18	17%	0	0%
Y02663	Droylsden Medical	Droylsden West	West	Denton	**15**	6	40%	6	40%	0	0%	3	20%	0	0%
P89029	Market Street	Droylsden East	West	Denton	**68**	32	47%	25	37%	3	4%	8	12%	0	0%
P89010	Medlock Vale	Droylsden East	West	Denton	**77**	41	53%	21	27%	1	1%	14	18%	0	0%
P89004	Awburn	Longdendale	South	Hyde	**72**	25	35%	32	44%	4	6%	10	14%	1	1%
P89012	Clarendon	Hyde Godley	South	Hyde	**69**	25	36%	31	45%	3	4%	10	14%	0	0%
P89016	Donneybrook	Hyde Godley	South	Hyde	**96**	41	43%	39	41%	7	7%	9	9%	0	0%
P89013	Hattersley	Longdendale	South	Hyde	**53**	23	43%	20	38%	1	2%	7	13%	2	4%
P89014	Haughton Thornley	Hyde Werneth	South	Hyde	**137**	67	49%	43	31%	7	5%	20	15%	0	0%
P89002	The Brooke	Hyde Godley	South	Hyde	**107**	45	42%	39	36%	4	4%	18	17%	1	1%
P89602	The Smithy	Longdendale	South	Hyde	**31**	16	52%	9	29%	0	0%	5	16%	1	3%
C81615	Cottage Lane	Hadfield South	Glossop	Glossop	**25**	10	40%	11	44%	0	0%	4	16%	0	0%
C81660	Hadfield	Padfield	Glossop	Glossop	**19**	6	32%	11	58%	0	0%	1	5%	1	5%
C81077	Howard Street	Howard Town	Glossop	Glossop	**29**	10	34%	15	52%	0	0%	4	14%	0	0%
C81106	Lambgates	Padfield	Glossop	Glossop	**51**	26	51%	21	41%	0	0%	4	8%	0	0%
C81081	Manor House	Howard Town	Glossop	Glossop	**97**	37	38%	42	43%	6	6%	12	12%	0	0%
C81640	Simmondley	Simmondley	Glossop	Glossop	**23**	8	35%	12	52%	0	0%	3	13%	0	0%
P89021	Davaar	Dukinfield	East	Stalybridge	**123**	54	44%	51	41%	5	4%	13	11%	0	0%
P89026	Grosvenor	Dukinfield Stalybridge	East	Stalybridge	**54**	28	52%	17	31%	2	4%	7	13%	0	0%
P89022	King Street	Dukinfield	East	Stalybridge	**33**	19	58%	11	33%	1	3%	2	6%	0	0%
P89005	Lockside	Stalybridge South	East	Stalybridge	**68**	22	32%	27	40%	5	7%	14	21%	0	0%
Y02936	Millbrook	Stalybridge South	East	Stalybridge	**16**	6	38%	7	44%	0	0%	3	19%	0	0%
P89612	Mossley	Mossley	East	Stalybridge	**8**	5	63%	2	25%	0	0%	0	0%	1	13%
P89618	Pike Medical	Mossley	East	Stalybridge	**21**	11	52%	8	38%	0	0%	2	10%	0	0%
P89023	St Andrews	Stalybridge North	East	Stalybridge	**46**	21	46%	15	33%	6	13%	4	9%	0	0%
P89007	Staveleigh	Stalybridge North	East	Stalybridge	**87**	40	46%	29	33%	9	10%	9	10%	0	0%
P89025	Town Hall	Dukinfield	East	Stalybridge	**28**	16	57%	10	36%	0	0%	2	7%	0	0%
ASHTON					**495**	**242**	**49%**	**175**	**35%**	**11**	**2%**	**67**	**14%**	**0**	**0%**
DENTON					**504**	**264**	**52%**	**150**	**30%**	**10**	**2%**	**79**	**16%**	**1**	**0%**
HYDE					**565**	**242**	**43%**	**213**	**38%**	**26**	**5%**	**79**	**14%**	**5**	**1%**
GLOSSOP					**244**	**97**	**40%**	**112**	**46%**	**6**	**2%**	**28**	**11%**	**1**	**0%**
STALYBRIDGE					**484**	**222**	**46%**	**177**	**37%**	**28**	**6%**	**56**	**12%**	**1**	**0%**
Tameside & Glossop					**2292**	**1067**	**47%**	**827**	**36%**	**81**	**4%**	**309**	**13%**	**8**	**0%**

*** Usual Place of Residence includes Nursing and Residential Home**

Mortality by Residential Care Homes in Tameside & Glossop by place of death				
Name of Nursing home	Total number of deaths in care home	Usual Residence	Not usual residence	Usual Residence but died in hospital
Auden House Care Home, Audenshaw	5	5	0	0
Balmoral Care Home, Hyde	15	13	2	2
Beechfield, Glossop	1	1	0	1
Beechwood House Glossop	1	1	0	2
Bourne House, Ashton-under-Lyne	11	11	0	3
Bowlacre, Hyde	8	8	0	5
Carson House Care Centre, Stalybridge	6	5	1	4
Charnley House Residential Home, Hyde	7	6	1	2
Clarkson House Nursing Home, Ashton-under-Lyne	8	8	0	3
Daisy Nook House, Ashton-under-Lyne	7	7	0	2
Darnton House Ashton-under-Lyne	6		6	0
Downshaw Lodge Care Centre, Ashton-under-Lyne	8	8	0	2
Fairfield View, Audenshaw	1		1	3
Fir Trees Centre, Dukinfield	11	9	2	0
Firbank House Nursing and Residential Home, Ashton-under-Lyne	8	5	3	0
Godley Court, Nursing Home, Hyde	19	17	2	0
Grange View Intermediate Care Home, Hyde	1	0	1	2
Greatwood House, Denton	18	16	2	7
Guide Lane Nursing Home, Audenshaw	20	19	1	2
Hatton Grange Care Home, Hyde	21	18	3	2
Holme Lea Care Home, Stalybridge	9	7	2	6
Hurst Hall Home, Ashton-under-Lyne	8	8	0	4
Hyde Nursing Home, Hyde	22	18	4	3
Kings Park Nursing Home, Ashton-under-Lyne	14	13	1	0
Kingsfield, Ashton-under-Lyne	2	2	0	0
Laurel Bank Care Home, Hyde	8	6	2	1
Millbrook Care Centre, Stalybridge	10	7	3	2
Moss Cottage Care Home, Ashton-under-Lyne	11	11		0
Newton Court, Hyde Nursing Home, Hyde	1	0	1	1
Oakford Manor Nursing Home, Glossop	17	14	3	2
Oakwood Care Centre, Stalybridge	4	3	1	2
Parkhill Care Home, Stalybridge	19	15	4	1
Pendlebury Court Care Home, Glossop	7	6	1	2
Pennine Care Centre, Glossop	9	9	0	1
Pole Bank Hall, Hyde	11	9	2	5
Riverside Care Centre, Hyde	23	20	3	1
Sandon House, Market Street, Mossley	0	0	0	0
St. Lawrence Lodge, Denton	4	4	0	1
Staley House Stalybridge	7	6	1	4
Stamford Court Nursing Home, Stalybridge	34	21	13	1
Staveleigh House, Hyde	1	1	0	0
Sunnyside	9	9	0	3
The Beeches, Yew Tree Lane, Dukinfield	7	7	0	3
The Lakes Care Centre, Dukinfield	31	29	2	7
The Regency Hall Care Home, Hadfield Glossop	1	0	1	0
The Risings, Glossop	6	6	0	1
The Sycamores, Hyde	5	5	0	4
The Vicarage Care Home, Audenshaw	10	9	1	4
Thorncliffe Grange Nursing Home, Denton	16	13	3	1
Werneth Court, Nursing Home, Hyde	1	1	0	0
Willow Bank Rest Home, Hadfield, Glossop,	7	7	0	1
Yew Tree Care Home, Dukinfield	15	15	0	5
Total	511	438	73	109

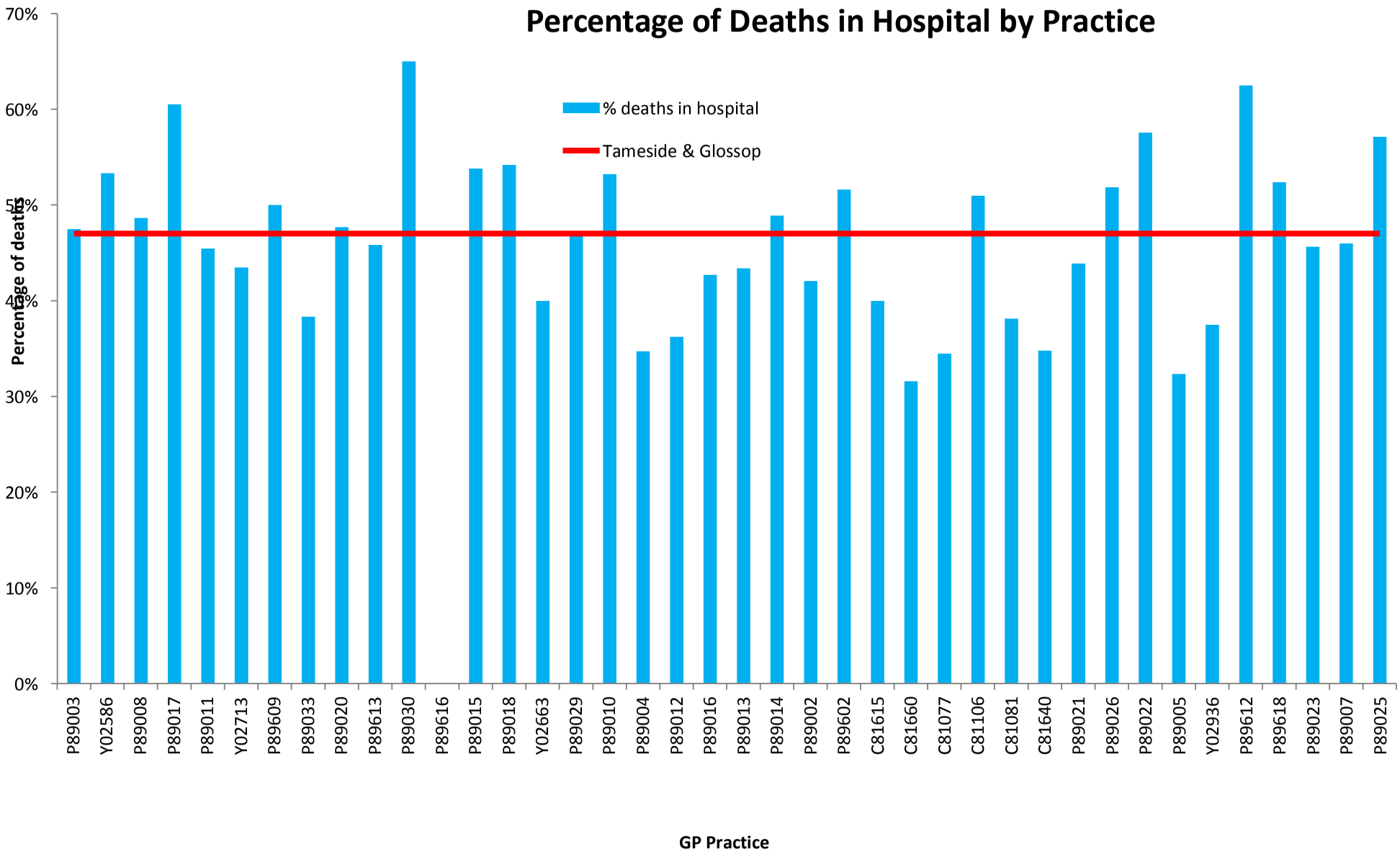
Deaths in hospital from conditions deemed applicable to end of life care

Condition	Total Deaths from condition	Hopsital	Usual Place of Residence	Hospice	Other
Chronic Respiratory	199	121	53	21	4
		61%	27%	11%	2%
Chronic Heart Failure	239	102	121	12	4
		43%	51%	5%	2%
Dementia and Alzheimers	405	106	220	44	35
		26%	54%	11%	9%
Other Neurological	31	14	12	5	31
		45%	39%	16%	100%
Cancer	739	252	263	196	28
		34%	36%	27%	4%



Neurological conditions included:

Parkinsons, Huntingtons, Motor Neurone disease, Multiple sclerosis, Muscular dystrophy, progressive supranuclear palsy, multiple-system atrophy


Percentage of Deaths in Hospital by Practice
% deaths in hospital
Tameside & Glossop
Percentage of deaths
70%
60%
50%
40%
30%
20%
10%
0%
P89003
Y02586
P89008
P89017
P89011
Y02713
P89609
P89033
P89020
P89613
P89030
P89616
P89015
P89018
Y02663
P89029
P89010
P89004
P89012
P89016
P89013
P89014
P89002
P89602
C81615
C81660
C81077
C81106
C81081
C81640
P89021
P89026
P89022
P89005
Y02936
P89612
P89618
P89023
P89007
P89025
GP Practice

Hospital deaths

Neighbourhoods	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4
ASHTON (North)	51%	49%														
DENTON (West)	51%	52%														
HYDE (South)	46%	43%														
GLOSSOP (Glossop)	46%	40%														
STALYBRIDGE (East)	45%	46%														
Tameside & Glossop	48%	47%